PD-ABF-559
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A.I.D. EVALUATION SUMMARY – PART I

1. BEFORE FILLING OUT THIS FORM, READ THE ATTACHED INSTRUCTIONS.
2. USE LETTER QUALITY TYPE, NOT "DOT MATRIX" TYPE

IDENTIFICATION DATA

A. Reporting A.I.D. Unit:

Mission or AID/W Office Office of Health
(ES# _____)

B. Was Evaluation Scheduled In Current FY Annual Evaluation Plan?

Yes ☐ Slipped ☒ Ad Hoc ☐

Evaluation Plan Submission Date: FY 91 Q ___

C. Evaluation Timing

Interim ☐ Final ☒ Ex Post ☐ Other ☐

D. Activity or Activities Evaluated (List the following information for project(s) or program(s) evaluated; if not applicable, list title and date of the evaluation report.)

Project No.	Project /Program Title	First PROAG or Equivalent (FY)	Most Recent PACD (Mo/Yr)	Planned LOP Cost (000)	Amount Obligated to Date (000)
931-1018	Communication for Child Health (HEALTHCOM)	1978	9/93	19,500	18,549

ACTIONS

E. Action Decisions Approved By Mission or AID/W Office Director

Action(s) Required	Name of Officer Responsible for Action	Date Action to be Completed
No action required - Follow-on project 936-5984 Communication and Marketing for Child Survival awarded 8/31/89.		

Date Submitted for Approval: 3/19/92

(Attach extra sheet if necessary)

APPROVALS

F. Date Of Mission Or AID/W Office Review Of Evaluation: (Month) January (Day) 21 (Year) 1991

G. Approvals of Evaluation Summary And Action Decisions:

	Project/Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or AID/W Office Director
Name (Typed)	Holly Fluty		Genease Pettigrew	Ann Van Dusen
Signature	Holly Fluty		Genease L. Pettigrew	Ann Van Dusen
Date	25 November 91		3-23-92	

ABSTRACT

H. Evaluation Abstract (Do not exceed the space provided)

The Academy for Educational Development (AED) was selected to administer the HEALTHCOM (Communication for Child Survival) project to build upon the public health communication methodology developed during the previous six-year Mass Media and Health Practices (MMHP) project. The methodology integrated communication and social marketing with traditional channels of health education, training and product distribution. Team members reviewed existing documentation and interviewed A.I.D. and HEALTHCOM staff, HEALTHCOM resident advisors and USAID missions (by facsimile and telephone), representatives of related projects, private voluntary organizations and international organizations. Findings in this approximately 85 page report issued in May, 1991 include:

- By focusing on communication only, HEALTHCOM could develop and provide state-of-the-art strategies, methodologies and tools for use by itself as well as ministries of health, related A.I.D. projects and other donors.
- Formative research has been highly relevant to implementation of the communication programs at the field level. Summative research is seen as less important to the immediate goals of the host country counterparts (and others working at the field level).
- There were a number of criticisms regarding the turn-around time on the research.
- HEALTHCOM's approach has generally produced the desired behavioral change. However, such a change does not result from every intervention in every country. Further comparative analysis is warranted.
- HEALTHCOM produced noteworthy products; however, there were complications. Delays, burdensome contract requirements, and deliverables with somewhat conflicting objectives characterized the problems HEALTHCOM experienced in producing key outputs.

Overall, the team found that HEALTHCOM has accomplished nearly all its objectives and can be considered a successful project.

COSTS

I. Evaluation Costs

1. Evaluation Team

Name	Affiliation	Contract Number OR TDY Person Days	Contract Cost OR TDY Cost (U.S. $)	Source of Funds
Tom Mosser, Pragma Corp Senior Associate		18 days	$264/day	R&D/Health
Dr. Jane Bertrand, Tulane University		15 "	$278/day	ASSIST
Christian Hougen, Pragma Corp Project Assistant		30 "	--	contract

2. Mission/Office Professional Staff Person-Days (Estimate) 65

3. Borrower/Grantee Professional Staff Person-Days (Estimate) 35

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A.I.D. EVALUATION SUMMARY - PART II

SUMMARY

J. Summary of Evaluation Findings, Conclusions and Recommendations (Try not to exceed the three (3) pages provided)
Address the following items:
- Purpose of evaluation and methodology used
- Purpose of activity(ies) evaluated
- Findings and conclusions (relat. to questions)
- Principal recommendations
- Lessons learned

Mission or Office:	Date This Summary Prepared:	Title And Date Of Full Evaluation Report:
Office of Health	November 25, 1991	May 1991 Final Evaluation of the HEALTHCOM Project

I. BACKGROUND

In August 1985, the Academy for Educational Development (AED) was selected through a competitive procurement by S&T/Health to administer the HEALTHCOM (Communication for Child Survival) project for five years to build upon the public health communication methodology developed during the previous six-year Mass Media and Health Practices (MMHP) project. The methodology integrated communication and social marketing with traditional channels of health education, training and product distribution. Overall, the team found that HEALTHCOM has accomplished nearly all its objectives and can be considered a successful project. Specific findings are based upon the 12 questions that S&T/Health asked the evaluation team to investigate. These questions are discussed under three headings: Project Management, Project Research and Project Deliverables and Outputs.

II. EVALUATION PLAN AND METHODOLOGY

S&T/Health requested the Pragma Corporation's Project ASSIST to undertake the final evaluation of HEALTHCOM during January 1991. The evaluation team was asked to assess the quality and documented accomplishments of the project. Team members reviewed existing documentation and interviewed A.I.D. and HEALTHCOM staff, HEALTHCOM resident advisors and USAID missions (by facsimile and telephone), representatives of related projects, private voluntary organizations and international organizations. S&T/Health identified three broad questions for the team to address:

1. What have A.I.D. and AED learned over the course of this project that could help them to manage HEALTHCOM II more efficiently and effectively?
2. Is HEALTHCOM's research portfolio technically sound and appropriate for A.I.D.'s needs?
3. Has AED successfully completed its contractual requirements under HEALTHCOM (contract DPE-1018-C-00-5063-00)?

Expanding on these general questions, S&T/Health specified a list of 12 specific questions for the evaluation team to investigate.

III. FINDINGS

A. Project Management

Horizontal versus Vertical. There are many advantages in a horizontal project, such as HEALTHCOM, which can apply expertise in communication to a wide range of public health interventions. By focusing on communication only, HEALTHCOM could develop and provide state-of-the-art strategies, methodologies and tools for use by itself as well as ministries of health, related A.I.D. projects and other donors.

Centrally Managed Buy-in Projects. Buy-ins account for some 45 percent of total project expenditures (USAID missions, 37 percent; Regional Bureaus, 8 percent), and S&T/Health the remaining 55 percent.

B. Research

The Multidisciplinary Nature of HEALTHCOM. One of the strengths of HEALTHCOM is that it has effectively integrated the principles and practices of a number of different fields into its methodology, including communication research, development communication, social marketing, applied anthropology, instructional design, and behavioral psychology.

Type of Research Conducted. HEALTHCOM's methodology is a research-based approach to the development of communications programs that bring about behavioral change in the area of child survival. Research conducted in the field falls into two broad categories: formative and summative. In addition to formative and summative research, the HEALTHCOM contract called for 10 behavioral studies to be conducted.

Quality of the Research. HEALTHCOM has assembled a very impressive research portfolio, both in terms of quantity of reports and the uniformly high quality of work. Researchers interviewed during this evaluation are clearly at the forefront of this field. No doubt some persons in the field still feel some of the reports are "too technical." However, HEALTHCOM's subcontractors have succeeded in communicating the basic points in a language that can be fairly readily understood by other health professionals.

Immediate and Long-term Relevance of the Research. Formative research has been highly relevant to implementation of the communication programs at the field level. Summative research is seen as less important to the immediate goals of the host country counterparts (and others working at the field level).

Timeliness of Results. There were a number of criticisms regarding the turn-around time on the research.

Evidence of the Effectiveness of the HEALTHCOM Methodology. HEALTHCOM's approach has generally produced the desired behavioral change. However, such a change does not result from every intervention in every country. The synthesis of results to be compiled from the different sites will allow for a greater understanding of the conditions under which change does or does not occur.

Institutionalization of the Communication Research Methodologies. Regarding formative research, there was consensus among the persons interviewed that in most countries institutionalization of the research methodology had occurred in a preliminary way. Summative research involves skills usually gained through doctoral level training in the social sciences. Thus, it is unrealistic to expect counterparts to master these skills through on-the-job training at the field level.

Potential Conflict of Subcontractor as Evaluator. Both the implementation and summative evaluation components of HEALTHCOM were included in a single contract. Questions were raised as to whether S&T/Health's interests would be better served by having the internal evaluation conducted by an independent contractor. While the current arrangement could be perceived as a conflict of interest, the benefits have outweighed the drawbacks.

C. Project Deliverables and Outputs

Contract Compliance. HEALTHCOM produced noteworthy products; however, there were complications. Particular consideration was given to the degree that contract-specified deliverables were achievable in light of the project's design. HEALTHCOM completed production of the required deliverables, which have achieved A.I.D.'s objectives in advancing behavioral research and health communication methodology while at the same time supporting public health interventions. However, delays, burdensome contract requirements,

and deliverables with somewhat conflicting objectives characterized the problems HEALTHCOM experienced in producing these key outputs.

HEALTHCOM's Major Media Products. Working with ministries of health, multilateral donors, USAID missions, private voluntary organizations, other A.I.D. projects, private research and advertising firms, HEALTHCOM designed a wide range of promotional and educational materials.

IV. RECOMMENDATIONS

Inasmuch as HEALTHCOM has ended, these recommendations are offered for their relevance to HEALTHCOM II, the HEALTHCOM follow-on project.

A. Management Issues *(abridged)*

- S&T/Health should pursue improved coordination of centrally managed projects involved in child survival communication work.
- S&T/Health should review the apportionment of central and buy-in funds over the past 15 months of HEALTHCOM activity to determine the extent to which central funds are being used to support country-specific buy-ins and the impact this is having, or will have, on the project's funding forecasts.

B. Research *(abridged)*

Quality of the Research:

- To the extent further summative research is done, HEALTHCOM should maintain its high standards; don't consider cutting corners to reduce costs.
- In future projects, HEALTHCOM should use a far greater percentage of the available research funds for formative research, with more emphasis on monitoring.

Relevance and Timeliness of the Research:

- HEALTHCOM should strengthen efforts to work with in-country counterparts to develop their skills in asking the appropriate research questions and tailor research to their specific interests.
- HEALTHCOM should design formative research that can be done locally, on a fairly small scale, and with rapid turn-around.
- HEALTHCOM should adapt each study to the local realities; it should not attempt "standardization" of the methodology.

Institutionalization of Communication Research:

- HEALTHCOM should encourage counterparts to select relatively easy research designs for the formative research, which can be used on similar projects in the future.
- HEALTHCOM should avoid the temptation to "do the job for them" for the sake of expediting it; allow time for counterparts to learn from their mistakes.

C. Project Deliverables and Outputs *(abridged)*

- HEALTHCOM should track and report its expenditures for key deliverables, enabling S&T/Health to monitor expenditure patterns and assess the opportunity cost of these allocations to the project's broader objectives.
- S&T/Health and HEALTHCOM should consider increasing staff for editing, document production and general information management. HEALTHCOM should also create a small-scale information resource center.
- The HEALTHCOM II Midterm Evaluation team should inquire into additional media outputs and their application during its field site visits.

ATTACHMENTS

K. Attachments (List attachments submitted with this Evaluation Summary; always attach copy of full evaluation report, even if one was submitted earlier, attach studies, surveys, etc., from "on-going" evaluation, if relevant to the evaluation report.)

Final Evaluation of the Communication for Child Survival Project

COMMENTS

L. Comments By Mission, AID/W Office and Borrower/Grantee On Full Report

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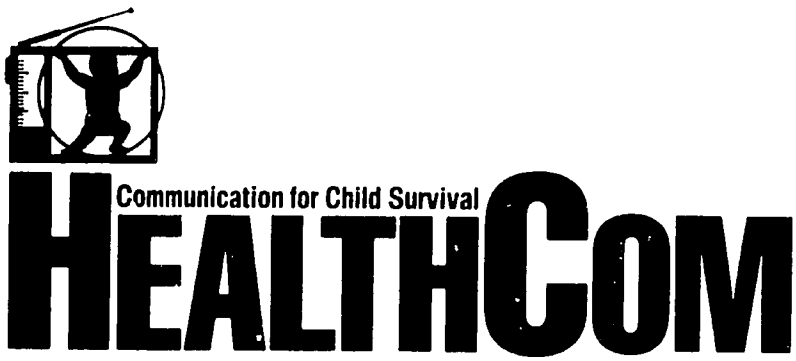
FINAL EVALUATION OF



Prepared by:

Thomas Moser
Jane T. Bertrand
Christian W. Hougen

Submitted to:

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

May 1991

THE PRAGMA CORPORATION
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HEALTHCOM Project
(Communication for Child Survival)
Final Evaluation

Prepared by:

Thomas A. Moser
Jane T. Bertrand
Christian W. Hougen

May, 1991

Submitted to the

Office of Health
Bureau for Science and Technology
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HEALTHCOM Project
(Communication for Child Survival)
Final Evaluation

Authors: Thomas A. Moser, Team Leader

Jane T. Bertrand

Christian W. Hougen

May, 1991

The Final Evaluation of HEALTHCOM was conducted under the auspices of the Office of Health, Bureau for Science and Technology, Agency for International Development. The evaluation was conducted by Project ASSIST of The Pragma Corporation and the report submitted to A.I.D. under Project #936-5939.05, Contract # DPE-5939-C-00-7003.

ACKNOWLEDGEMENTS

This evaluation was carried out at the request of the Office of Health, Bureau for Science and Technology (S&T/H), Agency for International Development (A.I.D.). It was coordinated by The Pragma Corporation through Project ASSIST, Project #936-5939.05, Contract #DPE-5939-C-00-7003.

The team members were:

Thomas A. Moser	Senior Associate The Pragma Corporation
Jane T. Bertrand	Associate Professor Tulane University, School of Public Health and Tropical Medicine
Christian W. Hougen	Project Assistant Project ASSIST The Pragma Corporation

This evaluation was conducted in Washington, D.C. from February 7, 1991 through February 23, 1991, with additional review from April 22, 1991, through May 31, 1991.

The team appreciates the assistance of the staff of HEALTHCOM, S&T/Health and all other persons interviewed. Special thanks go to the staff of Project ASSIST for their planning and logistical services, as well as their editorial and document production support.

SPECIAL ACKNOWLEDGEMENT

As part of on-going efforts to strengthen U.S. Government-Government of Japan aid donor coordination, S&T/Health invited Mr. Hideki Abe, Resident Representative of the Japan International Cooperation Agency (JICA), to observe key proceedings at the outset of this evaluation. S&T/Health has since had the pleasure of facilitating follow-up meetings to exchange information with JICA staff members, thereby improving our understanding of each Agency's policies, administrative procedures, and implementation and evaluation techniques. Team members and the Office of Health wish to thank Mr. Hideki for participating.

ACRONYMS AND ABBREVIATIONS

ACT	Applied Communication Technology
AED	Academy for Educational Development
A.I.D.	Agency for International Development
AIDSCOM	AIDS Communication Project
ARI	acute respiratory infection
ASCI-CCCD	Africa Child Survival Initiative-Combating Childhood Communicable Diseases Project
ASSIST	Advisory Service Support for Infant Survival Technology Project
CDD	Control of Diarrheal Disease
CDIE	Center for Development Information and Evaluation, A.I.D.
CTO	cognizant technical officer
DHS	Demographic and Health Surveys Project
EPI	Expanded Program on Immunization
FGD	focus group discussion
HEALTHCOM	Communication for Child Health Project
HPN	health, population, nutrition
INCAP	Institute of Nutrition of Central America and Panama
KAP	knowledge, attitudes and practices
MMHP	Mass Media and Health Practices Project
ORS	oral rehydration solution
ORT	oral rehydration therapy
PAHO	Pan American Health Organization
PATH	Program for Appropriate Technologies in Health
PIACT	Program for the Introduction and Adaptation of Contraceptive Technology
PPC	Bureau for Program and Policy Coordination, A.I.D.
PREMI	Programa de Reduccion de la Enfermedad y Muerte Infantil
PRICOR	Operations Research for Primary Health Care
PRITECH	Technologies for Primary Health Care
REACH	Resources for Child Health Project
S&T	Bureau for Science and Technology, A.I.D.
TAG	technical advisory group
UNICEF	United Nations Children's Fund
USAID	A.I.D. overseas mission
WHO	World Health Organization

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EXECUTIVE SUMMARY

BACKGROUND

In August 1985, the Academy for Educational Development (AED) was selected through a competitive procurement by S&T/Health to administer the HEALTHCOM (Communication for Child Survival) project for five years to build upon the public health communication methodology developed during the previous six-year Mass Media and Health Practices (MMHP) project. In September 1990, HEALTHCOM was granted a six month, no-cost extension and completed project activity in March, 1991.

The methodology integrated communication (radio, graphic print materials, and interpersonal communication) and social marketing with traditional channels of health education, training and product distribution. It relied on the development, testing and monitoring of communication strategies to bring about positive changes in health practices.

HEALTHCOM's mandate included additional countries and a broader range of child survival interventions than those addressed by MMPH. HEALTHCOM also was mandated to emphasize institutionalization of the methodology in project countries and to diffuse the methodology to other A.I.D. projects, U.S. academic centers, communication practitioners and other donor agencies.

Parts I and II of this report provide the project's background and the terms of reference for this final evaluation. Part III is a brief description of HEALTHCOM, including the project's major objectives and highlights of activities over the five-year period. Part IV presents the major findings of the evaluation team.

Overall, the team found that HEALTHCOM has accomplished nearly all its objectives and can be considered a successful project. Both AED and S&T/Health staff have earned high marks for their professionalism and conscientiousness in managing the project. Specific findings are based upon the 12 questions that S&T/Health asked the evaluation team to investigate. These questions are discussed under three headings: Project Management, Project Research and Project Deliverables and Outputs.

FINDINGS

A. Project Management

Horizontal versus Vertical. There are many advantages in a horizontal project, such as HEALTHCOM, which can apply expertise in communication to a wide range of public health interventions. By focusing on communication only, HEALTHCOM could develop and provide state-of-the-art strategies, methodologies and tools for use by itself as well as ministries of health, related A.I.D. projects and other donors. The only disadvantage of the HEALTHCOM approach is largely theoretical: such a project might find it difficult to keep informed of the technical advances in relevant disease interventions. The team found this to be more a potential, rather than real, problem. For example, HEALTHCOM had several mechanisms for insuring regular technical updates, including Technical Advisory Group meetings and a consultant roster that included experts in the interventions supported by the project.

Project Reports. Monthly reports have proved to be the most useful to A.I.D. and HEALTHCOM management, specifically the central monthly report for A.I.D. officers and the individual Resident Advisors' monthly reports for HEALTHCOM managers. Of secondary importance are the trip reports that generally contain country-specific intervention data not otherwise available. Reports from the field on formative and summative research, while in some cases reported by those interviewed to be too technical, were also considered useful.

Coordination with A.I.D. Projects, Other Donors, and Private Voluntary Organizations. AED has succeeded in coordinating HEALTHCOM activities as well as could be expected given the many players involved and the project's specific role and purpose.

Centrally Managed Buy-in Projects. Buy-ins account for some 45 percent of total project expenditures (USAIDs, 37 percent; Regional Bureaus, 8 percent), and S&T/Health the remaining 55 percent. S&T/Health should continue to urge regional bureaus and USAID missions to increase their share of buy-ins in HEALTHCOM II. However, experience shows that USAID missions and regional bureaus cannot be expected to provide total country project costs. It would be reasonable to set a target of a 75 percent-25 percent split between buy-ins and central funds for country-specific activities in projects such as HEALTHCOM.

B. Research

The Multidisciplinary Nature of HEALTHCOM. One of the strengths of HEALTHCOM is that it has effectively integrated the principles and practices of a number of different fields into its methodology, including communication research, development

communication, social marketing, applied anthropology, instructional design, and behavioral psychology. However, some of the behavior studies were not smoothly integrated into HEALTHCOM activities. Nonetheless, this effort has succeeded in focusing attention on the need to understand better what the behaviors being promoted entail and how each can be reinforced (and thus shaped) in the future.

Type of Research Conducted. HEALTHCOM's methodology is a research-based approach to the development of communications programs that bring about behavioral change in the area of child survival.

Research conducted in the field falls into two broad categories: formative and summative. Formative research is needed at several stages: to assess the health problem, develop and pretest materials, and monitor the program once in operation. In contrast to the formative research that focuses on process, summative research is needed to measure whether the program achieves its objectives in terms of the expected behavioral change in a given population.

In addition to formative and summative research, the HEALTHCOM contract called for 10 behavioral studies to be conducted. These studies were required in order to increase knowledge of specific behaviors being promoted and to foster experimentation with this new approach (of applying behavioral analysis to promoting new health practices in developing countries).

Quality of the Research. HEALTHCOM has assembled a very impressive research portfolio, both in terms of quantity of reports and the uniformly high quality of work. Researchers interviewed during this evaluation are clearly at the forefront of this field. AED and its subcontractors are to be commended on the clarity of presentation in their reports. (Though a few suggestions for improvement are noted in this report.) No doubt some persons in the field still feel some of the reports are "too technical." However, HEALTHCOM's subcontractors have succeeded in communicating the basic points in a language that can be fairly readily understood by other health professionals.

Immediate and Long-term Relevance of the Research. Formative research has been highly relevant to implementation of the communication programs at the field level and has been widely appreciated for its contribution. Summative research is seen as less important to the immediate goals of the host country counterparts (and others working at the field level). However, summative research is important to A.I.D. and other donor agencies, which stand to benefit greatly from the synthesis of findings based on cross-national data regarding communications for child survival.

Timeliness of Results. There were a number of criticisms regarding the turn-around time on the summative research; the 10 Health Practice Studies, also known as behavioral studies, also faced delays. While there were understandable reasons for these delays, the frustrations voiced by people at the field level cannot be overlooked.

Evidence of the Effectiveness of the HEALTHCOM Methodology. Summative research provides a test of the effectiveness of the HEALTHCOM methodology in changing specific health behaviors. HEALTHCOM's approach has generally produced the desired behavioral change. However, such a change does not result from every intervention in every country. The synthesis of results to be compiled from the different sites will allow for a greater understanding of the conditions under which change does or does not occur.

Institutionalization of the Communication Research Methodologies. Regarding formative research, there was consensus among the persons interviewed that in most countries institutionalization of the research methodology had occurred in a preliminary way. Summative research that uses large-scale surveys and advanced statistical analysis involves skills usually gained through doctoral level training in the social sciences. Thus, it is unrealistic to expect counterparts to master these skills through on-the-job training at the field level.

Potential Conflict of Subcontractor as Evaluator. Both the implementation and summative evaluation components of HEALTHCOM were included in a single contract. Questions were raised as to whether S&T/Health's interests would be better served by having the internal evaluation conducted by an independent contractor. While the current arrangement could be perceived as a conflict of interest, the benefits have outweighed the drawbacks. The subcontractor is governed by the professional standards of a research university, and its relationship to HEALTHCOM I/AED seems to be a non-issue at this time.

C. Project Deliverables and Outputs

Contract Compliance. HEALTHCOM operated under a "deliverables" contract, in contrast to many other contracts that specify "level of effort" for the technical assistance to be provided by the contractor. HEALTHCOM produced noteworthy products; however, there were complications. Our analysis was limited to the deliverables that best represented these complications and successes. Particular consideration was given to the degree that contract-specified deliverables were achievable in light of the project's design.

HEALTHCOM completed production of the required deliverables, including the start-up of nine new country programs, the maintenance of four programs started under MM&HP, completion of 10 behavioral studies and 13 country program evaluations submitted to A.I.D. but requiring further work. However, delays, burdensome contract requirements, and

deliverables with somewhat conflicting objectives characterized the problems HEALTHCOM experienced in producing these key outputs.

Despite these constraints, the project has produced a number of highly regarded studies, publications and videos. These products have achieved A.I.D.'s objectives in advancing behavioral research and health communication methodology while at the same time supporting public health interventions.

HEALTHCOM's Major Media Products. HEALTHCOM produced important media products in the course of supporting various child survival interventions. Though not explicitly required in the contract, these items are a natural result of the project's involvement with social marketing and mass media. Working with ministries of health, multilateral donors, USAID missions, private voluntary organizations, other A.I.D. projects, private research and advertising firms, HEALTHCOM designed a wide range of promotional and educational materials.

RECOMMENDATIONS

Inasmuch as HEALTHCOM has nearly ended, these recommendations are offered for their relevance to HEALTHCOM II, the HEALTHCOM follow-on project.

A. Management Issues (*abridged*)

1. HEALTHCOM should standardize the reporting format of its monthly reports.

2. HEALTHCOM should strengthen its summarizing of reports.

3. HEALTHCOM should increase its efforts to disseminate its communication methodologies to the academic community both in the U.S. and abroad.

4. HEALTHCOM should improve the timely dissemination of research findings to decision-makers.

5. HEALTHCOM and S&T/Health should ensure that the recently completed country-specific summative findings are disseminated widely and in a timely fashion to appropriate audiences in the U.S. and abroad.

6. S&T/Health should pursue improved coordination of centrally managed projects involved in child survival communication work.

7. S&T/Health should review the apportionment of central and buy-in funds over the past 15 months of HEALTHCOM activity to determine the extent to which central funds

are being used to support country-specific buy-ins and the impact this is having, or will have, on the project's funding forecasts.

B. Research *(abridged)*

Integration of Different Disciplines into the Methodology:

1. S&T/Health and HEALTHCOM should work to incorporate the behavioral research as an integral part of future projects, rather than an add-on to meet a deliverable requirement.

2. HEALTHCOM should "market" the basic principles of this behavioral perspective to its staff, counterparts and others in the field, clarifying the concept for persons unfamiliar with it.

3. HEALTHCOM should have one of the more readily understood behavioral experts work with the resident advisers in gaining a greater appreciation of what this approach has to offer in practical terms to specific projects.

Quality of the Research:

1. To the extent further summative research is done, HEALTHCOM should maintain its high standards; don't consider cutting corners to reduce costs.

2. If cost is an issue, S&T/Health and HEALTHCOM should limit summative research to specific projects that introduce new components "worthy of empirical testing."

3. In future projects, HEALTHCOM should use a far greater percentage of the available research funds for formative research, with more emphasis on monitoring.

4. HEALTHCOM should increase efforts to get project results published in scientific journals, both to increase the number of potential readers and to enhance the credibility of the findings in the eyes of the scientific community.

Relevance and Timeliness of the Research:

1. HEALTHCOM should strengthen efforts to work with in-country counterparts to develop their skills in asking the appropriate research questions and tailor research to their specific interests.

2. HEALTHCOM should design formative research that can be done locally, on a fairly small scale, and with rapid turn-around.

3. HEALTHCOM should adapt each study to the local realities; it should not attempt "standardization" of the methodology.

4. Wherever the human and financial resources exist, HEALTHCOM should use local research firms that deliver a quality product within a fixed time period.

5. HEALTHCOM should encourage local research firms and/or other counterpart institutions to carry out virtually simultaneous data collection/entry and to use computer software that will edit the data as it is entered.

6. HEALTHCOM should try to reduce and (if possible) eliminate formative research that cannot be analyzed in-country.

7. HEALTHCOM should devise and/or refine methods for presenting research findings to persons who are not research-oriented; it should prepare attractive, easy-to-read summaries of project results for in-country use by non-researchers.

8. HEALTHCOM should continue to provide opportunities for its subcontractors to visit countries and present the findings of the summative research to counterpart institutions, to increase understanding of the process and the results.

Institutionalization of Communication Research:

1. HEALTHCOM should encourage counterparts to select relatively easy research designs for the formative research, which can be used on similar projects in the future.

2. HEALTHCOM should avoid the temptation to "do the job for them" for the sake of expediting it; allow time for counterparts to learn from their mistakes.

3. S&T/Health should make institutionalization a more explicit objective of the project.

C. Project Deliverables and Outputs (*abridged*)

1. HEALTHCOM should track and report its expenditures for key deliverables, enabling S&T/Health to monitor expenditure patterns and assess the opportunity cost of these allocations to the project's broader objectives.

2. S&T/Health should maintain the Field Notes deliverable in HEALTHCOM but reduce the number required. HEALTHCOM should not slow production of the Field Notes with stringent standards, but emphasize timeliness and wide dissemination, especially of appropriately translated copies in-country.

3. HEALTHCOM should translate all important project research and findings into the language of the country in which they are produced and be widely disseminated among local authorities and interested parties.

4. S&T/Health and HEALTHCOM should consider increasing staff for editing, document production and general information management. HEALTHCOM should also create a small-scale information resource center to: 1) edit, track, maintain and distribute reports; 2) respond to overseas requests for project publications and sample media outputs; 3) manage document translation; 4) expand, maintain and disseminate samples from the materials archive of promotional and educational outputs produced and used in the field.

5. The HEALTHCOM Midterm Evaluation team should inquire into additional media outputs and their application during its field site visits.

I. BACKGROUND

A.I.D. began applying state-of-the-art social marketing and communication techniques to selected child survival practices in 1978, when it undertook the Mass Media and Health Practices project (MMHP). From 1978 to 1985, this contract with the Academy for Educational Development (AED) developed a methodology for public health education that reached large numbers of people in Honduras, The Gambia, Ecuador, Peru, Swaziland and Indonesia.

Integrating communication (radio, graphic print materials, and interpersonal communication) and social marketing with traditional channels of health education, training and product distribution, MMHP brought about positive changes in health behavior. Initially, the programs focused on the promotion of oral rehydration therapy (ORT) and other key elements of diarrheal disease control.

Initiation of the Communication for Child Survival project, competitively awarded to AED in August 1985, moved this effort into a second phase. Referred to as HEALTHCOM, the project's mandate was broadened to include additional countries and a wider range of child survival interventions than MMHP. HEALTHCOM also was mandated to institutionalize its methodology in project countries and to disseminate the methodology to other A.I.D. projects, U.S. academic centers and health communication practitioners, as well as other donor agencies.

In 1989, a mid-term evaluation of HEALTHCOM commended A.I.D. for being the one major international agency supporting health communication assistance in the developing world. Evaluators stressed the need to a) streamline the HEALTHCOM methodology; b) institutionalize health communication within national health programs; c) ensure that research was relevant to field programs and that in-country capabilities were tapped; d) develop process indicators for project impact and sustainability; and e) network with other A.I.D. projects, private voluntary organizations and the commercial sector to maximize project outreach.

Incorporating the recommendations of the mid-term evaluation, S&T/Health initiated a third health communication assistance project in the fall of 1989 with the competitive award of HEALTHCOM II to AED. Building upon the pioneering work of MMHP and HEALTHCOM, the new project is designed to institutionalize at-home health care provider (i.e., mother and caretaker) behavior and capability and improve the mix of mass media and inter-personal communication activities. Meanwhile, HEALTHCOM was granted a six months no-cost extension until March 30, 1991 for it to complete its contractual requirements. Extending HEALTHCOM created an 18-month overlap with the HEALTHCOM II project.

II. EVALUATION PLAN AND METHODOLOGY

S&T/Health requested the Pragma Corporation's Project ASSIST to undertake the final evaluation of HEALTHCOM during January 1991. The evaluation team was asked to assess the quality and documented accomplishments of the project. Team members reviewed existing documentation and interviewed A.I.D. and HEALTHCOM staff, HEALTHCOM resident advisors and USAID missions (by facsimile and telephone), representatives of related projects, private voluntary organizations and international organizations. S&T/Health identified three broad questions for the team to address:

1. What have A.I.D. and AED learned over the course of this project that could help them to manage HEALTHCOM II more efficiently and effectively?

2. Is HEALTHCOM's research portfolio technically sound and appropriate for A.I.D.'s needs?

3. Has AED successfully completed its contractual requirements under HEALTHCOM (contract DPE-1018-C-00-5063-00)?

Expanding on these three questions, S&T/Health specified a list of 12 questions for the evaluation team to investigate; these are provided in Annex A. See Annex C for a list of people interviewed during the course of the evaluation. No overseas travel was included in the team's scope of work (however, the mid-term evaluation visited country sites in the Philippines, Indonesia, Honduras and Nigeria).

III. PROJECT DESCRIPTION

A. PROJECT OBJECTIVES

HEALTHCOM's objectives are clearly stated in the contract-specified scope of work:

- To complete the development of the methodology and its application to the intervention strategies that influence the survival of children, including diarrhea control, infant feeding, breastfeeding, child spacing, handwashing and related personal hygiene, immunization, the use of foods rich in vitamin A, and cooperation with water and sanitation and vector-borne disease programs;

- To complete the integration of two major emphases from social marketing, a) product promotion and b) consumer education aimed at changing practices, into the methodology;

- To expand the applicability of the methodology by using it at approximately 10 new sites representing different institutional and/or technological conditions (such as the absence of a strong health services infrastructure in the poorest countries, expanded reliance on the private sector, or the increased use of television in countries where television is prevalent);

- To further support the process of institutionalization of the methodology at all project sites;

- To undertake 'diffusion' activities so that knowledge and use of the methodology is spread to other A.I.D. projects, U.S. academics and practitioners, and the broad community of donor agency professionals.

B. PROJECT COMPONENTS

1. Key Components

To achieve these objectives, work was divided into three components:

Health Practice Studies (subsequently referred to as behavioral studies). HEALTHCOM was directed to conduct at least 10 studies pertaining to the behavioral problems encountered and resolved in adapting the methodology to existing and new sites to achieve the acceptance of public health practices related to child survival.

Institutional Studies I and II. HEALTHCOM was assigned the responsibility of initiating 10 new country programs, (Institutional Studies I), as well as continuing its work in the seven countries started under MMHP (Institutional Studies II). As part of this component, HEALTHCOM was to design Implementation Plans for the new project sites, incorporating the findings of the Health Practice Studies mentioned above. A case study, or final evaluation, assessing the impact of project activities at each site was also required.

Diffusion Activities. Workshops, seminars, video tapes and print media were among the wide range of diffusion activities.

2. Documentation

In addition to the three major project components, HEALTHCOM was required to submit:

- Semi-annual Project Reports describing major activities undertaken in the preceding period, summarizing findings and future objectives.

- Up to eight annual Field Notes to provide brief, descriptive summaries of particular methods, techniques, events or findings of concern to those interested in HEALTHCOM methodology.

- At least eight overview "Special Reports," as the contract calls them, based upon the research conducted for the behavioral and institutional studies.

- A semi-annual Management Report containing comparative analysis of targeted and actual resource allocations, costs and projections (this was integrated into the semi-annual Program Report early in the life of the project).

- A Final Project Report outlining all major activities undertaken during the life of the project, level of effort, and associated costs.

HEALTHCOM'S contract also required annual meetings of an advisory board (later called the Technical Advisory Group (TAG)) composed primarily of U.S.-based contractor personnel to advise A.I.D. and AED regarding 1) programs under the project; 2) problems that need to be resolved; and 3) opportunities for greater project impact. Rather than evaluating HEALTHCOM's activities, the advisory board was tasked with "improving ways to realize the world-wide objectives of this project."

3. Subcontractors

Four subcontractors worked with AED on HEALTHCOM:

1. The Annenberg School for Communication of the University of Pennsylvania, for case study evaluations of the communication programs in each HEALTHCOM country;

2. Applied Communication Technology (ACT), for continued analysis of data from Honduras and The Gambia, and follow-up studies of the programs in those countries;

3. PATH/PIACT, to help develop print materials and appropriate health technologies for these programs; and

4. Porter/Novelli (P/N), for marketing and advertising assistance.

C. HIGHLIGHTS OF PROJECT ACTIVITIES

Under the Health Practice Studies component, the required studies were to be integrated into specific country programs as part of the investigative and formative evaluation stages of the methodology applied at a given site. The Health Practices Studies were expected to modify and improve the methodology over the long run, support the interventions, and advance behavioral analysis in general.

Under the Institutional Studies component, HEALTHCOM typically provided a professional resident advisor for two years. This person worked with local institutions (USAID missions, ministries of health and education, private foundations and organizations and other donors) to plan and implement health communication program and to train local counterparts in HEALTHCOM strategies and methods. Short-term advisors in marketing, behavioral analysis, anthropology and related disciplines were also provided to supplement the long-term assistance as needed. An evaluation of project process and impact was conducted using both qualitative and quantitative methods.

Under the Diffusion component, HEALTHCOM undertook: short-term technical assistance to developing countries; seminars for developing country health sector decision-makers and professionals; faculty seminars for university teachers and health education policy-makers; instructional videotapes on the project's methodology and field experience; publications, papers and presentations related to project methodology and findings.

HEALTHCOM initiated nine new long-term programs and maintained four of the existing programs established under MMHP. Highlights of major country activities are contained in Annex D.

IV. FINDINGS

Findings are grouped into three sections: A. Selected Project Management Issues; B. Research; and C. Project Deliverables and Outputs. Recommendations are presented at the end of each section, and again in composite form in section V of this report.

A. SELECTED PROJECT MANAGEMENT ISSUES

1. Overview

AED has provided effective program and administrative management throughout the five-year life of HEALTHCOM. Virtually all those interviewed corroborated this view, including A.I.D. personnel here and abroad, other donors, private voluntary organizations and staff of related S&T projects. Favorable opinions are based not only on the quality and comprehensiveness of the project's outputs, but also on its wide range of less tangible achievements. Such intangibles include the high regard in which HEALTHCOM staff are held by those with whom they work, Americans and foreign nationals alike. HEALTHCOM staff are characterized by their colleagues as professional, cooperative and conscientious in achieving the project's objectives. HEALTHCOM's responsiveness to the 1988 mid-term evaluation recommendations regarding the project's direction in its remaining years reinforced the evaluation team's positive evaluation of program and administrative management. S&T/Health project management was equally commended by respondents in this evaluation. AED and the project clearly have benefitted from the continuity of four years of effective program guidance from HEALTHCOM Cognizant Technical Officer Robert Clay and, in its final year Connie Carrino and Holly Fluty.

In its scope of work, the evaluation team was asked to respond to a number of specific questions, of which the following pertain to project management.

2. Horizontal versus Vertical Projects

Question:

> *What are the pros and cons of a project that had communication as its focus, versus a project that focuses on a specific disease complex (e.g., ARI, CDD, EPI)? How should a project that focuses on communication stay aware of state-of-the-art developments in all the different intervention strategies?*

There are many advantages in a horizontal project such as HEALTHCOM, which provides the communication methodology for adaptation to a wide variety of public health interventions. During MMHP and the early years of HEALTHCOM, public health communication methodologies needed to be tested to assess their viability, strengths and weaknesses, and appropriateness for different applications. Since then, communication methodology has demonstrated its importance and has been accepted and integrated into most of A.I.D.'s health and child survival service delivery projects.

As the pioneer in health communications, HEALTHCOM has become the recognized source of expertise on communication applications to a wide range of intervention strategies, including ARI, CDD, EPI, Vitamin A deficiency, and to a lesser extent, breastfeeding, child spacing and malaria control. Projects such as PRITECH, REACH, and ACSI-CCCD, are organized around particular disease complexes, generally look to HEALTHCOM for the communication guidance in their work. By focusing on communication, HEALTHCOM is able to develop and provide state-of-the-art strategies, methodologies and tools useful to the project, ministries of health, related A.I.D. projects and other donors. Methodology manuals, behavior analysis techniques, and formative and summative research models, as well as prototype social marketing and mass media products are among the tools used. Projects organized around specific disease-complexes would find it difficult and inefficient to produce such work on their own.

Rarely does HEALTHCOM work alone. Virtually all HEALTHCOM country projects include other major participants, such as, ministries of health, other A.I.D. projects, and donors like WHO or PAHO that provide disease-specific technical know-how. In those few cases where HEALTHCOM functions somewhat independently, it has demonstrated a capability to obtain the necessary technical inputs from appropriate in-country and international sources to ensure that it is proceeding in a responsible manner. However HEALTHCOM applies its communication methodology in a particular country, the lack of medical technical expertise on staff has not appeared to pose a problem except in the area of policy formation: it was reported that two resident advisors occasionally had experienced some difficulty in conveying their messages to senior host country medical personnel due to their lack of medical credentials.

Having communication as the focus of the project, the team feels, made it possible for HEALTHCOM to demonstrate that communication is an essential ingredient in child survival programs.

HEALTHCOM's mandate allows it to support various child survival interventions. However, its activities have generally been limited to supporting one, two, or at most three interventions in any given country. EPI and CDD have comprised about 80 percent of HEALTHCOM's work over the past five years; project staff have developed sufficient know-how to ensure that the most current understanding of technical aspects in these disease complexes are incorporated in their communication interventions. HEALTHCOM relies on networking with leaders in the particular disease disciplines to ensure that technical elements incorporated into HEALTHCOM's communication support are up-to-date and of the highest professional standards.

As the question posed implies, it is not an "either/or" situation. Indeed, the symbiosis between the two ways of organizing projects works well. Pivotal to success is how well a particular activity (whether it be a national immunization campaign or a communication manual for worldwide use in CDD) is coordinated among the key participants.

3. Project Reports

Question:

> *Among the various reports produced by the project (e.g., monthly reports, country reports, trip reports, research papers, briefings), which have been the most useful to HEALTHCOM and A.I.D. in managing project activities? Are there examples of reporting that could be omitted?*

Monthly reports are the most useful to A.I.D., HEALTHCOM management and HEALTHCOM country program backstopping staff. They contain information that is helpful in supporting field activities and reporting country project activities to other interested parties. Of secondary importance are the trip reports that contain country or specific intervention data not otherwise reported. Reports from the field on formative and summative research were also found to be useful when they were not too technical and were reasonably current. Several respondents suggested that these research reports would be more useful if they contained summaries.

From the HEALTHCOM resident advisors' viewpoint, while preparing monthly reports to send to HEALTHCOM/Washington is time consuming, this proves to be a useful exercise that forces them to review their activities during the past month and plan for the month ahead. Resident advisors also benefit from receiving the composite monthly report from the home office because of the useful information it contains on their colleagues'

activities in other countries. Further, becoming aware of the problems and activities of their colleagues in other countries makes them feel less isolated and part of a larger team effort. However, resident advisors suggested that a standardized reporting format would improve the monthly reports, some of which tended to lack structure and organization. Resident advisors generally showed less interest in the semi-annual report than in the monthly reports. However, technical field reports were considered useful, especially if no overly long or out-of-date.

AID/Washington officers commended HEALTHCOM's central monthly reports for their quality and relevance. Two officers thought the semi-annual report was too long and detailed to be of much use to managers. Few A.I.D. officers were conversant with the technical research and field trip reports, but most A.I.D. staff interviewed commended HEALTHCOM for the quality and comprehensiveness of its reporting.

USAID Health, Population, and Nutrition (HPN) officers generally agreed that HEALTHCOM reporting was of a high standard and found the monthly reports especially useful. The only criticisms concerned the delayed receipt of the research reports and the length of others, especially the semi-annual reports.

Other donors, such as WHO and UNICEF, usually receive HEALTHCOM's monthly reports and find them helpful, especially regarding the work they might be doing in the same country. Representatives of related A.I.D. projects such as PRICOR, PRITECH, REACH, and CCCD also found HEALTHCOM reporting to be effective and useful. Monthly reports from countries where these other A.I.D. projects and HEALTHCOM were all active were again singled out as most valuable.

4. Dissemination of Outcomes and Lessons Learned

Question:

> *Are the project's results being adequately disseminated to A.I.D. and A.I.D. supported projects and others active in international health? What have been the most effective ways to disseminate project outcomes and lessons learned?*

It appears that HEALTHCOM has done a good job of disseminating project results to S&T/Health and regional bureau HPN staff, and other interested parties; HEALTHCOM has routinely disseminated a wide range of project documents, (e.g., monthly and semi-annual reports, Field Notes, and Special Reports). Outstanding communication and information exchange between the S&T/Health CTO and HEALTHCOM staff is apparent on most aspects of the HEALTHCOM project. Both parties seem to be apprised of each other's activities and work well together to advance HEALTHCOM objectives to a far greater extent than in many A.I.D. projects. Principal officers of both organizations, specifically Robert Clay of

S&T/Health, and HEALTHCOM's Mark Rasmuson and Bill Smith, all of whom have been closely associated with HEALTHCOM and its predecessor MMHP since 1979, are responsible for this efficient communication network. The managerial and professional skills of these individuals, combined with their long association with the project, is a distinct asset. Effective dissemination of project results within A.I.D. and elsewhere is one manifestation of this unusually effective management team.

AID/Washington staff found Technical Advisory Group (TAG) meetings useful as a means of disseminating project results (although an A.I.D. officer complained that regional bureaus should have more than observer status at these meetings because they are major buy-in sources for the project). A regional bureau officer reported that HEALTHCOM was very skillful in making presentations on project outcomes and lessons learned at seminars and gatherings such as annual ACSI-CCCD meetings.

Some USAID HPN officers were more critical. While several respondents felt HEALTHCOM was effective in its dissemination efforts, others felt that messages on project outcomes were not getting across as much as they should. It was suggested that this might be due to the short time the project operated in a particular country (for example two years in the Philippines, which may not have been enough time for useful results). It may also be due to the unavailability of summative findings on project outcomes for many countries (which Annenberg has completed only recently).

PRITECH, PRICOR, REACH and ACSI-CCCD staff reported that HEALTHCOM was generally effective in its dissemination efforts. REACH exchanges monthly reports with HEALTHCOM, which it does not do with other projects. REACH also benefits from attending HEALTHCOM TAG meetings as do PRITECH & PRICOR staff who find such occasions useful for sharing project outcomes and lessons learned. ACSI-CCCD staff commended HEALTHCOM for its effective presentations at its periodic ACSI-CCCD meetings. HEALTHCOM was also cited by at least one related project for its effectiveness in presenting project results at international fora such as the International Conference on Oral Rehydration Therapy and the National Council for International Health. PRITECH also commended HEALTHCOM for its dissemination efforts and its teamwork, but suggested that it would be useful if S&T/Health took more initiative in convening joint sessions among related projects such as REACH, ACSI-CCCD, HEALTHCOM, and itself to discuss lessons learned of mutual interest. Other donors, such as PAHO, WHO and UNICEF, also commended HEALTHCOM for its effective dissemination efforts, citing TAG meetings as an example.

In addition, HEALTHCOM has made major efforts to disseminate its methodology and results to the academic community including:

- increasing the number and quality of publications and articles available in libraries or data bases, such as Medline;
- encouraging more universities to integrate HEALTHCOM methodology into their curricula. (See Annex VI for a list of institutions currently using HEALTHCOM material);
- maintaining and expanding mailing lists with the U.S. academic community for distribution of project documents, especially in the research area;
- arranging TAG meetings;
- making individual presentations at conferences and to academic groups (at least 100 to date); and
- publishing research findings on behavioral and formative studies in report form for use in professional journals or monographs (four published and eight to be submitted);

Now that Annenburg has completed its country-by-country impact reports, there is a significant opportunity for disseminating a summary of overall project outcomes.

5. Coordination with A.I.D.-related Projects, Donors and Private Voluntary Organizations

Question:

How has HEALTHCOM coordinated with other A.I.D.-related projects, donors and PVOs? Has HEALTHCOM incorporated the relevant work of CDIE, WHO, DHS, PRICOR and PRITECH into its activities?

Table 1 depicts the multiple S&T Bureau child survival projects having communication components. Not included are USAID bilateral projects and those of other donors such as UNICEF, PAHO and WHO.

Table 1
AID/Washington Projects With Communication Components

COMPONENT	HEALTH-COM	Nutrition Communication	PRITECH	REACH II	SUPPORT	PRICOR (1)	VITAL	ACSI-CCCD (2)	WASH	SOMARC	Mother-Care	WIN
CDD/ORT Incl. Child feeding	M	M	M		M			M				M
EPI	M			X				M			X	
ARI	X							X			X	
Vitamin A	X	M					M					
Breastfeeding	M	M	X								M	X
Growth Monitoring	X	M										X
Child Spacing	X	X								M		X
Vector Borne (Malaria)	X							X				
Hygiene, Water Sanitation	X		X						M			

M=Major, X=Some (1) PRICOR focused on operations research in counseling/interpersonal communication practices of health workers that touch on nearly all interventions.

(2) ACSI-CCCD is supported by the Bureau for Africa, but is included because of its close working relationship with HealthCom I in Africa

Given such a significant number and range of projects and interventions, there is an obvious need for coordination. HEALTHCOM has been sensitive to this need as well as to its intricacy and appears to have effectively coordinated project activities. Most respondents gave AED high marks in this area, as they look to HEALTHCOM for leadership in health communication methodologies and applications.

HEALTHCOM uses both formal and informal means to coordinate with other projects. At the central level, TAG meetings are particularly useful because they involve most of the principal actors in the field: REACH, PRICOR, ACSI-CCCD, WHO and UNICEF, in addition to regional bureau and S&T/Health personnel. Special Task Force meetings, which generally precede TAG meetings, have also involved related project staff. HEALTHCOM periodically exchanges information with PRITECH, REACH and ACSI-CCCD, especially when they are undertaking activities in the same countries. Resident advisors are reported to be effective in coordinating their work with other projects and donors. Such collaboration generally takes place within their respective host government organizations and/or USAID missions and uses formal (briefings, reports, etc.) and informal (counterpart relationships, visits to USAID HPN officers, etc.) mechanisms. Annex VII provides insight into the wide array of local institutions and projects with whom HEALTHCOM coordinates and collaborates in its country programs.

Coordination has led to successful integration of project activities. For example: the Philippines, where PRITECH, HEALTHCOM and WHO worked closely with the national CDD program; Nigeria, where the ACSI-CCCD project and HEALTHCOM joined forces in a CDD and EPI program; and the currently planned trip to Uganda and Zambia of a joint team from PRICOR, PRITECH, and HEALTHCOM, which is to review national CDD training programs.

While coordination with related projects such as REACH, PRITECH, and PRICOR conceivably could be constrained by the competitive nature of the respective cooperating agencies, the evaluation team did not discern a problem of this type. Indeed, relationships among them appear to be close. AED/HEALTHCOM staff were repeatedly referred to as professional, cooperative and forthcoming by related contractors. Some differences in program philosophy with WHO/PAHO occasionally surfaced, for example, in the Philippines and Mexico. WHO/PAHO traditionally have been less concerned with communication methodology than with the medical aspects of the interventions. Consequently, they characterized some HEALTHCOM activities as too independent from their own or local ministry of health policies as well as being too "behaviorally" oriented. While these organizations appear to be working more synchronously today, HEALTHCOM could make a particular effort to harmonize its activities with PAHO/CDD, which claims it would welcome closer teamwork as demonstrated in the recent joint production of the successful video *Miriam: El Uso Exitoso de la Terapia de Rehidratacion Oral* in Mexico City.

Regarding HEALTHCOM's incorporation of the work of related projects into its activities, HEALTHCOM receives technical guidance from projects such as PRITECH, REACH and ACSI-CCCD, as well as WHO at both the central and field levels. UNICEF also provides guidance, mostly at the field level because of its decentralized organization. However, A.I.D. and UNICEF have disagreed on policies and practices on several occasions. UNICEF has supported some large-scale national immunization campaigns, for example, which were not always in harmony with A.I.D.'s approach.

HEALTHCOM has particularly benefitted from the work of related projects in the area of research. The project's subcontractor, the Annenberg School for Communication, has incorporated research conducted by other organizations into HEALTHCOM's communication interventions. Some examples include:

- A ACSI-CCCD study of health centers was used to plan the Niger State program in Nigeria.

- PRICOR-gathered data about radio use in Lubumbashi, Zaire, was used to plan a program.

- UNICEF supported a qualitative survey of ORT in West Java, the results of which were used in developing the HEALTHCOM intervention.

- HEALTHCOM helped design an EPI survey in Lesotho, carried out by ACSI-CCCD, WHO, UNICEF, and the Ministry of Health. A similar survey was subsequently used by Annenberg to evaluate interim HEALTHCOM program effects.

- Some HEALTHCOM research questions regarding feeding during bouts of diarrheal disease have reflected work done by the Dietary Management of Diarrhea Project.

- The Ecuador knowledge, attitudes and practice survey instrument reflected work done by a REACH consultant as well as a HEALTHCOM research advisor.

- PRITECH reviewed and made valuable recommendations for West Java survey instruments for CDD-related questions.

- The Demographic Health Survey work in Ecuador confirmed HEALTHCOM estimates of certain diarrheal disease treatment rates.

- WHO/CDD surveys in Cebu, a Philippine island, were used to check HEALTHCOM estimates of diarrhea rates and ORS use rates.

HEALTHCOM has benefitted from the Center for Development Information and Evaluation (CDIE) studies on institutionalization in health sector programs. In addition, access to CDIE information services has been relatively easy because AED is also the prime contractor for the CDIE Research and Reference Service. Additionally, demographic and health surveys produced by DHS have also been used by Annenberg in its research and analysis activities.

One of the reasons why HEALTHCOM seems to be effective in coordinating its activities is because of AED's contractual involvement in so many related projects. AED is the prime contractor in three major projects and subcontractor in six others in areas related to health communications. While contractor employees who are assigned full-time to one project cannot work directly on related projects, there are instances in AED where a person's time is apportioned between or among projects such as HEALTHCOM and Nutrition, Education and Social Marketing Field Support Project (NCP). Even when such apportioning is not possible, the physical proximity of related project staff in the AED Washington, D.C. office encourages sharing of experiences, ideas and information among the respective projects. For example, HEALTHCOM and NCP staff occupy adjoining offices and often exchange information of use to both projects. Likewise, AED staff officers in such projects as HEALTHCOM exchange information with other AED employees serving in subcontracting capacities with contractors such as Management Sciences for Health, prime contractor of the PRITECH project.

6. Centrally Managed Buy-In Projects

Question:

> *What effect has the practice of buy-ins had on the project's financial profile? What was the S&T/Health and non-S&T/Health breakout of project expenditures by country each year? What does your analysis suggest for the amount of the S&T/Health funds needed to support Mission and Regional Bureau buy-ins?*

Presented in Table 2 on the next page is an analysis by fiscal year of the expenditures under HEALTHCOM covering the period from August 31, 1985 till September 30, 1990:

Table 2

EXPENDITURE ANALYSIS BY FISCAL YEAR

EFFECTIVE DATES: AUGUST 31, 1985 - SEPTEMBER 30, 1990
SUMMARY

	CENTRAL S&T/H EXPENDITURES	REGIONAL BUY-IN EXPENDITURES	MISSION BUY-IN EXPENDITURES	TOTAL EXPENDITURES
'Y85	11,904			11,904
'Y86	1,296,621	19,615	630,638	1,946,874
'Y87	2,049,791	281,932	1,401,198	3,732,921
'Y88	2,695,206	492,916	1,425,705	4,613,827
'Y89	2,148,565	497,980	1,729,015	4,375,560
'Y90	1,739,249	138,636	1,541,870	3,419,755
	9,941,336	1,431,079	6,728,426	18,100,841

As this table shows, USAID mission buy-ins accounted for 37 percent of total expenditures, regional bureau buy-ins eight percent, and S&T/Health the remaining 55 percent. Included in the S&T/Health figures are the costs of maintaining the HEALTHCOM home office and subcontractors, which totaled approximately $5 million over the life of the project. To give a truer picture of the apportionment of funds for specific in-country program activities, we have subtracted HEALTHCOM home office and subcontractor costs from the S&T and total expenditures columns. Accordingly, the pro-rated share of costs is as follows:

Mission buy-ins	51 percent
Regional bureaus	11 percent
S&T/Health	38 percent

This overall ratio of S&T/Health funds to buy-in funds for specific in-country programs of 38 percent to 62 percent more clearly shows the extent to which Missions and S&T/Health have been sharing the costs of specific country activities. Please see Annex E for country-by-country project expenditure analysis.

Current funding arrangement of HEALTHCOM II which, we understand, is predicated on the idea that buy-ins would cover 100 percent of the costs of specific country activities, while S&T/Health core funds would be dedicated to HEALTHCOM home office and subcontractor expenses. If our assumption is correct that few, if any, USAID missions will provide 100 percent of the funds for country specific activities, then HEALTHCOM will be forced to request authorization from S&T/Health to use central funds to defray the costs of undertaking programs in most of the 15 countries proposed in the HEALTHCOM II contract. To the extent that core funds are used in this manner, HEALTHCOM II would have to either: 1) reduce proportionally some of its other non-country-specific planned activities such as global research strategies; or 2) obtain additional core funds to replace what was siphoned off for country projects.

S&T/Health should continue to urge regional bureaus and USAID missions to increase their share of buy-ins and strive for the 100 percent goal set for HEALTHCOM II. However, the trend in Missions with major health sector programs to shift to bilateral projects makes it reasonable to set a target of a 75 percent-25 percent split between buy-ins and central funds for country-specific activities. Note that this proposed split excludes home office and subcontracting costs, which, as mentioned above, accounted for approximately 28 percent of total project costs. When these costs are included in the S&T/Health column, the ratio between buy-ins and central funds in HEALTHCOM II would be approximately 50-50.

A difficult funding shortage occurred last year during the transition from HEALTHCOM to HEALTHCOM II. Substantial funds were shifted from the latter to the former to enable HEALTHCOM to complete its deliverables, causing significant cutbacks in HEALTHCOM II's planned level of effort. According to HEALTHCOM management, this problem was caused by: a shortfall in funding from S&T/Health and at least one USAID mission in FY 1990; the unanticipated need to use HEALTHCOM II core funds to match USAID mission funds in a number of countries; and delays in both S&T/Health and USAID mission funding in FY 1991.

The team suggests that S&T/Health monitor HEALTHCOM II activities closely to ascertain the funding pattern that has developed over the past 15 months, as well as emerging funding trends as additional country programs commence, and make whatever funding adjustments are necessary.

As for the buy-in process itself, most of those interviewed felt it is an effective mechanism for harmonizing the research and development interests of the S&T Bureau with the more operational objectives of USAID missions and host countries. Sharing costs tends to generate ownership on the part of the funding partners and augers well for joint participation, which is essential to HEALTHCOM's overall success. However, there is a downside to the buy-in mechanism as reported by many respondents, especially those responsible for the paper work involved. A widely held sentiment is that buy-ins are tedious

and excessively time consuming, often taking months to complete. Indeed, it was reported that in one extreme case the process became so involved that a long-expected buy-in never came to fruition, posing a major setback to the project in that country. Another criticism is that unspent buy-in money, if allocated by a mission through its administrative reserve funds, is not returned to the original 'purchaser' (e.g., the USAID mission); rather, to the consternation of the mission, it reverts to the overall project. A less frequent complaint concerns the buy-in ceiling, which was becoming a constraint in the final stages of HEALTHCOM.

7. Conclusions and Recommendations

A.I.D. and AED have learned a great deal over the course of HEALTHCOM that, from all indications, is helping them manage the follow-on HEALTHCOM II project. Fortunately, the same principal officers in A.I.D. and HEALTHCOM are still involved. This provides an important continuity often lacking in long-term A.I.D. projects.

HEALTHCOM's mid-term evaluation report contained design and implementation recommendations for HEALTHCOM II. While it is not in our scope of work to assess the extent to which these recommendations have been applied to HEALTHCOM II, discussions we have held with A.I.D. and HEALTHCOM staff, and a review of relevant documents, suggest that the recommendations in the mid-term evaluation report were carefully considered and applied as appropriate in the design and implementation of the HEALTHCOM II project.

Recommendations made below relate specifically to the management questions raised in this team's scope of work. Inasmuch as HEALTHCOM has nearly ended, these recommendations are offered for their relevance to HEALTHCOM II.

1. HEALTHCOM should standardize the format of its monthly reports to help ensure that comparable and relevant information is obtained and consolidated for the use of interested parties in A.I.D., related project contractors, resident advisors, USAID missions and host country organizations.

2. HEALTHCOM should strengthen its practice of preparing summaries of its reports. As a rule, any report over 10 pages in length should be summarized.

3. HEALTHCOM should increase its efforts to introduce its communication methodologies to the academic community both in the United States and abroad. This might include:

    - converting selected studies from the HEALTHCOM final report into academic journal format;

- publishing compendiums of materials, as well as a brochure and price list, on 'health communications in the international context' appropriate for classroom use. This brochure should be sent to schools of public health and universities known to have strong international health interests, and indicate the types of courses in which this material could be used: health education/communication in developing countries; applied social science research/communication research; social marketing; applied anthropology; and

- producing video material on HEALTHCOM methodologies available on loan to universities as teaching aids.

4. HEALTHCOM should improve the timely dissemination of research findings to decision makers.

5. HEALTHCOM and S&T/Health should ensure that the country-specific summative findings, soon to be completed by Annenberg, are disseminated widely and in a timely fashion to appropriate audiences in the U.S. and abroad.

6. S&T/Health should pursue coordinating the work of centrally-managed projects involved in child survival communication. Regular meetings could be convened by the bureau in order to exchange information and to identify areas where increased collaboration would be productive.

7. S&T/Health should review the apportionment of central and buy-in funds over the past 15 months of HEALTHCOM II activity to determine the extent to which central funds are being used to support country-specific buy-ins and the impact this is having, or will have, on the project's funding forecasts. While the goal of obtaining the total costs of country-specific project activities from buy-ins is commendable, an apportionment of 75 percent buy-in to 25 percent central funds is more realistic. This apportionment excludes the centrally-funded operational costs of HEALTHCOM and its subcontractors, which amount to 25 to 30 percent of total project costs. Thus, from an overall project cost viewpoint, there would be an approximate 50-50 split between S&T/Health funding and that generated by buy-ins.

B. RESEARCH

Evaluation of the research component is based on a review of selected research reports, a two-day visit to the Annenberg School for Communication (University of Pennsylvania), one meeting with Porter/Novelli, and interviews with HEALTHCOM staff (including several residents advisors), AID/Washington and USAID mission personnel, and other S&T/Health contractors. Since there were no visits to field sites, we were not able to talk with those whom the research was most intended to benefit: the program managers using it for decision-making purposes.

A difficulty experienced in evaluating the research was that the many studies were done by different groups. Four subcontractors were responsible for different aspects of the formative and summative research. In those countries that had organizations capable of doing social research--for example, marketing research firms in Indonesia, Philippines, Honduras, Papua New Guinea; universities in Zaire and Nigeria; and health research institutions such as INCAP in Guatemala--part of the work was done by these groups. To this, one must add the 10 behavioral studies designed and directed by consultants and HEALTHCOM staff in collaboration with host country institutions. In short, this assessment of "the research" covers a large number of institutions conducting various types of studies in vastly different field settings, making it difficult to generalize. It should be stressed that comments on the summative research are limited largely to the Annenberg work, since they have been responsible for most of the recent studies.

Despite these limitations, the evaluation team obtained sufficient information on the research component with which to address the questions raised in the scope of work.

1. The Multidisciplinary Nature of HEALTHCOM

Question:

> *How have the fields of communication research, development communications, social marketing, behavioral psychology, applied anthropology, and instructional design contributed to the HEALTHCOM project? How are these disciplines represented in the country programs? Is the mixture adequate to achieve the project goals? Suggest any changes.*

One of the strengths of the HEALTHCOM project is that it uses a multidisciplinary approach. While many projects pay lip service to doing so, HEALTHCOM has effectively integrated the principles and practices of a number of different fields into its methodology. The main contributions of these disciplines include the following:

Communication research
- assess existing knowledge, attitudes, beliefs, and practices of target population
- determine the reach of different media, peak listening hours, preferred types of programming
- measure the impact of specific communication programs on the target population
- identify factors in the communication process facilitating or impeding the transmission of messages

Development communications
- experiment with mass media (especially radio) as an important communication medium, especially for instructional purposes
- assess the relative strengths of different channels for conveying messages intended to improve social/health conditions
- analyze the role of interpersonal networks in the diffusion of innovations
- use multiple channels in a complementary way

Social marketing
- design products and packaging to meet consumer needs
- promote the product extensively through mass and interpersonal channels
- identify convenient places and channels for distributing the product
- create incentives and adjust the pricing structure to make the product affordable

Applied anthropology
- analyze the behavior of individuals in the context of the belief structure, social norms and values of the larger community
- focus on the details of "routine" behaviors
- identify ways in which traditional values and practices are changing in response to external forces of modernization

Instructional design
- transmit specific information to a target population through factually correct materials appropriate to the educational level and cultural context of the audience
- use graphic techniques to enhance comprehension and interest
- test material at several stages and modify it as needed to ensure that the learner receives the message as the transmitter intends it

Behavioral psychology
- analyze human behavior in terms of a pattern described as the "ABCs": Antecedents, the Behavior and its Consequences
- identify sources of positive reinforcement for a specific behavior, which can be used to shape future behavior
- study specific behaviors in detail to understand the costs and barriers to carrying them out
- measure behavior by observation rather than (or in addition to) self-report

Whereas HEALTHCOM can achieve this mix of disciplines at its home office by drawing on staff and consultants with different skills, at the field level the project has had to rely on a single individual--the resident advisor--to integrate these different perspectives into the project in each country. To familiarize the resident advisors with, and to a lesser degree capacitate them in these fields, HEALTHCOM has done the following:

- conducted workshops, including a series of presentations by the top experts in each of these areas during the 1986 training for the first cohort of resident advisors;

- provided each resident advisor with a working library of books, manuals and publications to serve as a reference for the theory and a guide for the application of these approaches; and

- provided technical assistance in the form of short-term consultants to complement the skills of the resident advisor.

HEALTHCOM staff and others familiar with the project recognize that it is not possible for a single individual to be fully proficient in all six disciplines. Thus, it is not surprising that resident advisors tend toward project activities that match their own backgrounds. For example, one resident advisor who was a former advertising executive designed a project strong in social marketing. In fact, it is logical to capitalize on one's strengths, and where possible, HEALTHCOM has matched the background of potential resident advisors to the perceived needs of the country. According to the project director, the main mechanism for maintaining the multidisciplinary approach has been to use short-term consultants in subject areas where the resident advisors need the assistance.

Of the six disciplines outlined above, the first five have become so intertwined with the HEALTHCOM methodology that it would be difficult to conceive of the methodology without them. By contrast, behavioral psychology has proved to be the most difficult to apply systematically in a way that has been understood and appreciated by those involved with the project. There are a number of explanations for this difficulty:

First, while these principles were very much a part of the theoretical design behind HEALTHCOM, they had only been tested in closely controlled environments such as schools and mental institutions within the United States. The few experts in this field came from strongly academic settings and had little experience in developing countries, which led to problems in integrating the behavioral focus into the ongoing activities at field sites.

Second, in this very specialized discipline leaders of the field were accustomed to discussing their ideas among fellow academics; perhaps because of this, their presentations at the initial training of resident advisors in 1986 were viewed by several to be high on jargon

and low on applicability. When in the field to consult on specific projects, several of these experts lacked interpersonal, linguistic and/or cross-cultural skills which would have facilitated the job of integrating their perspective into ongoing project activities.

Third, HEALTHCOM did not have a full-time staff member specifically responsible for coordinating the behavioral research until August 1987. At that time they hired a Ph.D. in Behavioral Psychology who had extensive international experience. (While her official title is "Senior Communication Advisor, Africa Region," she is referred to in this report as the "behavioral specialist.")

Fourth, because this element was new to HEALTHCOM and it was not entirely clear to all staff what the behavioral perspective entailed, the behavioral research was not integrated into ongoing activities (as called for in the contract and further discussed in Section C). One of the HEALTHCOM staff described these studies as "somewhat artificial."

Despite the rocky start, there have been a number of positive results with regard to behavioral analysis. First, with the arrival of the behavioral specialist, HEALTHCOM was better able to deal with this subject. It would appear that this individual succeeded in bridging the gap between the ideas from the academe and the realities of the field, in terms of making the best use possible of the external consultants and working with resident advisors to better understand the approach as it applied to their own circumstances. Over time and with experience in developing countries, certain experts became more skilled at presenting their ideas to non-academic audiences and at least one other consultant was identified who in fact had previous international experience and strong cross-cultural skills.

Perhaps the most lasting contribution from this aspect of the work has been the strong focus placed on understanding behaviors, which HEALTHCOM seeks to achieve. Whereas traditional health education programs put the primary emphasis on the "antecedents" (e.g., the messages which were to be transmitted), there is now much more attention given to (a) small but important details involved in practicing the specific behavior of interest (e.g., preparing ORS, breastfeeding, taking a child for immunization) and (b) reinforcement ("consequences"), which needs to be structured into the program to maintain a behavior once it has been tried. While some would claim that this is "nothing new," it does represent a shift in emphasis from the conventional approach to health education.

In sum, behavioral analysis was not as smoothly integrated into HEALTHCOM activities as were other disciplines (social marketing, anthropology, communication research); one individual at AED noted, "we would have liked the outcomes to be tidier." Nonetheless, this effort has succeeded in focusing attention on the need to understand better what the behaviors being promoted actually entail and how each can be reinforced (and thus shaped) in the future.

HEALTHCOM's project director mentioned that in the future the project intended to incorporate behavioral analysis in a way that would be more user-friendly. The evaluation team believes that HEALTHCOM II should continue its attempt to integrate these principles into its ongoing projects. It should (1) define in simple terms the basic principles which are directly applicable to its projects, (2) work with HEALTHCOM II staff (especially resident advisors) to identify how these principles might be tested to a greater extent in their own projects, and (3) prepare an easily understood brochure for use by counterpart institutions as to why this approach makes sense. HEALTHCOM has successfully "marketed" its methodology in general and should use the same techniques to market these basic principles in simple terms to their own staff and counterparts. Completely overhauling all ongoing projects is not suggested, but rather HEALTHCOM II should maintain a strong focus on the specifics of the behavior to be changed.

2. Type of Research Conducted

Background to the question:

> *What is the technical quality, relevance, and timeliness of the project's research on health behavior and behavioral change? To what extent has the project succeeded in institutionalizing these communication methodologies?*

As described earlier, the HEALTHCOM methodology is a research-based approach to the development of communications programs to bring about behavioral change in support of child survival interventions. The five stages in this approach are:

1. Assess the health problem in the target population;
2. Plan the communications strategy;
3. Develop and pretest the material;
4. Implement the strategy; and
5. Monitor its implementation.

Research conducted in the field sites for HEALTHCOM falls into two broad categories: formative and summative. Formative research is needed at several of the above-mentioned stages: to assess the health problem (#1), develop and pretest materials (#3), and monitor the program once in operation (#5). Efforts must focus not only on the communication aspects of the program, but also on the ways in which the services are being delivered. The number and types of studies to be conducted in a given country at each stage has depended on the information needs of the project managers (as well as the availability of funds). Table 3 lists the types of formative research that have been conducted to date in different HEALTHCOM field sites.

Table 3

TYPES OF FORMATIVE RESEARCH CONDUCTED AT DIFFERENT STAGES OF THE PROJECT

ASSESSING THE TARGET POPULATION:

- Knowledge, attitude and practice (KAP) survey among mothers, fathers, caretakers of children under five
- KAP among physicians, health workers, or other service providers
- Focus group discussions (FGD) with mothers, fathers, etc.
- Ethnographic in-depth interviewers with members of the population or key informants
- Market share study (e.g., ORS)
- Feasibility study of private sector production and distribution (ORS)
- Clinic-based observation of provider-client interactions

DEVELOPING AND PRETESTING MATERIALS:

- Concept test (to determine how to present a given product to the population)
- Visual look test (to measure audience interpretations of alternative characters or images to be used in the campaign)
- Pretests of posters, radio or TV spots to measure comprehension, recall, empathy, etc.
- Day-after recall studies of radio and TV spots

MONITORING PROJECT ACTIVITIES:

- Monitoring of broadcaster compliance to air spots (review of broadcast logs, watching programs on the air)
- Audience-tracking studies (to measure exposure to communications program, knowledge, attitudes, intentions)
- Observational studies of the behavior of service providers or mothers during or after the intervention
- Monitoring of service delivery activities from data provided by service providers (availability of vaccines, numbers of client visits, problems encountered, etc.)

HEALTHCOM contracted with two organizations for the formative research in selected countries: Porter/Novelli (primarily for social marketing) and PATH/PIACT (for materials development, pretesting and training of local personnel in these skills). In other sites, the resident advisors were responsible for the formative research, in some cases with assistance from local research firms. Personnel from the counterpart institutions (generally the ministry of health) tended to be actively involved in this aspect of the research. HEALTHCOM had not initially planned that Annenberg, the main subcontractor for the summative research, would also become involved in the formative research, but this in fact occurred in a number of sites.

In contrast to formative research, which focuses on process, summative research is intended to measure whether the program achieves its objectives in terms of the expected behavioral change in a given population. It is this type of research that tests the extent to which the HEALTHCOM methodology is effective. Given that relatively little work had been done in this field of health communication for behavioral change at the time HEALTHCOM was designed, it was extremely important for AID/Washington to have this type of systematic assessment of the impact of its activities in multiple countries. In most cases, this evaluation was based on baseline and follow-up ("before-after") knowledge, attitude and practice studies of the target population. In a few instances service statistics available from program records were used instead.

The subcontractors for the summative evaluation were (1) Applied Communication Technology (ACT) for the two sites that were carry-overs from the MMHP study (Honduras and The Gambia) and (2) Annenberg for all remaining countries. Because Annenberg did most of the summative evaluations, many of the persons interviewed in connection with this evaluation equated "research" with Annenberg. In fact, Annenberg received the largest share

of the research funds.[1] However, the current evaluation covers all of the research components, not just the summative.

In addition to the formative and summative research, the HEALTHCOM contract called for 10 behavioral studies to be conducted. These were included as a deliverable to ensure that HEALTHCOM would devote project staff and resources to the integration of behavioral principles into on-the-ground activities. These studies were designed to increase knowledge of specific behaviors being promoted and to foster experimentation with this new approach (of applying behavioral analysis to promoting new health practices in developing countries). While they were a separate deliverable, they were to constitute part of the formative research in the countries where they were conducted; however, they were not "standard" as was, for example, the pretesting of materials.

Given the newness of the behavioral approach, there was no obvious institution available to serve as a subcontractor for these behavioral studies. Rather, they were designed by HEALTHCOM staff and selected experts from the field of behavioral psychology, who worked with resident advisors and host-country counterparts in the execution of the fieldwork. One HEALTHCOM staff member reflected that it might have been easier to direct attention on the behavioral component of the project, had there been an outside subcontractor who was identified with this group of studies.

[1] Research funding percentages below are based on the amounts paid to each subcontractor for salaries, fringe, travel, per diem, operational expenses, other direct and indirect costs; they do not reflect the field costs for data collection which were often paid from other sources. From these figures, readers will have a better understanding of research funds were; these figures are not for accounting purposes.

Subcontractor	Percent - Total Research Funds
Annenberg	57
ACT	16
Porter/Novelli	10
AED consultants-behavioral studies	13
PATH/PIACT	4

3. Quality of the Research

Continuation of response to the question:

> *What is the technical quality, relevance, and timeliness of the project's research on health behavior and behavioral change? To what extent has the project succeeded in institutionalizing these communication methodologies?*

Whereas the *quantity* of research can be measured in terms of deliverables, the *quality* of research is less tangible. In assessing quality for the purposes of this evaluation, we considered a series of questions. Was the study design appropriate for the problem? Was the sampling done to yield a truly representative sample of the population? Were the questionnaires which were translated to other languages then translated back to English by a second source to assure that the meaning of each item remained intact? Were the questionnaires pretested? Were the interviewers fluent in the native language? Was the fieldwork closely supervised to assure compliance with the rules established for selecting and interviewing respondents? Were the questionnaires checked for errors before data entry? Were the data entered onto microcomputers using a program which checked for range errors and logical consistency among responses (or if not, was this conducted as a separate step)? In the case of focus groups, were the moderators able to elicit participation from all members of the group, stimulate truly spontaneous discussion, cover all questions on the guide, avoid dominance of the discussion by a single individual?

At the stage of data analysis and report preparation, there are additional issues to consider. Did the researchers use appropriate statistical techniques in analyzing the results? Did they control for confounding variables which could have explained the results?[2] Did they consider and present "alternative explanations" for given relationships rather than allowing the reader to jump to unwarranted conclusions?[3] Did they analyze a given set of data in detail to truly understand the underlying relationships among variables, even if many of these analyses were not used in the actual report? Did they present the results in a format

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[2] For example, if it found that the respondents in the follow-up survey had a higher level of education than those in the baseline survey AND that they were more likely to practice the desired behavior, one must ask: was the essential difference their educational level or the intervention itself?

[3] For example, there is often an association between knowledge and practice of a given behavior in cross-sectional data, but this is not necessarily causal. Whereas one could claim that increased knowledge results in greater practice of the behavior, it could also be argued that people who practice a behavior may then become more attentive to messages about it via the media.

that reflects the thoroughness of their work, yet which is relatively easy for other health professionals to read and understand?

It is difficult to assess the quality of fieldwork without observing it first-hand. Nonetheless, a review of selected research reports suggests that the standard procedures for maintaining quality control during the data collection stage were generally respected. Many of the items cited above are reported in the various country studies, suggesting that appropriate procedures were followed.

With regard to data analysis, the two-day visit to Annenberg allowed us to assess quality at this stage. It was clear from the lengthy discussions over small technical details that the Annenberg team is very methodical in its data analysis work. For example, as of January 1991, they had not submitted one of the final reports to HEALTHCOM because the "data didn't make sense yet" (the implication being that further analysis would allow them to better understand the seemingly anomalous results they had obtained in one study). When questioned about the quality of the research from Annenberg, several HEALTHCOM staff jokingly said that sometimes they wished Annenberg didn't put such a premium on quality; i.e., as project managers, they would prefer fast turnaround and "educated guesses" to academic rigor. As deadlines approach, some research organizations might be tempted to produce results for the sake of expediency, glossing over troublesome inconsistencies in the data just to "get the report out." Given Annenberg's level of professionalism, this option seems virtually out of the question.

Almost unanimous consensus was expressed among all persons interviewed that the research conducted in connection with the HEALTHCOM project was well done. Two exceptions surfaced. One involved a behavioral study conducted in Nigeria. The problems that characterized HEALTHCOM's early attempts at behavioral research are described above and need not be reiterated here. In the specific case of Nigeria, the research in question was a longitudinal study intended to measure whether certain changes at the level of the clinic (improving the patient flow to reduce waiting time and to give more opportunity for individualized counseling of mothers) would result in an increased rate of complete immunizations among children in the target population. This study was funded by the A.I.D. Bureau for Policy and Program Coordination (PPC).

The study was designed in Nigeria by one of HEALTHCOM's behavioral consultants in collaboration with host country counterparts. PPC was provided with a description of the methodology and seemingly approved it. Shortly thereafter (and in no way directed at HEALTHCOM's consultant in particular), the local USAID mission refused further use of expatriates for technical assistance to USAID projects in the health sector. Meanwhile, the MOH began giving immunizations outside the clinic setting, which threatened to bias the study results. The local Nigerian counterpart made some attempt to continue data collection on his own and sent part of the data back to Annenburg. However, it became clear that the

study could not be completed as scheduled. According to HEALTHCOM's behavioral specialist, HEALTHCOM recommended discontinuing the funding for this study and requested that it be reallocated to other behavioral studies. It appears that this incident occurred at a time of staff turnover at the USAID mission, which may have contributed to mixed lines of communication over this study.

Three staff members at S&T/Health commented on this study in quite negative terms. Among their comments: the study wasn't useful; it wasn't essential to improving the success of the child survival program; it was weak methodologically; it didn't move forward. One of the three objected to the fact that she had been asked to comment on a early draft of the report and had identified a "gaping hole" in the data analysis. Though pointed out to the principal investigator (a consultant), he reportedly presented the same data at an A.I.D. briefing, having made no attempt to address this problem, thus giving the impression he was trying to "push it by" them. (Apparently he was between institutions and the data were in transit, but this incident did not inspire confidence among the A.I.D. staff.) This same staff member summarized the Nigeria study as a combination of "bad methodology and bad luck."

A second study also described in strongly negative terms was one done by ACT in Honduras. It involved an evaluation of mothers' behavior regarding diarrheal disease control. According to one of the individuals interviewed, "it was too long..too big...an academic, university study that was overly designed and missed the point...and the final report was not done in Spanish." Far from the learning experience which was intended, it became a frustrating experience for those involved.[4] (This same individual otherwise had strong praise for HEALTHCOM activities in Honduras.)

However, these two negative experiences should be weighed against the consistently positive comments made from persons at all levels regarding the quality of the

[4] The ACT response to this criticism centered on two main points. First, the rigorous study design was not intended to serve the interests of local USAID mission and ministry of health staff, but rather the objectives of A.I.D./Washington, which were to have a very strong research design such that, if the approach worked, "it wouldn't leave people quibbling over the small points." Thus, the survey research conducted under HealthCom I was based on a design which had been established under MMHP. Second, with regard to the long turn-around time, the data were collected in mid-1987. Preliminary data were presented at the TAG meeting in early 1988. The full text of the final report was submitted to AED in mid-1989. At that point, there appear to have been further delays which resulted from the AED review process and their request to ACT to include more information on the intervention itself. This proved to be more difficult than expected (the records did not exist, or were not readily accessible in Honduras), and in the end it was decided to abandon the attempt to include this information. However, this final review/revision period did take over a year. This chronology indicates why action-oriented individuals at the field level have labeled the process as "slow."

HEALTHCOM research. With regard to other behavioral studies, several have met with very positive response (including high marks for the performance of the HEALTHCOM behavioral specialist on other projects). A pilot study in Mexico, "How Much ORS Solution is Actually Administered During Home Based Therapy?", followed by an expanded replication in Lesotho focused on the question of whether mothers administered sufficient quantities of ORS to their babies during diarrheal episodes. These studies involved actual observations (not just self-reports) of the mothers at home. Results of the Mexico pilot have been published in the *Journal of Tropical Medicine and Hygiene* and have addressed an important issue, both for host country counterparts and for the larger scientific community. (As an example of the relevance of this study in Lesotho, it was a ministry of health staff member who originally raised this question to the HEALTHCOM resident advisor, not vice versa.)

With regard to the formative research conducted by Porter/Novelli in Mexico (one of the two main sites where the firm worked), one staff member characterized the quality of the research as "higher than was needed." She went on to explain that in a situation where the medical community needs to be persuaded of the value of this approach, it is sometimes necessary to conduct more research (to have convincing evidence for this audience) than is in fact necessary to get the job done.

In summary, HEALTHCOM has assembled a very impressive research portfolio, both in terms of the quantity of publications and the uniformly high quality of the work. The researchers interviewed during this evaluation are clearly at the forefront of this field. They are guided by the professional standards of their respective institutions, as well as the personal commitment they clearly feel to advancing the state-of-the-art in this field.

Finally, HEALTHCOM and its subcontractors are to be commended on the clarity of presentation in their reports. It is difficult to make result findings easily digestible, and no doubt some persons in the field still feel the Annenberg and ACT country reports are "too technical." On the other hand, it is unfair to judge the "readability" of a research report against, say, a newspaper, and HEALTHCOM's subcontractors have succeeded in communicating the basic points in a language that can be fairly readily understood by other health professionals.[5]

[5] The publications produced for professional journals included more "jargon," but in fact this may be appropriate for the intended audience. Also, different researchers have different styles of presentation, such that even within the journal articles there was a range from "readily understandable" to "unnecessarily obscure."

At the same time, there is room for improvement in the presentation of results in the summative evaluation reports, as follows:

1. Objectives of the communication program should be described, and the presentation of findings should highlight the extent to which each objective is achieved. (This is done well in most of the reports, but not all.)

2. Present the data to take fullest advantage of the design used. (The comment is directed most specifically to the Zaire report, in which it would have been appropriate to consistently compare the treatment versus comparison areas for the before and after surveys on the variables of interest. The analysis should have focused more specifically on the questions: Did change occur in the treatment area between the surveys, and was this change significantly greater than that which occurred in the comparison area?)

3. Clarify to the reader any "special considerations" that applied to the evaluation. (The Jordan report appears to under-emphasize the actual results obtained in the evaluation. As explained subsequently by the author, Jordan was not intended to by one of the large-scale "tests" of the HEALTHCOM methodology. However, this is not stated clearly in the report and leaves the reader wondering why so little emphasis was given to the evaluation of impact.)

4. In the case of the Zaire report, explain why the activities carried out and the outcomes evaluated don't seem to match.

4. Immediate and Long-term Relevance of the Research

Questions:

What is the technical quality, relevance and timeliness of the project's research on health behavior and behavioral change? To what extent has the project succeeded in institutionalizing these communication methodologies?

What is the importance of the research component to the overall project objectives? Could the research be eliminated or reformulated without compromising the project's effectiveness?

In discussing relevance, one must differentiate between formative and summative research. Moreover, one must weigh the short-term needs of program managers for information to develop and modify a specific communication program against the long-term needs of A.I.D. and the donor community for cross-national studies demonstrating communication effects that will inform policy-making in the future.

There was near-unanimous agreement among the persons interviewed that the formative research component of HEALTHCOM was essential. That is, the HEALTHCOM methodology is research-based, and without the research one does not have the methodology. Virtually all of the individuals interviewed indicated the importance/relevance of this portion of the research.

Curiously, the most negative comments concerning the relevance of the research to the development of the communication programs in-country came from Annenberg. (It should be stressed that in fact formative evaluation was **not** in Annenburg's original contract with HEALTHCOM; however, HEALTHCOM's field staff often pressed Annenburg for early release of baseline data so that it could be used for formative purposes.) Staff at Annenberg found that "with some exceptions, little of the analysis we did affected program plans in an effective way. One hypothesis explaining this failure was that there were many determinants of the shapes of programs, and since, with the exception of Ecuador, we were not able to lobby day by day for the decisions we thought the data suggested, the results were often ignored. Another hypothesis is that the data were not presented in a fashion whose implications for action were clear enough...We think a certain level of expertise or experience is needed to be able to turn research results into communication interventions or programs."

As for the relevance/importance of the summative research, the response was mixed. Those who were involved with HEALTHCOM at the field level (resident advisors, collaborators from other S&T/Health projects, USAID mission personnel) generally acknowledged the need for summative research; some considered it essential. However, there

was widespread concern over the costs of this research. Several implied that the research was too expensive and/or sophisticated, making it difficult to sustain in future years. A few of those interviewed mentioned "overkill." As one person put it, HEALTHCOM had "developed a Cadillac when they could have gotten the job done with a Chevy." In brief, many in the field questioned whether research at this level of expense and sophistication was appropriate for developing country settings.

At the same time, one should not lose sight of the value of the summative evaluation to the field of communication research and to the donor community. Prior to HEALTHCOM there was little empirical evidence of the effects of mass media on health practices (notable exceptions being Honduras and The Gambia). Moreover, while the HEALTHCOM methodology appeared to be a rational approach to the development of communication programs, it was relatively "untested" (had not been the subject of summative evaluation in field settings of developing countries). In Annenberg's view, the major contribution of the summative research will be the compilation of cross-national data for the purposes of advancing knowledge in the field of health communication for behavioral change. This conforms closely to the design of the HEALTHCOM II project, in which Annenberg will not conduct summative evaluation of ongoing projects but rather will conduct further analysis of the HEALTHCOM data, in an attempt to derive a better understanding of communication processes based on empirical data from multiple sites which can be used to inform policy-making in this area in the long-term.

In brief, the formative research has been highly relevant to implementation of the communication programs at the field level and has been widely appreciated for its contribution. Second, the summative research is seen as less important to the immediate goals of the host country counterparts (and others working at the field level). While many acknowledged that it did have a place in this type of project, they questioned the expense and level of effort involved in supporting and producing it. And third, the summative research is important to A.I.D. and other donor agencies who stand to benefit greatly from the synthesis of findings based on cross-national data regarding communication for child survival.

5. Timeliness of Results

Continuation of the Question:

> *What is the technical quality, relevance and timeliness of the project's research on health behavior and behavioral change? To what extent has the project succeeded in institutionalizing these communication methodologies?*

A number of criticisms were heard regarding the turn-around time on the summative research done by Annenberg and ACT. In this regard, several points merit discussion.

First, as mentioned above, it was not originally intended that Annenberg would be involved in the formative research. Rather, they were to conduct summative evaluation. However, the "before-after" study design used in the summative evaluation for most countries meant that they collected baseline data (which in some cases were the only data) on the health problem in question, and field-level personnel were understandably interested in obtaining the results for the purposes of incorporating the information into their communication strategies. However, HEALTHCOM had not specified in its agreement with Annenberg that they (Annenberg) would be responsible for generating reports from the baseline studies as a separate deliverable.[6] Once it became apparent that their baseline data would be very useful to project managers in the field, Annenberg made concerted efforts to produce specific information requested by the resident advisors in-country.[7] However, they had not programmed staff time for this task, which explains in part why their response may have been "slow." Moreover, the distance between Annenberg and the field sites meant that project managers could not get quick answers to specific questions.

Second, the project was originally designed such that the program activities and thus the summative evaluations for the different countries would be staggered over the life of the project. This would have allowed the Annenberg staff to direct their full attention to each project as it came on line, and to finish one evaluation before going on to the next. However, the implementation of the studies was delayed in a number of countries, such that the different projects tended to converge in terms of timing. Also, several resident advisors wanted to delay the final evaluation until the end of the project period to allow more time for the communication activities to have an impact. In short, rather than having a staggered schedule of follow-up studies, Annenberg had to supervise fieldwork and/or analyze the data from seven different countries during calendar year 1990. Given staff resources, they could not necessarily begin the analysis of data for a given country once the raw data became available, since they also had to cover the collection of data in other countries. It is understandable why country counterparts and USAID mission personnel considered the turnaround to be "slow" in some cases. At the same time, the change in the timing of the interventions and thus of their evaluation was beyond the control of Annenberg.

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[6] In terms of summative evaluation, the results of the baseline are of interest only in comparison to the follow-up survey results. As such, Annenberg expected the bulk of its work to occur near the end of a given project, when the data from both baseline **and** follow-up surveys would be available.

[7] This took a number of forms: provision of basic frequencies and cross-tabs or more elaborate reports based on data collected under Annenberg's design/supervision; tables or graphs in response to specific questions; brief summaries of the results of the baseline surveys; and face-to-face presentations of results.

Third, Annenberg was not responsible for the data entry process in a number of countries. They could not begin analysis until they received a clean data tape from the local firm. The delay in this part of the work may have further added to the impression that the process was slow.

Fourth, quality research takes time. This is especially true in the context of developing countries, many of which do not have research firms that can provide the full range of skills and at an acceptable level of quality to complete summative evaluation.

At the same time, the frustrations voiced by people at the field level cannot be overlooked. One individual familiar with the project in Nigeria reported that the ministry of health personnel and, to a certain extent, the USAID mission personnel recognized the value of the research, but became very impatient when it dragged on and the communication program was still not launched. Eventually the cry goes up: "Where are the billboards?" In fact, it seemed that the resident advisor eventually felt sufficient pressure to "produce" that he may have cut some corners in terms of not waiting for the results to come in before designing materials.

Turnaround time for survey research can be reduced in several ways. One is to enter data onto microcomputers at the field site simultaneous with the data collection, such that the data entry is completed within days of the data collection. This was done at some sites (especially where Annenberg rather than a local firm supervised the data collection). A second way is to use data entry programs that edit the data as they are entered. Such programs reject "out-of-range" values and produce a list of logical inconsistencies in the data. According to Annenberg, they adopted these "time-savers" as they became available, which meant they were more likely to use them on later than earlier studies.

A third means of reducing turn-around time on research is to have research consultants who are able to spend up to six months at a time at a given field site and work on the data analysis in-country. However, the viable options for technical assistance tend to be short-term advisors on one hand (up to 2-3 months maximum) or full-time advisors who reside in country. Whereas the latter system was used in the earlier MMHP projects in Honduras and The Gambia, this represents an enormous expense which donor agencies are unlikely to accept at the present time.

6. Evidence of the Effectiveness of the HEALTHCOM Methodology

Question:

Do HEALTHCOM's research findings provide evidence that communication has a significant role to play in health service delivery in developing countries?

This is a central question to the evaluation of HEALTHCOM: Does it produce results? Summative research provides a test of the effectiveness of the HEALTHCOM methodology in changing specific health behaviors. In practice, it is a test not only of HEALTHCOM activities, but of the various efforts of all participating agencies for a given intervention. Thus for example, in a specific country one cannot measure the relative contributions of HEALTHCOM, the REACH project and UNICEF to the ministry of health program to increase immunization coverage. Rather, it is an evaluation of the extent to which the collective efforts of **all agencies involved** result in a measurable change in behavior.

What is the evidence to indicate that HEALTHCOM "works"? (i.e., that those countries which have followed this research-based approach to health communication achieved the objectives of their programs in terms of a change in behavior among the target population). Data addressing this question are available from 10 of the case studies done under HEALTHCOM:[8]

- the two original countries under MMHP, for which the evaluation research was done by ACT (Honduras and The Gambia)
- two countries for which the bulk of the work was done under the earlier project, but the evaluation was completed by Annenberg under HEALTHCOM (Peru and Swaziland)
- six sites in five countries for which the interventions were developed and carried out primarily under HEALTHCOM and evaluated by Annenberg (Ecuador, Central Java, West Java, Lesotho, Philippines, Zaire)

While it is difficult to summarize the findings from such a large and diverse body of information, a review of the final reports of these projects leads to the following observations.

[8] Note: narrative case studies were prepared for two additional countries--Jordan and Papau New Guinea--but these were not intended as empirical tests of the impact of the approach.

In general, most programs showed a substantial (and statistically significant) change on at least one of the key behaviors targeted by the program.

Control of diarrheal disease was central to seven of the 10 projects with a summative evaluation component. In five of the seven (The Gambia, Honduras, Swaziland, Ecuador and Lesotho), use of ORS among mothers or caretakers increased significantly, and in the sixth (West Java), performance in administering ORS improved among health workers. Only in West Java and Zaire was there little change in the use of ORS among the mothers/caretakers.

Immunization was the focus of interventions in six of the 10 sites. Increased coverage and/or more timely vaccination of children was documented in five of the six: Peru, Philippines, Ecuador, Central Java and Lesotho. In the sixth site, Zaire, change was also observed, though it was slight.

Vitamin A was the topic of the intervention in only one site: Central Java. Levels of coverage did increase following the campaign in those communities with access to health posts, the distribution point for the Vitamin A capsules.

These changes, documented in great detail in the country reports, provide strong evidence that a research-based approach to public health communication, integrated with service delivery mechanisms, can produce desired behavioral change.

At the same time, it cannot "guarantee" change, as evidenced by the lack of change regarding birth spacing in Peru, and mothers' use of ORS in West Java and Zaire. On the balance, however, the conclusion that emerges is that significant behavioral change has occurred following the HEALTHCOM interventions.

The study designs used in most countries do not unequivocally demonstrate causality.

One of the most convincing means of demonstrating impact is a controlled field experiment using a control or comparison group. However, where mass media are used, this is often a virtual impossibility, since all areas of the country are potentially exposed to the program and those which are not tend to be atypical.

Instead, the HEALTHCOM evaluations are generally based on before/after surveys of a random sample of the target population, without the benefit of a control or comparison group. Whereas non-researchers would tend to accept changes in behavior in the target population between the two surveys as "evidence of impact," there is a lingering doubt as to whether that change could have occurred in the absence of the program (i.e. whether it was caused by factors other than the program).

In fact, the study designs used in the HEALTHCOM research were generally appropriate to the circumstances; further "rigor" could have been obtained only at extremely high cost (in terms of human and financial resources), which would have been unacceptable to donor agencies and host-country personnel.

Annenberg tried to overcome the limitation of this study design in several of its analyses by analyzing the link between knowledge of the intervention, exposure to the media, and change in desired behavior (e.g. in the reports from Ecuador, Philippines, Central and West Java). When further refined, these analyses will represent an important contribution to the literature on health communication. At the same time, S&T/Health and others who intend to use these results to demonstrate the impact of HEALTHCOM should be aware that this body of research is open to criticism from the purists on the basis that "there is no control group."

The study designs were at times compromised by the realities of the field.

In a project involving both implementation and evaluation, what is best for the project manager may not be best for the researcher. For example, the project manager may be under constraints to launch a campaign within a certain budgetary period or before the rainy season begins, whether or not the programmed baseline survey has been undertaken. In Central Java, the "baseline survey" was conducted after the communication program had begun. In Zaire, the follow-up survey was carried out before the third round of the immunization campaign was completed. In the Philippines, the survey instruments (i.e., questions) were changed between surveys. It appeared from the reports that the research was not allowed to "get in the way" of program activity, which is appropriate for this type of action-oriented project. However, there is a trade-off, since it is then more difficult to accurately measure the extent of change that occurs.

The presence of HEALTHCOM in country by no means guarantees an impact if the intervention itself is not strong.

HEALTHCOM efforts in Zaire, for example, suffered from lack of a clearly defined counterpart institution; the Resident Advisor (RA) worked with different groups largely on interpersonal communication activities. The intensive immunization campaign originally planned did not materialize. Thus, the evaluation (a before/after survey in the city of Lubumbashi) failed to show impact. The authors concluded: "...it is not surprising that the overall results concerning the use of ORT are the same for the two surveys, and that the increase in immunization was small."

Despite the methodological limitations, the summative research conducted under HEALTHCOM has set a new standard for the evaluation of health communication projects

HEALTHCOM research (1) requires health communication to be accountable, (2) extends the domain of "communication" to include the highly important aspect of what happens at the level of the service provider,[9] and (3) attempts to explain why the program had an effect, by linking media exposure, knowledge and behavioral change.

In summary, this body of research reports generally shows positive change in the wake of the interventions developed using the HEALTHCOM methodology and confirms the value of the research-based approach to health communication. An equally significant "result" of the project is the standard of excellence it has helped to establish in terms of evaluating communication projects.

Regarding the results of the final report, it is essential that they be disseminated to as wide an audience as possible, as previously mentioned in the management section. HEALTHCOM has an impressive portfolio of survey results, field notes and other research reports to date, but relatively few studies have been published in professional journals. This is understandable, given that the summative results were not available until the end of a project; moreover, there is usually a period of two to nine months in the turnaround time for social science journals from submission to acceptance. However, publication of these results in professional journals should remain a key objective of HEALTHCOM II for two reasons. First, it increases the number of health professionals who will have access to these findings, and second, it gives the findings greater credibility in the eyes of the scientific community.

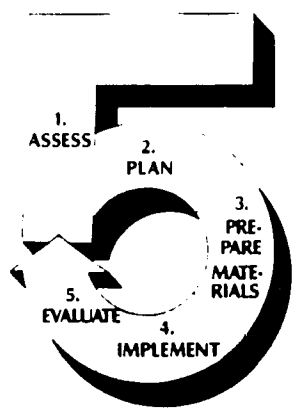
[9] IEC has traditionally dealt specifically with the communication content of a program and evaluated its impact on knowledge, attitudes and behaviors. By contrast, the HEALTHCOM approach also integrates the role of service delivery more directly; this is done by focusing on training as part of the "communication strategy" and evaluating what actually happens at point of service delivery. Example: the evaluation of the PREMI campaign in Ecuador showed that the campaign had successfully increased knowledge of ORS, but use did not increase given deficiencies in availability of the product.

7. Institutionalization of the Communication Research Methodologies

Continuation of response to the Question:

> *What is the technical quality, relevance and timeliness of the project's research on health behavior and behavioral change? To what extent has the project succeeded in institutionalizing these communication methodologies?*

Because this evaluation did not include field visits, our assessment of "institutionalization" is limited to our interviews with those people familiar with the local institutions at different field sites and the case studies/evaluation reports for selected countries. In this evaluation we have interpreted "institutionalization" to refer to the five-step approach, shown in the illustration below. As such, it includes the formative research, but not the summative research component.



HEALTHCOM's five-step methodology

In terms of the formative research, there was fairly widespread consensus among the persons interviewed that in most countries institutionalization of the research methodology had occurred at least preliminarily. First, local counterparts had come to appreciate that the messages needed to be based on a solid understanding of the target population--their knowledge and beliefs, media habits, etc. In short, most had internalized the need for a detailed assessment of the target population prior to message development. Second, most local counterparts had come to appreciate the value of pretesting materials prior to production and diffusion. This seemed to stem from their first-hand experiences of learning that *what they saw* in the materials was very different from *what the intended audience saw*; in fact, the materials in some cases would have transmitted the wrong idea if these problems had not be identified and remedied before final production.

Porter/Novelli, a subcontractor that assisted with the social marketing aspect in the projects in both the Philippines and Mexico, indicated that a great deal depended on the host-country counterpart's skill and motivation level. In more developed countries, existing market research firms have capability to conduct social research (as measured by the sampling procedures, quality of interviewers, availability of trained personnel to code and analyze data on microcomputer). Porter/Novelli staff cited Mexico as an example where their initial investment paid off later on. Whereas ministry of health personnel had not used marketing techniques in their previous health communication programs, they gained sufficient insight into the process during their work with HEALTHCOM so that they were able to move much more quickly and were much more knowledgeable when AED later worked with them on an AIDSCOM activity. As one of the Porter/Novelli staff commented, "it was a major triumph when they assessed the picture not only in terms of whether it was pretty, but whether it also fit into the strategy."

At the same time, an appreciation of the basic principles of assessing the situation and pretesting materials does not necessarily translate into the skills and political will needed to actually conduct formative in the absence of external assistance. In countries in which ministry of health personnel had to take on data collection for lack of in-country research capability, it is unclear whether their limited exposure to these procedures would allow them to be self-sufficient in carrying out this type of work on their own in the future. Moreover, would governments choose to use their own funds to pay for this type of research?

While the comments made during the telephone interviews suggested that at least portions of the HEALTHCOM methodology had been successfully institutionalized, the findings presented in the case study evaluations for selected countries indicate distinct problems in the area of institutionalization. Country reports which specifically addressed this issue included Ecuador, Jordan, Lesotho and Papua New Guinea.

Several themes recurred with respect to the difficulties of institutionalization:

1. In several instances, agencies other than the Ministry of Health were selected as the host-country institutional counterpart, though the MOH played a collaborating role (e.g., the Queen Noor Foundation in Jordan and INNFA in Ecuador). They were initially chosen because they were seen to have fewer bureaucratic constraints in implementing the program. However, in the long run this resulted in less technical capability being transferred to the MOH and less of a sense of identification with project activities.

2. Priority was generally given to activities that contributed directly to achieving the program objectives of changing health behaviors, with only secondary consideration to ensuring that the knowledge and skills needed to conduct similar activities at a later date were passed along to host-country counterparts.

3. Staff turnover has impeded institutionalization. In Jordan, where the process was basically institutionalized in two individuals, one had already left the institution by the time of the evaluation.

4. Pressure from expatriate staff to "select" a specific health topic as the focus of the HEALTHCOM project (in preference to one judged to be a higher priority by local counterparts) appears to have reduced commitment to the activity and diminished the probability of long-term involvement conducive to institutionalization (examples include Jordan and Papua New Guinea.)

In sum, a conclusion made with reference to the program in Ecuador would seem to refer as well to the other countries in which HEALTHCOM has worked:

> "The potential of public health communication seems clearly documented, even if the ways of permanently institutionalizing it are not."

One final comment concerns the midterm evaluation report of HEALTHCOM, which recommended "streamlining" the process. The current evaluation team supports the simplification of research designs at the formative stage, but does not endorse the idea of standardization, which would tend to make the projects less flexible and adaptable to local needs. While some might argue that it is redundant to repeat the same types of studies over and over in different countries, one of our respondents made the astute comment that "the value of HEALTHCOM is that you do reinvent the wheel each time. You want people to go through the process to see it and believe in it."

8. Potential Conflict of "Subcontractor as Evaluator"

Question:

> *What are the pros and cons of having the research/evaluation and service delivery aspects contained within HEALTHCOM?*

Under the MMHP project, implementing the communication program was the job of one contractor (AED); the task of evaluating it was given to a separate contractor, to assure objectivity in the reporting. Under HEALTHCOM, both the implementation and summative evaluation components were included in a single contract with subcontracts to various groups.

This raises the question: Is this an optimal arrangement, or would the interests of S&T/Health be better served by having the evaluation conducted under a separate contract?[10]

The argument in favor of having the two components under a single contract is that the evaluator is more likely to know the history and details of the project. Thus, he might be able to derive greater insights from the findings than would someone unfamiliar with the project, who "parachuted in" to conduct the research. Another reason is that this system builds a two-way trust among the evaluator and implementor.

The argument against having the two components under a single contract is that the evaluator might lose his objectivity, especially if there were any pressure from the main contractor (who in essence pays his/her salary) to portray the project in a favorable light. In fact, the bias might even be so subtle as to go unnoticed by most; for example, the evaluator might omit a small detail which might reflect unfavorably on the project, or he/she might give an interpretation to negative findings that might cushion the blow.

None of the persons questioned about the current contractual arrangement (whereby the subcontractors Annenberg and ACT evaluate the main contractor AED) seemed to have considered the issue of a potential conflict of interest prior to our questioning. When asked the specific question and given time to reflect on it, a few recognized that there could be a conflict of interest and mentioned that it might be preferable to have separate contracts in the future. It seemed clear to the evaluation team that this type of response was triggered more by our question than by doubts which had surfaced based on their observation of these groups in the field. Among these, the majority also added that while the potential for conflict of interest (or the perception of it) was there, in fact they did not question the integrity of the evaluators in this case.

The evaluation team concludes that while the current arrangement could be perceived as a conflict of interest, the benefits have outweighed the drawbacks under the HEALTHCOM project. The Annenberg group is governed by the professional standards of a research university. Their professional rewards in participating in this project come primarily from advancing knowledge in the health communication field. Given the level of professionalism in the institutions involved, it seems to be a non-issue, at least in this evaluation.

[10] It should be noted that A.I.D. has had two external evaluation teams assess the project. However, these teams were not responsible for evaluating project impact in terms of behavior change.

9. Conclusions and Recommendations

Inasmuch as HEALTHCOM has ended, these recommendations are offered for their relevance to HEALTHCOM II.

Integration of Different Disciplines into the Methodology

1. HEALTHCOM should continue to integrate the behavioral perspective into its projects, focusing especially on the details of the behavior itself and the need for reinforcing this behavior to sustain it in the future.

2. HEALTHCOM should "market" the basic principles of this behavioral perspective to HEALTHCOM staff, counterparts and others in the field in a form that will clarify the concept for persons unfamiliar with it.

3. HEALTHCOM should have one of the more readily understood behavioral experts work with the resident advisers in gaining a greater appreciation of what this approach has to offer in practical terms to specific projects.

4. S&T/Health and HEALTHCOM should incorporate the behavioral research as an integral part of future projects, rather than an add-on to meet a deliverable requirement.

Quality of the Research

1. To the extent further summative research is done, HEALTHCOM should maintain the same high standards as currently exist; it should not consider cutting corners to reduce costs.

2. If cost is an issue, S&T/Health and HEALTHCOM should limit summative research to specific projects which introduce new components "worthy of empirical testing"; it should not be conducted routinely as "part of the HEALTHCOM package"; (in fact, this is the case in HEALTHCOM II, in which no further summative research is foreseen).

3. In future activities, HEALTHCOM should use a far greater percentage of the available research funds for formative research, with a strong focus on monitoring. (Note: this is not to detract from the summative evaluation done under HEALTHCOM, but rather it reflects the needs of the field and a shift in priorities now that HEALTHCOM data are available for in-depth analysis.)

4. HEALTHCOM should increase efforts to get project results published in scientific journals, both to increase the number of potential readers and to enhance the credibility of the findings in the eyes of the scientific community

Relevance and Timeliness of the Research

1. HEALTHCOM should strengthen efforts to work with in-country counterparts to develop their skills in asking the appropriate research questions and tailor research to their specific interests.

2. HEALTHCOM should design formative research that can be done locally on a fairly small scale with rapid turn-around.

3. HEALTHCOM should adapt each study to the local realities; it should not attempt "standardization" of the methodology (beyond the five steps).

4. Wherever the human and financial resources exist, HEALTHCOM should use local research firms that deliver a quality product within a fixed time period.

5. HEALTHCOM should encourage local research firms and/or other counterpart institutions to conduct (near) simultaneous data collection/entry and to use programs that edit the data at the time of entry.

6. HEALTHCOM should try to reduce and (if possible) eliminate formative research which can not be analyzed in-country.

7. HEALTHCOM should devise and/or refine methods for presenting research findings to persons who are not research-oriented; it should prepare attractive, easy-to-read summaries of project results for in-country use by non-researchers.

8. HEALTHCOM should provide opportunities for HEALTHCOM subcontractors to visit countries and present the findings of the summative research to counterpart institutions, to increase understanding of the process and the results.

Institutionalization of communication research

1. HEALTHCOM should encourage counterparts to select relatively easy research designs for the formative research, which can be used on similar projects in the future.

2. HEALTHCOM should avoid the temptation to "do the job for them" for the sake of getting it done; allow time for counterparts to learn from their mistakes.

3. S&T/Health should make institutionalization a more explicit objective of the project (as it now is in HEALTHCOM II).

Evaluator as subcontractor

1. HEALTHCOM should continue with the current system of "partnership" between the implementor (prime contractor) and evaluator (subcontractor), provided the latter has demonstrated a high level of professional standards with respect to evaluation work.

C. PROJECT DELIVERABLES AND OUTPUTS

HEALTHCOM was a "deliverables" contract, in contrast to many others that specify "level of effort" for the technical assistance to be provided by the contractor. The project's performance was judged here according to its completion of the contract-specified outputs. HEALTHCOM, in its contract and subsequent amendments, was required to submit the deliverables listed in Table 4 on the next page.

1. Contract Compliance

Question:

> *Has the Academy for Educational Development and its subcontractors successfully executed the deliverables listed in the contract, contract amendments and the adjoining subcontracts? Be specific.*

In reviewing the project's outputs, the team concluded that HEALTHCOM implemented nine successful new country programs and produced a number of noteworthy products despite complications. Our analysis is limited to the deliverables that best represent the project's strengths and weaknesses. The team has also given particular consideration to the degree that contract-specified deliverables were achievable in light of the project's design.

1.a. Noteworthy Products

HEALTHCOM has produced noteworthy items drawing praise worldwide. These HEALTHCOM products have helped A.I.D. achieve its objectives of advancing behavioral research and improving HEALTHCOM's methodology, while also contributing significantly to public health interventions. Highlights of these products are presented below.

Health Practice Studies. In spite of complications described below, these studies achieved their purpose of focusing attention on behavioral analysis and health behavior change, while lending credibility to HEALTHCOM's activities. This was accomplished by communicating project results in discrete studies. Four out of the five Health Practice Studies completed at the time of this evaluation have been published or accepted for publication in professional journals. A HEALTHCOM study published in the *Journal of Tropical Medicine and Hygiene*, "How Much ORS Solution is Actually Administered During Home Based Therapy?" drew praise from several donor organizations, including the U.S. Centers for Disease Control.

Table 4

HEALTHCOM DELIVERABLES

	Deliverables	Required	Delivered
1.	Institutional Studies I (new country sites)	10	9[11]
2.	Institutional Studies II (continued MMHP sites)	7	4[12]
3.	Implementation Plans	1 per country site	15[13]
4.	Semiannual Reports	8	8
5.	Resurveys for Honduras and The Gambia	2	2
6.	Technical Advisory Group Meetings	1 annually	4
7.	Case Study Evaluations (a final impact study)	1 per country site	13[14]
8.	Health Practice Studies	10	10
9.	Special Reports	8	8
10.	Field Notes	up to 40	40
11.	Developing Country Workshops	3	15+[15]
12.	Faculty Workshops (for developing country and U.S. schools of public health,	1	1
13.	Regional Workshops	3	3
14.	Videotapes, accompanying brochure	3	3
15.	Publications, papers and presentations	30	170+

[11] This accounting is derived by the team through its interpretation of contract terminology requiring HealthCom to implement the contract scope of work in each country site, as compared to initiating activities in which the scope of work, by the close of HealthCom I, had not been implemented. The nine long term sites in which HealthCom seems to have satisfied most Institutional Studies I criteria include: Zaire, Jordan, Philippines, Paraguay, Guatemala, Nigeria, Papua New Guinea, Mexico and Malawi.

[12] These are Ecuador, Honduras, Indonesia and Lesotho.

[13] Includes Guatemala, Jordan, Malawi, Mexico, Nigeria, Papua New Guinea, Paraguay, Philippines, Yemen, Zaire, Ecuador, Honduras, Indonesia (separate reports submitted for West and Central Java) and Lesotho.

[14] Includes Ecuador, The Gambia, Honduras, West Java, Central Java, Jordan, Lesotho, Papua New Guinea, Paraguay, Peru, Philippines, Swaziland and Zaire.

[15] These figures represent the contractor's own accounting; the evaluation team was in no position to evaluate previous Faculty Workshops, Regional Workshops, Presentations, etc.

Special Reports. Reports produced by HEALTHCOM under the Special Reports section of the contract were the project's most highly demanded and widely circulated publications, surpassing contract requirements in terms of the numbers of copies printed and distributed.

- *Communication for Child Survival.* Approximately 4000 copies have been published in response to numerous requests from over 60 countries, 500 of which were paid for by AED; the report underwent several publications in English, Spanish, French and Bahasa Indonesia, and received Second Prize from the Academy for Health Services Marketing, a division of the American Marketing Association.

- The *Handbook for Excellence in Focus Group Research.* One thousand copies have been reproduced with AED funds to meet demand. HEALTHCOM covered the cost of translation into Spanish and French.

- *Managing a Communication Program on Immunization: A Decision-Making Guide.* Two thousand copies of the manual have been printed, with AED paying for half. Produced in cooperation with the Philippine Department of Health, the manual discusses managing health communication support for immunization programs.

Videos. In addition to videos produced independently by the project's country programs, the HEALTHCOM contract called for three instructional video tapes about the methodology and its findings aimed at senior developing country technical staff, decision makers, and donor agency collaborating professionals. Videos produced for this purpose were:

1. *Miriam: El uso Exitoso de la Terapia de Rehidratacion Oral* (Miriam: The Successful Use of Oral Rehydration Therapy). In collaboration with the Pan American Health Organization, HEALTHCOM produced this dramatized, educational video in Mexico. A companion study guide was produced with additional assistance from A.I.D.'s Technology for Primary Health Care (PRITECH) project. This video has been used to train and raise awareness among medical students throughout Latin America.

2. "*Making Things Clear*" was produced in Papua New Guinea and is in use at various project sites as a health worker training aid. It is considered an example of how effective education materials like this video can be produced in an environment having only minimal resources.

3. *Health Communication: Partnerships for Survival* was produced by HEALTHCOM in English, Spanish and French to explain the HEALTHCOM methodology and offer insights into public health communication methodology. It was the winner of an Honorable Mention in the John Muir Medical Film Festival and the Houston International Film Festival.

These three HEALTHCOM videos have been popular with universities, other donors, such as PAHO and WHO which use the videos in several developing countries, and other A.I.D. projects as well; all are considered to have been very successful.

Field Notes. Field Notes were valuable in disseminating HEALTHCOM's activities, especially within developing countries and to other interested organizations. As mini-case studies with a focus on technology transfer and the operational aspects of the project, Field Notes translated into the language of prospective ministry of health counterparts during the first half of the project proved helpful in marketing HEALTHCOM's activities in new countries. To date, eight of the reports have been translated into Spanish and five into French; their appeal to host national counterparts emphasizes the importance of translating project documents.

1.b. Complications

HEALTHCOM has completed the specified deliverables under a six-month, no-cost extension granted by A.I.D. for this purpose. However, the project experienced difficulties in satisfying contract requirements for several reasons: production delays, burdensome contract requirements, deliverables that were required to satisfy somewhat conflicting output and process objective.

New project sites: Institutional Studies I. The contract language is somewhat ambiguous regarding the number of new project sites HEALTHCOM was required to establish, but it is accepted as 10 new long-term sites which fulfil the scope of work.[16]

HEALTHCOM implemented nine new, long-term country programs in which it fulfilled the scope of work, and submitted a composite of additional country site

[16] Reference to expanding the "applicability of the methodology by using it at approximately ten new sites..." is made in section C.2. of the contract; while section C.3.2.d. requires public health communication interventions "at a minimum of ten sites in addition to the seven existing sites". . ..

initiatives in Haiti and Yemen, and a second project site in Indonesia. A.I.D. has accepted these country programs as completing the Institutional Studies I requirement. The team, however, is concerned about the effects of site selection on HEALTHCOM's ability to carry out its scope of work.

Services of A.I.D.'s centrally managed projects, like HEALTHCOM, are made available to USAID missions based principally on two criteria: 1) Is the site conducive to the project's scope of work?; 2) Are there USAID buy-in funds as well as the accompanying USAID mission Health, Population and Nutrition office support? However, the site selection process is not clear-cut. Other non-technical, non-programmatic factors are often part of the selection equation. Factors such as personalities and politics, within and between a USAID mission and AID/Washington, may either positively or negatively affect HEALTHCOM's ability to complete its scope of work in the countries selected.

In Papua New Guinea, for example, HEALTHCOM began a project at the request of the USAID mission, but found Papua New Guinea very expensive and USAID mission funds less than expected, amounting to $50,000. As a result, HEALTHCOM dedicated approximately $500,000 from central and regional buy-in funds to support this activity, discovering along the way that the ministry of health was more interested in population and family planning than in health communication. Considering the lack of ministry of health interest and mission buy-in support, the team feels that HEALTHCOM's chances for successfully meeting contract requirements under these circumstances were compromised. S&T/Health project management staff remarked that the country program had not functioned long enough for its activities to affect behavior change, but tempered their comments by noting that A.I.D. was able to introduce its technical assistance capabilities to ministry of health counterparts.

In the case of Paraguay, such factors as its relatively healthy population in terms of child survival morbidity and mortality indicators, the low level of USAID mission buy-in funds, and the apparent lack of program direction served to limit HEALTHCOM's ability to achieve the "significant change in practices for a significant portion of the population" required in the contract. The Applied Communication Technology country program review, *The HEALTHCOM Project in Paraguay: A Case Study*, prepared in 1989, characterized the Paraguay program as "a small project in a small country, trying to accomplish an ambitious agenda with limited resources." ACT's report points out that USAID funds were "never sufficient nor secure enough to mount the scale of activity HEALTHCOM would normally have...USAID was not able to respond with a significant influx of support at the point that the project was most in need."

While it is not in the team's scope of work to analyze site selection per se, country programs were a deliverable. In light of concerns expressed by some during the evaluation, the team wishes to point out the possibility that project management undertook activities in countries that were not prime candidates for HEALTHCOM because it strove to meet deliverable objectives, or was influenced by non-technical, non-programmatic considerations, making it difficult for the project to achieve the desired results.

Implementation Plans. HEALTHCOM's contract called for the production of a project site Implementation Plan "60 days after commencement of work in any site." Written in cooperation with local participating institutions, the Implementation Plans were to describe the project's scope of work, the management roles and responsibilities of the local ministry of health, the USAID mission and HEALTHCOM, as well as identify project objectives and the means to achieve them. These documents were collaboratively produced and, in practice, served to cultivate support and a sense of ownership within the local ministry of health. Because of this important function, the Implementation Plans could not also be the rapidly drawn-up, comprehensive blue prints called for in the contract. It was not realistic to expect that HEALTHCOM resident advisors would be able to successfully chart two years of project activity after only two to three months in-country. We understand that the Nigeria program evolved into a distinctly different activity than was anticipated by the Implementation Plan. While the project should change to meet changing needs, the Implementation Program should be updated to remain relevant. Otherwise it becomes a document of minimal utility to either HEALTHCOM or A.I.D. management, produced for the most part primarily to meet a deliverable requirement.

While these Implementation Plans did foster collaboration and a sense of ownership, achieving their procedural objective, it is less clear that they served as program documents, their output objective, for country program planning purposes. We are aware that A.I.D. had a verbal agreement with HEALTHCOM to extend the 60 day deadline. However, HEALTHCOM management reported that A.I.D. did not specify a secondary deadline and the agency may therefore be partially accountable for the delays in producing these Implementation Plans.

Health Practice Studies. Originally intended as part of the investigative and formative evaluation stages of the HEALTHCOM methodology, the HEALTHCOM contract specified that these behavioral studies are to: 1) be integrated into each country program; and 2) advance the understanding of behavior change and investigate the impact of anticipated behavior change problems on the individual country programs.

In some cases, HEALTHCOM was able to integrate aspects of the Health Practice Studies into the country programs. However, because the studies were very discrete, they were not always relevant to the country programs they were intended to support. An example is the Health Practice Study undertaken in Mexico that examined whether mothers administered enough ORS. Despite the merits of the study, it was unrelated to the main HEALTHCOM activity there--the design of a packet for oral rehydration salts.

As with the Implementation Plans, contract specifications were such that A.I.D. was apparently hoping to accomplish the two separate objectives mentioned above. Requiring the Health Practice Studies to satisfy these dual criteria led HEALTHCOM to invest heavily in this deliverable. Project management felt, however, that such allocations were necessary to produce studies suitable for dissemination among communication and behavioral science practitioners. HEALTHCOM staff told the team that, even if the project had not been required to carry out the Health Practice Studies, similar studies could have been conducted at less cost as part of the normal formative research process. Project management has acknowledged that the benefit of these studies to the country programs was not, in all cases, commensurate with the amount of resources they consumed. In one case, HEALTHCOM was criticized in Nigeria by their ministry of health counterparts and the USAID mission for undertaking extensive research that was of little relevance to the Nigerians.

Given that these behavioral studies were intended to guide project design as part of the formative research, they clearly could not have met this objective because of the delay in their availability. While the team questions whether they were very effective as program planning resources, the Health Practice Studies will serve to advance the field of behavioral analysis in the context of health programs in developing countries.

Case Study Evaluations. The primary reason HEALTHCOM requested a six-month extension was to allow Annenberg additional time to complete the required country program impact evaluations, referred to as "case study evaluations" in the contract.

Scheduling of data collection for the impact evaluations was the primary cause for this delay. Final data collection was pushed back in Zaire, as well as in the Philippines, where the resident advisor postponed collection until September 1990 to allow more time for the project's communication activities to have an impact on the target population before the summative surveys were conducted. By then, HEALTHCOM's Zaire program had concluded project activities. Partly because of these delays, Annenburg had difficulty meeting the March 1991 end-of-project

deadline, despite the project extension, and some evaluations, though submitted, still require further work.

Field Notes. Both A.I.D. and HEALTHCOM staff considered Field Notes to be problematic for three reasons: 1) the number required in the contract; 2) the lack of editorial and production staff at HEALTHCOM; and 3) the rigorous standards applied by Annenburg and, to a lesser degree, HEALTHCOM staff.

First, A.I.D. project managers and HEALTHCOM staff agreed that the 40 Field Notes produced over the life of the project was an excessive number. A.I.D. project managers have many demands on their time, and reading these Field Notes, often distributed twice by HEALTHCOM (first in draft form then again in final), was considered a managerial burden.

Second, while the project produced and distributed a large volume of respectable reports, it has done so despite limited production and editorial staff. Field Notes' production delays are partially attributable to the relatively low priority HEALTHCOM placed on maintaining the staff necessary for more timely document production and dissemination.[17]

Third, as late as one month prior to the project completion date, 37 percent of the Field Notes remained in draft form. This was attributed to the rigorous production and editorial standards Annenburg in particular chose to apply to this deliverable and to the complicated clearance process for documents co-produced by counterparts overseas. At first glance, strict standards, whether applied by HEALTHCOM or Annenburg, seem commendable. However, the contract called for Field Notes to be inexpensively produced, periodic methodological summaries of lessons learned useful to communication practitioners. While revision and clearance of Field Notes, co-authored by host national counterparts in some cases, is expected to have taken time, the team found they were often treated not as semi-formal updates as implied in the contract, but as detailed reports of research and project activity. A.I.D. noted that because of production delays and the restricted circulation of the drafts, Field Notes have benefitted the project more than the wider development community and communication practitioners as the contract intended. HEALTHCOM management in turn pointed out that draft copies of several Field Notes have been circulating for years overseas prior to their submission to A.I.D. Nevertheless, the team credits HEALTHCOM for having completed the optional, maximum number of 40 Field Notes, but feels the project invited production burdens by doing so.

[17] HealthCom I editorial and document production staff amounts to a technical editor sharing a secretary with four others; an editorial assistant position was terminated by the project as it tightened its belt during the transition between HealthCom I and II.

2. Major Media Outputs

Question

> *Beyond the contract requirements, what were the important media "outputs" of this project (e.g., manuals, radio spots, videos, flip charts)? What happened to these outputs once they served their initial purpose? Are they being catalogued or used in other ways?*

Important media outputs were produced in the course of providing social marketing and communication support to the country sites. These media products were not explicitly required in the contract, but are a natural result of the project's use of social marketing and mass media.

2.a. Media Products

Working with local ministries of health, multilateral donors, USAID missions, private voluntary organizations, local advertising and media production firms, private research and advertising firms, and other A.I.D. projects, HEALTHCOM helped design and produce numerous media products; Table 5 presents a sample.

Table 5

INNOVATIVE MEDIA AND PROMOTIONAL ITEMS	
radio spots	videos for mobile film units
television spots	videos
slides	records and cassettes
animated dehydration/rehydration characters	flip charts
theater	coloring books
songs	stickers
comic, cross-cultural, and thematic posters	various containers
oral rehydration packaging designs	t-shirts
hats	handkerchiefs
child survival spreads in newspapers	calendars
a picture novel	cardboard televisions

HEALTHCOM's resident advisor in Honduras pointed out that a number of the most important HEALTHCOM materials have been reproduced by international and national organizations. For example, the United Nations High Commission on Refugees and the United States and Honduran Armed Forces have reproduced oral

rehydration and acute respiratory infection materials for use in Honduran refugee camps. The United Nations reported to the resident advisor that use of these materials in the camps contributed to reductions in mortality due to diarrhea and dehydration. Additionally, the ministry of health has requested HEALTHCOM II to reprint HEALTHCOM materials. The evaluation team acknowledges this as illustrating the best of possible outcomes.

2.b. Cataloguing Project Outputs

At HEALTHCOM's home office, the team reviewed the inventory of media products and a slide archive of sample promotional materials produced by various country programs, primarily in support of oral rehydration and immunization interventions.

Video tape inventory. HEALTHCOM maintains a collection of approximately 55 different videos on various public health interventions. These videos are the by-product of HEALTHCOM support of interventions in approximately 12 different countries, and represent seven different intervention. The majority of the videos were produced in Ecuador, Guatemala, The Gambia, Paraguay, and Honduras; they emphasized oral rehydration therapy and EPI.

Audio tape inventory. Similarly, HEALTHCOM maintains an inventory of over 100 radio spots used in 16 countries and recorded in 14 different languages and dialects. Forty radio spots supported immunization, and 36 spots supported control of diarrheal disease interventions, together accounting for 76 percent of all radio spots. Sixteen spots supported breastfeeding and were aired in Honduras and Jordan. Acute respiratory infection was the theme of three spots aired in Honduras, while six spots supported a vitamin A intervention in Central Java, Indonesia. The majority were produced in Spanish and French; while other languages included Siswati, Tagalog, Quechua, Bahasa Indonesia, Arabic and Guarani.

Materials Archive. Comprised of over three binders of color slides, and files of original materials form all HEALTHCOM project sites, the materials archive contains samples of media items produced in some of the country programs. Unfortunately, HEALTHCOM stopped maintaining the archive in December 1989, due to a lack of funds. Containing samples of the products listed above, the team found several of the media outputs from the archive particularly innovative:

- a first-issue stamp produced by Ecuador's PREMI, (Plan de Reduccion de la Enfermedad y Muerte Infantil or the Infant Morbidity and Mortality Reduction Plan), and an accompanying first-day-issued envelope;

- an engaging, animated television spot produced in the Philippines and depicting two cartoon characters, dehydration and diarrhea, that focuses on the distinction between the two to increase mothers' awareness of dehydration;

- a 45 rpm record of the song, *Levanta el Alma*, or Raise Your Spirit, again produced in coordination with PREMI;

- various durable, plastic vaccination cards; an attractive Diploma de Vacunacion; and a health worker training seminar certificate of completion with the catchy slogan "Por Ninos Sanos Trabajamos" (We Work For Healthy Children).

- a system of color-coded treatment protocol cards for use by Indonesian health workers indicating questions regarding the nature of the diarrhea for the health worker to ask the patient, leading to a diagnosis; a health worker can then treat that diarrhea using the appropriate counseling card.

Maintaining this materials archive is expensive, but could be capitalized upon if compiled into a reference book of sample health communication items for possible use by other communication practitioners.

3. Conclusions and Recommendations

HEALTHCOM deliverables have been submitted to and approved by A.I.D. These products achieved the objectives A.I.D. intended in the contract and won praise by multinational donor organizations such as WHO and PAHO, collaborating A.I.D. projects such as REACH and PRITECH, as well as public health and health communication practitioners. However, significant delays have been experienced with key project outputs. The team found that in the case of the country Implementation Plans and the Health Practice Studies, these important deliverables were required to satisfy conflicting output and process objectives, compromising the ability of these activities to meet both contract requirements effectively. This may have also resulted in inefficient allocations of resources (e.g., in producing the Health Practice Studies) in terms of opportunity cost to HEALTHCOM's broader objectives.

Furthermore, HEALTHCOM and its subcontractors should not have set such high standards for the Field Notes; their value as dissemination tools suffered commensurately with their delay in production.

Inasmuch as HEALTHCOM has nearly ended, these recommendations are offered for their relevance to HEALTHCOM II:

1. HEALTHCOM should track and report project expenditures for key deliverables, enabling S&T/Health to monitor expenditure patterns and assess the opportunity cost of these allocations to the project's broader objectives.

2. S&T/Health should maintain the Field Notes deliverable, but reduce the number required. HEALTHCOM should not slow the production of Field Notes, subjecting them to overly stringent production standards: rather, it should emphasize timeliness and wide dissemination, especially of appropriately translated versions in-country.

3. HEALTHCOM should translate all important project research, findings and methodological updates into the language of the country in which they are produced and be widely disseminated among local authorities and interested parties.

    - HEALTHCOM should actively pursue translation and in-country dissemination of project documents to better enable the country programs to meet their institutionalization contract requirements.

- HEALTHCOM should translate and disseminate reports to address the concerns of some USAID Health, Population and Nutrition officers and the midterm evaluation team that national and regional authorities are not always duly informed about project objectives, intentions, and research findings.

- HEALTHCOM should carry out document translation within the context of an upgraded document production and general information management capability as recommended below.

4. S&T/Health and HEALTHCOM should consider increasing staff for editing, document production and general information management; and create a small-scale information resource center to: 1) edit, track, maintain and distribute reports; 2) respond to overseas requests for project publications and sample media outputs; 3) manage document translation; 4) expand, maintain and disseminate samples from the materials archive of outputs produced and used in the field.[18]

5. During its field site visits, the future HEALTHCOM midterm evaluation team inquire into the production, application, and cataloguing of additional media outputs produced by the country programs to provide A.I.D. a field perspective on the purpose and use of such products.

[18] For example, the A.I.D. Appropriate Technologies for Child Health (PRITECH) project maintains an information clearing house with three full-time staff, responding to overseas requests for information with free document delivery.

V. COMPOSITE RECOMMENDATIONS

A. SELECTED PROJECT MANAGEMENT ISSUES

1. HEALTHCOM should standardize the format of its monthly reports to help ensure that comparable and relevant information is obtained and consolidated for the use of interested parties in A.I.D., related project contractors, resident advisors, USAID missions and host country organizations.

2. HEALTHCOM should strengthen its practice of preparing summaries of its reports. As a rule, any report over 10 pages in length should be summarized.

3. HEALTHCOM should increase its efforts to introduce its communication methodologies to the academic community both in the United States and abroad. This might include:

    - converting selected studies from the HEALTHCOM final report into academic journal format;

    - publishing compendiums of materials, as well as a brochure and price list, on 'health communications in the international context' appropriate for classroom use. This brochure should be sent to schools of public health and universities known to have strong international health interests, and indicate the types of courses in which this material could be used: health education/communication in developing countries; applied social science research/communication research; social marketing; applied anthropology; and

    - producing video material on HEALTHCOM methodologies available on loan to universities as teaching aids.

4. HEALTHCOM should improve the timely dissemination of research findings to decision makers.

5. HEALTHCOM and S&T/Health should ensure that the country-specific summative findings, soon to be completed by Annenberg, are disseminated widely and in a timely fashion to appropriate audiences in the U.S. and abroad.

6. S&T/Health should pursue coordinating the work of centrally-managed projects involved in child survival communication. Regular meetings could be convened by the bureau in order to exchange information and to identify areas where increased collaboration would be productive.

7. S&T/Health should review the apportionment of central and buy-in funds over the past 15 months of HEALTHCOM activity to determine the extent to which central funds are being used to support country-specific buy-ins and the impact this is having, or will have, on the project's funding forecasts. While the goal of obtaining the total costs of country-specific project activities from buy-ins is commendable, an apportionment of 75 percent buy-in to 25 percent central funds is more realistic. This apportionment excludes the centrally-funded operational costs of HEALTHCOM and its subcontractors, which amount to 25 to 30 percent of total project costs. Thus, from an overall project cost viewpoint, there would be an approximate 50-50 split between S&T/Health funding and that generated by buy-ins.

B. RESEARCH

Integration of Different Disciplines into the Methodology

1. HEALTHCOM should continue to integrate the behavioral perspective into its projects, focusing especially on the details of the behavior itself and the need for reinforcing this behavior to sustain it in the future.

2. HEALTHCOM should "market" the basic principles of this behavioral perspective to HEALTHCOM staff, counterparts and others in the field in a form that will clarify the concept for persons unfamiliar with it.

3. HEALTHCOM should have one of the more readily understood behavioral experts work with the resident advisers in gaining a greater appreciation of what this approach has to offer in practical terms to specific projects.

4. S&T/Health and HEALTHCOM should incorporate the behavioral research as an integral part of future projects, rather than an add-on to meet a deliverable requirement.

Quality of the Research

1. To the extent further summative research is done, HEALTHCOM should maintain the same high standards as currently exist; it should not consider cutting corners to reduce costs.

2. If cost is an issue, S&T/Health and HEALTHCOM should limit summative research to specific projects which introduce new components "worthy of empirical testing"; it should not be conducted routinely as "part of the HEALTHCOM package"; (in fact, this is now the case in HEALTHCOM, in which no further summative research is foreseen).

3. In future activities, HEALTHCOM should use a far greater percentage of the available research funds for formative research, with a strong focus on monitoring. (Note: this is not to detract from the summative evaluation done under HEALTHCOM, but rather it reflects the needs of the field and a shift in priorities now that HEALTHCOM data are available for in-depth analysis.)

4. HEALTHCOM should increase efforts to get project results published in scientific journals, both to increase the number of potential readers and to enhance the credibility of the findings in the eyes of the scientific community

Relevance and Timeliness of the Research

1. HEALTHCOM should strengthen efforts to work with in-country counterparts to develop their skills in asking the appropriate research questions and tailor research to their specific interests.

2. HEALTHCOM should design formative research that can be done locally on a fairly small scale with rapid turn-around.

3. HEALTHCOM should adapt each study to the local realities; it should not attempt "standardization" of the methodology (beyond the five steps).

4. Wherever the human and financial resources exist, HEALTHCOM should use local research firms that deliver a quality product within a fixed time period.

5. HEALTHCOM should encourage local research firms and/or other counterpart institutions to conduct (near) simultaneous data collection/entry and to use programs that edit the data at the time of entry.

6. HEALTHCOM should try to reduce and (if possible) eliminate formative research which can not be analyzed in-country.

7. HEALTHCOM should devise and/or refine methods for presenting research findings to persons who are not research-oriented; it should prepare attractive, easy-to-read summaries of project results for in-country use by non-researchers.

8. HEALTHCOM should provide opportunities for HEALTHCOM subcontractors to visit countries and present the findings of the summative research to counterpart institutions, to increase understanding of the process and the results.

Institutionalization of Communication Research

1. HEALTHCOM should encourage counterparts to select relatively easy research designs for the formative research, which can be used on similar projects in the future.

2. HEALTHCOM should avoid the temptation to "do the job for them" for the sake of getting it done; allow time for counterparts to learn from their mistakes.

3. S&T/Health should make institutionalization a more explicit objective of the project.

Evaluator as Subcontractor

1. HEALTHCOM should continue with the current system of "partnership" between the implementor (prime contractor) and evaluator (subcontractor), provided the latter has demonstrated a high level of professional standards with respect to evaluation work.

C. PROJECT DELIVERABLES AND OUTPUTS

1. HEALTHCOM should track and report project expenditures for key deliverables, enabling S&T/Health to monitor expenditure patterns and assess the opportunity cost of these allocations to the project's broader objectives.

2. S&T/Health should maintain the Field Notes deliverable, but reduce the number required. HEALTHCOM should not slow the production of Field Notes, subjecting them to overly stringent production standards: rather, it should emphasize timeliness and wide dissemination, especially of appropriately translated versions in-country.

3. HEALTHCOM should translate all important project research, findings and methodological updates into the language of the country in which they are produced and be widely disseminated among local authorities and interested parties.

   - HEALTHCOM should actively pursue translation and in-country dissemination of project documents to better enable the country programs to meet their institutionalization contract requirements.

   - HEALTHCOM should translate and disseminate reports to address the concerns of some USAID Health, Population and Nutrition officers and the midterm evaluation team that national and regional authorities are not always duly informed about project objectives, intentions, and research findings.

   - HEALTHCOM should carry out document translation within the context of an upgraded document production and general information management capability as recommended below.

4. S&T/Health and HEALTHCOM should consider increasing staff for editing, document production and general information management; and create a small-scale information resource center to: 1) edit, track, maintain and distribute reports; 2) respond to overseas requests for project publications and sample media outputs; 3) manage document translation; 4) expand, maintain and disseminate samples from the materials archive of outputs produced and used in the field.[19]

5. During its field site visits, the future HEALTHCOM II midterm evaluation team inquire into the production, application, and cataloguing

[19] For example, the A.I.D. Appropriate Technologies for Child Health (PRITECH) project maintains an information clearing house with three full-time staff, responding to overseas requests for information with free document delivery.

of additional media outputs produced by the country programs to provide A.I.D. a field perspective on the purpose and use of such products.

Annex A

HEALTHCOM FINAL EVALUATION SCOPE OF WORK

The Project

HEALTHCOM is a five-year, $19.5 million project designed to promote appropriate health behaviors in developing countries. Managed by the Academy for Educational Development (AED), HEALTHCOM has provided technical and financial assistance to 18 developing countries, including long-term assistance to 14 countries, using the specialized inputs of four subcontractors (The Annenberg School of Communication, Applied Communication Technology, Porter/Novelli and the Program for the Adaptation of Health Technology) and various consultants.

The project aims to change the behaviors among mothers and caretakers in order to prolong the lives of their children, prevent diseases, and treat diseases in a timely and effective manner. It completes these tasks primarily by convincing Ministries of Health, donors and non-governmental organizations, through results-oriented programs, that communication is an important part of delivering child survival services, and that it works to change knowledge, attitudes and practices. In-country resident country advisors are a mainstay of the project's professional inputs.

Background

HEALTHCOM is part of a phased approach adopted by the S&T Offices of Health and Education to provide and improve upon health communication assistance. In Phase I the "Mass Media and Health Practices Project" (1978-1984) undertook a research-and-action application of state-of-the-art communication and social marketing methods to diarrheal disease programs in The Gambia and Honduras. Phase II, the "Communication for Child Survival Project (HEALTHCOM)," was designed as a series of demonstration projects in up to 17 countries that emphasized mass media campaigns to reach a large number of mothers and caretakers quickly.

In 1988, a midterm evaluation commended A.I.D. for being the only international agency that supported health communication assistance in developing countries. The evaluators stressed the need to: 1) concentrate more on streamlining the HEALTHCOM methodology; 2) institutionalize health communication within national health programs; 3) ensure that project research was directly relevant to field programs and that in-country research talent was tapped; 4) develop process indicators for project impact and sustainability (both financial and technical); and 5) network with other A.I.D. projects, voluntary organizations and the for-profit sector.

Last year Phase III of S&T's health communication assistance began. Based on project experience, the midterm evaluation of HEALTHCOM, and a strong desire to sustain health communication activities, the HEALTHCOM II (1989-1994) project was designed to: institutionalize at-home behavior and health provider capability, and b) improve the mix of mass media and interpersonal communication initiatives. Again the project team for HEALTHCOM II is headed by the AED. Concurrently, communication components have been integrated into other major intervention projects within the S&T Office of Health's Health Services Division (PRITECH, REACH and Mothercare).

The Evaluation

This evaluation is designed to assess the quality and documented impact of HEALTHCOM. It is a two-week desk study that will rely heavily on existing documentation and interviews with staff of A.I.D., HEALTHCOM and other relevant institutions. The evaluation team will be asked to focus on questions that could not be completely addressed at the time of the mid-term evaluation. These questions are designed to measure the project's achievements and to inform those beginning work on the follow-on HEALTHCOM II project. Three major questions must be answered:

1. Has AED successfully completed its contractual requirements under HEALTHCOM (contract DPE-1018-C-00-5063-00)?

2. What have A.I.D. and AED learned over the course of this project that could help us more efficiently and effectively manage the follow-on HEALTHCOM II project?

3. Is HEALTHCOM's research portfolio technically sound and appropriate for A.I.D.'s needs?

Specifically, S&T/H would like the team to answer the attached list of 12 questions.

"TWELVE QUESTIONS"

Project Deliverables and Outputs

Has AED successfully completed its contractual requirements under the HEALTHCOM (contract DPE-1018-C-00-5063-00)?

1. Has the Academy for Educational Development (AED) and its subcontractors successfully executed the deliverables listed in the contract, contract amendments and the adjoining subcontracts? Be specific.

2. Beyond the contract requirements, what were the important media "outputs" of this project (e.g., manuals, radio spots, videos, flip charts)? What happened to these outputs once they served their initial purpose? Are they being catalogued or used in other ways?

Project Management

What have A.I.D. and AED learned over the course of this project that could help us more efficiently and effectively manage the follow-on HEALTHCOM II project?

3. What are the pros and cons of a project that had communication as its focus, versus a project that focused on a specific disease complex (e.g. ARI, CDD, EPI)? How should a project that focuses on communication stay aware of state-of-the-art developments in all the different intervention strategies?

4. Among the various reports produced by the project (e.g., monthly reports, country reports, trip reports, research papers, briefings), which have been the most useful to AED and A.I.D. in managing project activities? Are there examples of reporting that could be omitted?

5. Are the project's results being adequately disseminated to A.I.D. and A.I.D.-supported projects and others active in international health? What have been the most effective ways to disseminate project outcomes and lessons learned?

6. How has AED coordinated with other A.I.D.-related projects, donors and PVOs? And how has AED incorporated the relevant work of CDIE, WHO, DHS, PRICOR and Pritech into its activities?

7. What effect has the practice of buy-ins had on the project's financial profile? What was the S&T/H and non-S&T/H breakout of project expenditures by

country each year? What does your analysis suggest for the amount of the S&T/H funds needed to support Mission and Regional Bureau buy-ins?

Research Quality and Findings

The midterm evaluation of HEALTHCOM concentrated on the in-country conduct and relevance of project research for project activities. This team is asked to focus on research quality and findings.

Is HEALTHCOM's research portfolio technically sound and appropriate for A.I.D.'s needs?

8. What is the technical quality, relevance and timeliness of the project's research on health behavior and behavioral change? To what extent has the project succeeded in institutionalizing these communication methodologies?

9. How have the fields of communication research, development communication, social marketing, behavioral psychology, applied anthropology and instructional design contributed to the HEALTHCOM Project? How are these disciplines represented in the country programs? Is the mixture adequate to achieve the project goals? Suggest any changes.

10. What is the importance of the research component to the overall project objectives? Could the research be eliminated or reformulated without compromising the project's effectiveness?

11. Does HEALTHCOM's research findings provide evidence that communication has a significant role to play in health service delivery in developing countries?

12. What are the pros and cons of having the research/evaluation and service delivery aspects contained within HEALTHCOM?

Annex B

PERSONS INTERVIEWED

AID/WASHINGTON AND FORMER A.I.D.

Connie Carrino	S&T/H/HSD
Eunyong Chung	S&T/N
Robert Clay	S&T/H/HSD
Lorrie Doheny	MS/OP/W/HP
Ann Van Dusen	S&T/H
Holly Fluty	S&T/H/HSD
James Heiby	S&T/H/AR
Bill Jansen	ANE/TR/HPN
Julie Johnson	S&T/H/CD
Linda Lou Kelley	ANE/TR/HPN
Melanie Marlett	PPC/PPPR/SP
John McEnany	FVA/PVC/CSS
Anthony Meyer	S&T/ED
Tom Park	LAC/DR/HPN
Nancy Pielemeier	S&T/H
Sam Rhea	S&T/Ed
James Sheppard	AFR/TR/HPN
Nick Studzinski	LAC/DR/HPN

USAID MISSIONS

Liliana Ayalde	former USAID/Guatemala City
Rosendo Capul	USAID/Manila
Kate Crawford	USAID/Zaire
Lynn Gorton	USAID/Guatemala City
Robert Haladay	USAID/Tegucigalpa
Patrick Lowry	USAID/Suva
Chris McDermott	USAID/Zaire
Joy Riggs-Perla	USAID/Jakarta (fax)
Stanley Terrell	Technical Advisor for Child Survival Fellow/Honduras

OTHER A.I.D.-RELATED PROJECTS

Andy Agle		former U.S. Centers for Disease Control
Susan Eastman		Hellen Keller International
Diane Hedgecock	REACH	John Snow International
John Nelson	CCCD	U.S. Centers for Disease Control
Jeanne Newman	PRICOR	University Research Corporation
David Nicholas	PRICOR	University Research Corporation
Kathy Parker	ACSI-CCCD	U.S. Centers for Disease Control
Jean Roy	ACSI-CCCD	U.S. Centers for Disease Control
Linda Sanei	ASSIST	The Pragma Corporation
Robert Simpson	PRITECH	Management Sciences for Health
Peter Spain	PRITECH	Management Sciences for Health
Robert Steinglass	REACH	John Snow Incorporated

OTHER DONORS

James Cheyne	WHO/EPI/Geneva
Chris Drasbeck	PAHO/CDD
Tony Hewitt	UNICEF/New York
Robert Hogan	WHO/CDD/Geneva
Anne Tinker	World Bank, former S&T/H
Juan Urrutia	PAHO/CDD
Cathy Wolfheim	WHO/CDD/Geneva

HEALTHCOM STAFF AND SUBCONTRACTORS

Joseph Diedrich	Financial Manager
Judith Graeff	Senior Communication Advisor Africa Region
Clarence Hall	Senior Communication Advisor
Mark Rasmuson	Project Director
Anne Roberts	Senior Communication Advisor Asia/Near East
Renata Seidel	Senior Technical Editor
Willard Shaw	Deputy Project Director
William Smith	Senior Technical Director
Cecilia Verzosa	Senior Communication Advisor Asia/Near East

Program Resident Advisors

Patricio Barriga	Honduras (fax)
Edward F. Douglass	former Resident Advisor/Lesotho
Ernie Hernandez	former Resident Advisor/Manila
Andy Piller	former Resident Advisor/Papua New Guinea
Thomas K. Reis	Indonesia

Subcontractors

Mary Debus	Porter/Novelli
Dennis Foot	Applied Communication Technologies
Robert Hornik	Annenberg School for Communication, U. of Penn.
Judith McDivitt	Annenberg School for Communication, U. of Penn.
Michael Ramah	Porter/Novelli
Stanley Yoder	Annenberg School for Communication, U. of Penn.

UNIVERSITIES

Robert Black	Johns Hopkins University
Robert Northrup	Brown University

Annex C

UNIVERSITIES AND THE RESPECTIVE DEPARTMENTS USING HEALTHCOM PUBLICATIONS

Cornell University	Department of Communication
Harvard University	School of Public Health
Johns Hopkins University	School of Public Health
Michigan State University	Urban Affairs Programs/Telecommunications
Tulane University	School of Public Health
Yale University	School of Public Health
University of California, Berkeley	School of Public Health
University of California, San Diego	School of Public Health
University of California, Los Angeles	
University of Massachusetts, Amherst	Center for International Education
University of Maryland	
University of North Carolina, Chapel Hill	School of Public Health

Also used by:

ARHEC-CCCD course, with Tulane University	
U.S. Centers for Disease Control	Atlanta, Georgia
INCAP	subregions training
University of Ibadan	Nigeria

Annex D

HEALTHCOM
In-Country Collaborating Institutions

Country	Primary Institution	Collaborative A.I.D. Projects	Collaborative Donors
Ecuador	MOH/INNFA	DRI & PAAMI	UNICEF & PAHO
Guatemala	MOH/Promo Unit	Proj. SUPPORT	PAHO, WHO, UNICEF, INCAP, Rotary Int'l, EEC
Honduras	MOH/HED, Epid, MCH	Proalma, Forpride, CEPROD	UNICEF, PAHO, WHO, EEC
Malawi	MOH	ASCI-CCCD	UNICEF, WHO
Mexico	Sec. of Health CDD Program; National Oral Rehydration Program, Dir. Gen. of Preventative Medicine, Dir. Gen. of Epidemiology	PRITECH, SOMARC	UNICEF, WHO
Nigeria	FHH/FHED	ACSI-CCCD, Family Health Service	UNICEF, WHO
Papua New Guinea	DOH, Provinical Health Office, Central Province and National Capital District	Radio Science Program	ADB, UNICEF, WHO
Paraguay	MOH/MCH & HED	PRITECH, Project SUPPORT	PAHO, FRG

HEALTHCOM
In-Country Collaborating Institutions
(continued)

Country	Primary Institution	Collaborative A.I.D. Projects	Collaborative Donors
Philippines	DOH/Pub. Information & Health Education Service (PIHES)	PRITECH, REACH	WHO, UNICEF
Yemen	Gen. Dir. of Health Ed./Dept. of Health Services, Dir of Primary Health Care, Governorate HO's, Min. of Info, Local CD Councils	REACH	WHO, UNICEF
Zaire	MOH (FONAMES)	REV. SANRU, PSND, CCCD, PRICOR	UNICEF
Lesotho	MOH/HED	CCCD/Lesotho, Family Health Services	UNICEF, WHO, Rotary Int'l, Save the Children Fund (UK), World Bank, UNFPA
Indonesia	Center for Community Health Ed., Provincial Health Offices/West & Central Java, MOH/CDD	SOMARC, PRITECH, PATH, FVA, CHIPPS, EPI, Field Epidemiology Training Project, Health Training R & D Project	UNICEF, Ciba-Geigi, WHO, HKI

Annex E

COUNTRY EXPENDITURE ANALYSES

Original documents attached.

HEALTHCOM I
CONTRACT No. DPE-1018-C-00-5036-00
THE ACADEMY FOR EDUCATIONAL DEVELOPMENT
CONTRACT EFFECTIVE DATES: August 31, 1985 - March 31, 1991

HEALTHCOM I COUNTRY SPECIFIC EXPENDITURES
By Source of Funding

August 31, 1985 - September 30, 1990

FUNDING SOURCE	CENTRAL S&T/H EXPENDITURES THROUGH 9/30/90	BUREAU BUY-IN EXPENDITURES THROUGH 9/30/90	MISSION BUY-IN EXPENDITURES THROUGH 9/30/90	TOTAL EXPENDITURES THROUGH 9/30/90	% CENTRAL S&T/H THROUGH 9/30/90	% BUREAU BUY-IN THROUGH 9/30/90	% MISSION BUY-IN THROUGH 9/30/90
AFRICA REGION							
LESOTHO	225,554	150,000	183,000	558,554	40.38%	26.86%	32.76%
MALAWI	537,665			537,665	100.00%		
NIGERIA	254,755	703,485		958,240	26.59%	73.41%	
ZAIRE	180,501	260,380	246,838	687,719	26.25%	37.86%	35.89%
ASIA/NEAR EAST REGION							
BANGLADESH			29,000	29,000			100.00%
BURMA			18,599	18,599			100.00%
INDONESIA	384,212	150,000	1,828,905	2,363,117	16.26%	6.35%	77.39%
JORDAN	371,501		191,759	563,260	65.96%		34.04%
PAPUA NEW GUINEA	241,664		50,000	291,664	82.86%		17.14%
PHILIPPINES	614,769		1,017,128	1,631,897	37.67%		62.33%
YEMEN	102,603		193,646	296,249	34.63%		65.37%
LATINA AMERICA REGIONAL							
ECUADOR	345,385		454,000	799,385	43.21%		56.79%
GUATEMALA	541,536		659,089	1,200,625	45.10%		54.90%
HAITI			138,560	138,560			100.00%
HONDURAS	106,865		1,250,658	1,357,523	7.87%		92.13%
MEXICO	307,818		137,244	445,062	69.16%		30.84%
PARAGUAY	89,593		330,000	419,593	21.35%		78.65%
PERU	3,628			3,628	100.00%		
TOTAL	4,308,049	1,263,865	6,728,426	12,300,340	35.02%	10.28%	54.70%

Funding Summary of Long-term Country Activities *

Central Funds:	Bureau Funds:	Mission Funds:
0% 0 Countries	0% 10 Countries	0% 2 Countries
1-25% 3 Countries	1-25% 1 Country	1-25% 1 Country
26-50% 7 Countries	26-50% 2 Countries	26-50% 4 Countries
51-75% 2 Countries	51-75% 1 Country	51-75% 4 Countries
76-99% 1 Country	76-99% 0 Countries	76-99% 3 Countries
100% 2 Country	100% 0 Countries	100% 0 Countries

* Excluding Bangladesh, Burma, Haiti and Peru which were cancelled.

EXPENDITURE ANALYSIS BY FISCAL YEAR
CONTRACT No. DPE-1018-C-00-5036-00
THE ACADEMY FOR EDUCATIONAL DEVELOPMENT
EFFECTIVE DATES: August 31, 1985 - March 31, 1991

FUNDING SOURCE	NO.	CENTRAL S&T/H EXPENDITURES IN FY90	CENTRAL BUY-IN EXPENDITURES IN FY90	MISSION BUY-IN EXPENDITURES IN FY90
HOME OFFICE	2700	664,840		
DIFFUSION/DOCUMENTATION	2738	122,130		
HEALTH PRACTICE STUDIES	2735	13,313		
PPC STUDY	2743		15,176	
BREASTFEEDING ACTIVITIES	2751	5		
LA REGIONAL CONFERENCE	2750	1,421		
AFRICAN REGIONAL CONFERENCE	2755	1,426		
ASIA/NEAR EAST REGIONAL CONF	2758	3,829		
CHILD SURVIVAL ACTION	2704	5,969		
AFRICA REGION				
AFRICA REGIONAL	2727	(10)		
LESOTHO/CENTRAL	2716	24,587		
LESOTHO/AFRICA BUREAU	2715		6,779	
LESOTHO/MISSION	2757			112,316
MALAWI/CENTRAL	2707	(7)		
NIGERIA/BUREAU & CENTRAL	2728	127,486		
NIGERIA/CENTRAL	2764	101,115		
ZAIRE/CENTRAL	2746	(79)		
ZAIRE/MISSION	2749			143,124
ZAIRE/AFR BUREAU	2747		113,077	
ASIA/NEAR EAST REGION				
ASIA/NEAR EAST REGIONAL	2703			
ASIA/NEAR EAST REGIONAL 2	2740			
BANGLADESH/MISSION	2719			15,395
BURMA/CENTRAL	2718			
BURMA/MISSION	2717			11
INDONESIA	2701			
INDONESIA/MISSION 2	2739			42,591
INDONESIA/CENTRAL	2725	23,134		
INDONESIA/TRAINING	2723			12,581
INDO./CENTRAL JAVA	2736	38,032		
INDO./CENTRAL JAVA/BUY-IN	2737		3,604	
INDONESIA/W. JAVA BUY-IN	2731			208,023
INDONESIA/W. JAVA	2763			
JORDAN/MISSION	2712			766
JORDAN/MISSION 2	2733			385
JORDAN/CENTRAL	2732	55,054		
JORDAN/BREASTFEEDING	2754	(5,654)		
PAPUA NEW GUINEA/CENTRAL	2741	12,670		
PAPUA NEW GUINEA/MISSION	2744			8,305
PAPUA NEW GUINEA/BREASTFEEDING	2753	9		
PHILIPPINES/CENTRAL	2729	133,370		
PHILIPPINES/MISSION/IEC	2730			248,011
PHILIPPINES/MISSION/ORT	2756			292,486
YEMEN/CENTRAL	2742	(782)		
YEMEN/MISSION	2745			113,806
YEMEN/ASIA	2706			
LATIN AMERICA REGIONAL				
LATIN AMERICA REGIONAL	2726	6		
ECUADOR/CENTRAL	2721	24,112		
ECUADOR/MISSION	2705			14,092
GUATEMALA/CENTRAL	2709	35,036		
GUATEMALA/MISSION	2711			(72,269)
GUATEMALA/MISSION II	2761			241,255
GUATEMALA/CENTRAL II	2762	202,321		
HAITI/MISSION	2714			(3)
HAITI/MISSION	2713			(2)
HONDURAS	2702			(69,623)
HONDURAS/CENTRAL	2759	68,594		
HONDURAS/MISSION2	2760			194,778
HONDURAS/ORT	2710			27,171
MEXICO/CENTRAL	2708	0		
MEXICO/MISSION	2722			
MEXICO/MISSION 2	2734			
MEXICO/CENTRAL 2	2748	216		
PARAGUAY/MISSION	2720			8,671
PARAGUAY/BREASTFEEDING	2752	87,105		
PERU/CENTRAL	2724			
TOTAL		1,739,249	138,636	1,541,870

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EXPENDITURE ANALYSIS BY FISCAL YEAR
CONTRACT No. DPE-1018-C-00-5036-00
THE ACADEMY FOR EDUCATIONAL DEVELOPMENT
EFFECTIVE DATES: August 31, 1985 - March 31, 1991

FUNDING SOURCE	NO.	CENTRAL S&T/H EXPENDITURES IN FY89	CENTRAL BUY-IN EXPENDITURES IN FY89	MISSION BUY-IN EXPENDITURES IN FY89
HOME OFFICE	2700	914,225		
DIFFUSION/DOCUMENTATION	2738	98,361		
HEALTH PRACTICE STUDIES	2735	8,011		
PPC STUDY	2743		49,754	
BREASTFEEDING ACTIVITIES	2751			
LA REGIONAL CONFERENCE	2750	25,708		
AFRICAN REGIONAL CONFERENCE	2755	14,866		
ASIA/NEAR EAST REGIONAL CONF	2758	20,120		
CHILD SURVIVAL ACTION	2704	(215)		
AFRICA REGION				
AFRICA REGIONAL	2727	214		
LESOTHO/CENTRAL	2716	57,825		
LESOTHO/AFRICA BUREAU	2715		23,569	
LESOTHO/MISSION	2757			70,684
MALAWI/CENTRAL	2707	4,694		
NIGERIA/BUREAU & CENTRAL	2728	26,154	218,903	
NIGERIA/CENTRAL	2764			
ZAIRE/CENTRAL	2746	103,560		
ZAIRE/MISSION	2749			103,714
ZAIRE/AFR BUREAU	2747		146,019	
ASIA/NEAR EAST REGION				
ASIA/NEAR EAST REGIONAL	2703			
ASIA/NEAR EAST REGIONAL 2	2740	(40)		
BANGLADESH/MISSION	2719			(3)
BURMA/CENTRAL	2718			
BURMA/MISSION	2717			(10)
INDONESIA	2701			(2,669)
INDONESIA/MISSION 2	2739			190,792
INDONESIA/CENTRAL	2725	609		
INDONESIA/TRAINING	2723			6,638
INDO./CENTRAL JAVA	2736	121,176		
INDO./CENTRAL JAVA/BUY-IN	2737		59,735	
INDONESIA/W. JAVA BUY-IN	2731			228,200
INDONESIA/W. JAVA	2763			
JORDAN/MISSION	2712			
JORDAN/MISSION 2	2733			11,740
JORDAN/CENTRAL	2732	162,875		
JORDAN/BREASTFEEDING	2754	41,818		
PAPUA NEW GUINEA/CENTRAL	2741	184,911		
PAPUA NEW GUINEA/MISSION	2744			40,671
PAPUA NEW GUINEA/BREASTFEEDING	2753			
PHILIPPINES/CENTRAL	2729	215,519		
PHILIPPINES/MISSION/IEC	2730			95,831
PHILIPPINES/MISSION/ORT	2756			207,789
YEMEN/CENTRAL	2742	49,611		
YEMEN/MISSION	2745			79,840
YEMEN/ASIA	2706	(34)		
LATIN AMERICA REGIONAL				
LATIN AMERICA REGIONAL	2726			
ECUADOR/CENTRAL	2721	25,657		
ECUADOR/MISSION	2705			46,917
GUATEMALA/CENTRAL	2709	5,834		
GUATEMALA/MISSION	2711			242,894
GUATEMALA/MISSION II	2761			79,424
GUATEMALA/CENTRAL II	2762	960		
HAITI/MISSION	2714			(26)
HAITI/MISSION	2713			(7)
HONDURAS	2702			144,436
HONDURAS/CENTRAL	2759	38,271		
HONDURAS/MISSION2	2760			78,412
HONDURAS/ORT	2710			4,616
MEXICO/CENTRAL	2708	(16)		
MEXICO/MISSION	2722			
MEXICO/MISSION 2	2734			(4,462)
MEXICO/CENTRAL 2	2748	25,403		
PARAGUAY/MISSION	2720			103,594
PARAGUAY/BREASTFEEDING	2752	2,488		
PERU/CENTRAL	2724			
TOTAL		2,148,565	497,980	1,729,015

EXPENDITURE ANALYSIS BY FISCAL YEAR
CONTRACT No. DPE-1018-C-00-5036-00
THE ACADEMY FOR EDUCATIONAL DEVELOPMENT
EFFECTIVE DATES: August 31, 1985 - March 31, 1991

FUNDING SOURCE	NO.	CENTRAL S&T/H EXPENDITURES IN FY88	CENTRAL BUY-IN EXPENDITURES IN FY88	MISSION BUY-IN EXPENDITURES IN FY88
HOME OFFICE	2700	1,005,534		
DIFFUSION/DOCUMENTATION	2738	129,911		
HEALTH PRACTICE STUDIES	2735	62,414		
PPC STUDY	2743		2,284	
BREASTFEEDING ACTIVITIES	2751			
LA REGIONAL CONFERENCE	2750			
AFRICAN REGIONAL CONFERENCE	2755			
ASIA/NEAR EAST REGIONAL CONF	2758			
CHILD SURVIVAL ACTION	2704	33		
AFRICA REGION				
AFRICA REGIONAL	2727	30,539		
LESOTHO/CENTRAL	2716	122,359		
LESOTHO/AFRICA BUREAU	2715		39,104	
LESOTHO/MISSION	2757			
MALAWI/CENTRAL	2707	158,176		
NIGERIA/BUREAU & CENTRAL	2728		358,726	
NIGERIA/CENTRAL	2764			
ZAIRE/CENTRAL	2746	77,020		
ZAIRE/MISSION	2749			
ZAIRE/AFR BUREAU	2747		1,284	
ASIA/NEAR EAST REGION				
ASIA/NEAR EAST REGIONAL	2703	43,541	4,857	
ASIA/NEAR EAST REGIONAL 2	2740	23,914		
BANGLADESH/MISSION	2719			877
BURMA/CENTRAL	2718			
BURMA/MISSION	2717			18,598
INDONESIA	2701			94,359
INDONESIA/MISSION 2	2739			112,910
INDONESIA/CENTRAL	2725	43,292		
INDONESIA/TRAINING	2723			78,380
INDO./CENTRAL JAVA	2736	70,470		
INDO./CENTRAL JAVA/BUY-IN	2737		86,661	
INDONESIA/W. JAVA BUY-IN	2731			197,467
INDONESIA/W. JAVA	2763			
JORDAN/MISSION	2712			131
JORDAN/MISSION 2	2733			87,696
JORDAN/CENTRAL	2732	117,333		
JORDAN/BREASTFEEDING	2754			
PAPUA NEW GUINEA/CENTRAL	2741	44,074		
PAPUA NEW GUINEA/MISSION	2744			1,024
PAPUA NEW GUINEA/BREASTFEEDING	2753			
PHILIPPINES/CENTRAL	2729	258,941		
PHILIPPINES/MISSION/IEC	2730			151,103
PHILIPPINES/MISSION/ORT	2756			
YEMEN/CENTRAL	2742	24,604		
YEMEN/MISSION	2745			
YEMEN/ASIA	2706	3		
LATIN AMERICA REGIONAL				
LATIN AMERICA REGIONAL	2726	3,436		
ECUADOR/CENTRAL	2721	169,783		
ECUADOR/MISSION	2705			43,911
GUATEMALA/CENTRAL	2709	214,130		
GUATEMALA/MISSION	2711			63,755
GUATEMALA/MISSION II	2761			
GUATEMALA/CENTRAL II	2762			
HAITI/MISSION	2714			26,562
HAITI/MISSION	2713			13,052
HONDURAS	2702			269,984
HONDURAS/CENTRAL	2759			
HONDURAS/MISSION2	2760			
HONDURAS/ORT	2710			9,940
MEXICO/CENTRAL	2708	85,597		
MEXICO/MISSION	2722			5,283
MEXICO/MISSION 2	2734			100,819
MEXICO/CENTRAL 2	2748	10,085		
PARAGUAY/MISSION	2720			149,854
PARAGUAY/BREASTFEEDING	2752			
PERU/CENTRAL	2724	17		
TOTAL		2,695,206	492,916	1,425,705

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EXPENDITURE ANALYSIS BY FISCAL YEAR
CONTRACT No. DPE-1018-C-00-5036-00
THE ACADEMY FOR EDUCATIONAL DEVELOPMENT
EFFECTIVE DATES: August 31, 1985 - March 31, 1991

FUNDING SOURCE	NO.	CENTRAL S&T/H EXPENDITURES IN FY87	CENTRAL BUY-IN EXPENDITURES IN FY87	MISSION BUY-IN EXPENDITURES IN FY87
HOME OFFICE	2700	1,141,486		
DIFFUSION/DOCUMENTATION	2738			
HEALTH PRACTICE STUDIES	2735	3,155		
PPC STUDY	2743			
BREASTFEEDING ACTIVITIES	2751			
LA REGIONAL CONFERENCE	2750			
AFRICAN REGIONAL CONFERENCE	2755			
ASIA/NEAR EAST REGIONAL CONF	2758			
CHILD SURVIVAL ACTION	2704	48,666		
AFRICA REGION				
AFRICA REGIONAL	2727	52,754		
LESOTHO/CENTRAL	2716	20,783		
LESOTHO/AFRICA BUREAU	2715		80,548	
LESOTHO/MISSION	2757			
MALAWI/CENTRAL	2707	263,800		
NIGERIA/BUREAU & CENTRAL	2728		125,856	
NIGERIA/CENTRAL	2764			
ZAIRE/CENTRAL	2746			
ZAIRE/MISSION	2749			
ZAIRE/AFR BUREAU	2747			
ASIA/NEAR EAST REGION				
ASIA/NEAR EAST REGIONAL	2703		75,528	
ASIA/NEAR EAST REGIONAL 2	2740			
BANGLADESH/MISSION	2719			7,012
BURMA/CENTRAL	2718			
BURMA/MISSION	2717			
INDONESIA	2701			264,556
INDONESIA/MISSION 2	2739			
INDONESIA/CENTRAL	2725	87,499		
INDONESIA/TRAINING	2723			73,375
INDO./CENTRAL JAVA	2736			
INDO./CENTRAL JAVA/BUY-IN	2737			
INDONESIA/W. JAVA BUY-IN	2731			36,195
INDONESIA/W. JAVA	2763			
JORDAN/MISSION	2712			45,325
JORDAN/MISSION 2	2733			45,716
JORDAN/CENTRAL	2732	75		
JORDAN/BREASTFEEDING	2754			
PAPUA NEW GUINEA/CENTRAL	2741			
PAPUA NEW GUINEA/MISSION	2744			
PAPUA NEW GUINEA/BREASTFEEDING	2753			
PHILIPPINES/CENTRAL	2729	6,939		
PHILIPPINES/MISSION/IEC	2730			21,908
PHILIPPINES/MISSION/ORT	2756			
YEMEN/CENTRAL	2742			
YEMEN/MISSION	2745			
YEMEN/ASIA	2706	3		
LATIN AMERICA REGIONAL				
LATIN AMERICA REGIONAL	2726	56,885		
ECUADOR/CENTRAL	2721	125,833		
ECUADOR/MISSION	2705			200,463
GUATEMALA/CENTRAL	2709	64,930		
GUATEMALA/MISSION	2711			100,750
GUATEMALA/MISSION II	2761			
GUATEMALA/CENTRAL II	2762			
HAITI/MISSION	2714			67,479
HAITI/MISSION	2713			30,984
HONDURAS	2702			249,240
HONDURAS/CENTRAL	2759			
HONDURAS/MISSION2	2760			
HONDURAS/ORT	2710			154,710
MEXICO/CENTRAL	2708	173,372		
MEXICO/MISSION	2722			34,717
MEXICO/MISSION 2	2734			887
MEXICO/CENTRAL 2	2748			
PARAGUAY/MISSION	2720			67,881
PARAGUAY/BREASTFEEDING	2752			
PERU/CENTRAL	2724	3,611		
TOTAL		2,049,791	281,932	1,401,198

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EXPENDITURE ANALYSIS BY FISCAL YEAR
CONTRACT No. DPE-1018-C-00-5036-00
THE ACADEMY FOR EDUCATIONAL DEVELOPMENT
EFFECTIVE DATES: August 31, 1985 - March 31, 1991

FUNDING SOURCE	NO.	CENTRAL S&T/H EXPENDITURES IN FY86	CENTRAL BUY-IN EXPENDITURES IN FY86	MISSION BUY-IN EXPENDITURES IN FY86
HOME OFFICE	2700	1,084,388		
DIFFUSION/DOCUMENTATION	2738			
HEALTH PRACTICE STUDIES	2735			
PPC STUDY	2743			
BREASTFEEDING ACTIVITIES	2751			
LA REGIONAL CONFERENCE	2750			
AFRICAN REGIONAL CONFERENCE	2755			
ASIA/NEAR EAST REGIONAL CONF	2758			
CHILD SURVIVAL ACTION	2704	40,547		
AFRICA REGION				
AFRICA REGIONAL	2727			
LESOTHO/CENTRAL	2716			
LESOTHO/AFRICA BUREAU	2715			
LESOTHO/MISSION	2757			
MALAWI/CENTRAL	2707	111,002		
NIGERIA/BUREAU & CENTRAL	2728			
NIGERIA/CENTRAL	2764			
ZAIRE/CENTRAL	2746			
ZAIRE/MISSION	2749			
ZAIRE/AFR BUREAU	2747			
ASIA/NEAR EAST REGION				
ASIA/NEAR EAST REGIONAL	2703		19,615	
ASIA/NEAR EAST REGIONAL 2	2740			
BANGLADESH/MISSION	2719			5,719
BURMA/CENTRAL	2718			
BURMA/MISSION	2717			
INDONESIA	2701			285,507
INDONESIA/MISSION 2	2739			
INDONESIA/CENTRAL	2725			
INDONESIA/TRAINING	2723			
INDO./CENTRAL JAVA	2736			
INDO./CENTRAL JAVA/BUY-IN	2737			
INDONESIA/W. JAVA BUY-IN	2731			
INDONESIA/W. JAVA	2763			
JORDAN/MISSION	2712			
JORDAN/MISSION 2	2733			
JORDAN/CENTRAL	2732			
JORDAN/BREASTFEEDING	2754			
PAPUA NEW GUINEA/CENTRAL	2741			
PAPUA NEW GUINEA/MISSION	2744			
PAPUA NEW GUINEA/BREASTFEEDING	2753			
PHILIPPINES/CENTRAL	2729			
PHILIPPINES/MISSION/IEC	2730			
PHILIPPINES/MISSION/ORT	2756			
YEMEN/CENTRAL	2742			
YEMEN/MISSION	2745			
YEMEN/ASIA	2706	29,198		
LATIN AMERICA REGIONAL				
LATIN AMERICA REGIONAL	2726			
ECUADOR/CENTRAL	2721			
ECUADOR/MISSION	2705			148,617
GUATEMALA/CENTRAL	2709	18,325		
GUATEMALA/MISSION	2711			3,280
GUATEMALA/MISSION II	2761			
GUATEMALA/CENTRAL II	2762			
HAITI/MISSION	2714			521
HAITI/MISSION	2713			
HONDURAS	2702			180,431
HONDURAS/CENTRAL	2759			
HONDURAS/MISSION2	2760			
HONDURAS/ORT	2710			6,563
MEXICO/CENTRAL	2708	13,161		
MEXICO/MISSION	2722			
MEXICO/MISSION 2	2734			
MEXICO/CENTRAL 2	2748			
PARAGUAY/MISSION	2720			
PARAGUAY/BREASTFEEDING	2752			
PERU/CENTRAL	2724			
TOTAL		1,296,621	19,615	630,638

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EXPENDITURE ANALYSIS BY FISCAL YEAR
CONTRACT No. DPE-1018-C-00-5036-00
THE ACADEMY FOR EDUCATIONAL DEVELOPMENT
EFFECTIVE DATES: August 31, 1985 - March 31, 1991

FUNDING SOURCE	NO.	CENTRAL S&T/H EXPENDITURES IN FY85	CENTRAL BUY-IN EXPENDITURES IN FY85	MISSION BUY-IN EXPENDITURES IN FY85
HOME OFFICE	2700	11,904		
DIFFUSION/DOCUMENTATION	2738			
HEALTH PRACTICE STUDIES	2735			
PPC STUDY	2743			
BREASTFEEDING ACTIVITIES	2751			
LA REGIONAL CONFERENCE	2750			
AFRICAN REGIONAL CONFERENCE	2755			
ASIA/NEAR EAST REGIONAL CONF	2758			
CHILD SURVIVAL ACTION	2704			
AFRICA REGION				
AFRICA REGIONAL	2727			
LESOTHO/CENTRAL	2716			
LESOTHO/AFRICA BUREAU	2715			
LESOTHO/MISSION	2757			
MALAWI/CENTRAL	2707			
NIGERIA/BUREAU & CENTRAL	2728			
NIGERIA/CENTRAL	2764			
ZAIRE/CENTRAL	2746			
ZAIRE/MISSION	2749			
ZAIRE/AFR BUREAU	2747			
ASIA/NEAR EAST REGION				
ASIA/NEAR EAST REGIONAL	2703			
ASIA/NEAR EAST REGIONAL 2	2740			
BANGLADESH/MISSION	2719			
BURMA/CENTRAL	2718			
BURMA/MISSION	2717			
INDONESIA	2701			
INDONESIA/MISSION 2	2739			
INDONESIA/CENTRAL	2725			
INDONESIA/TRAINING	2723			
INDO./CENTRAL JAVA	2736			
INDO./CENTRAL JAVA/BUY-IN	2737			
INDONESIA/W. JAVA BUY-IN	2731			
INDONESIA/W. JAVA	2763			
JORDAN/MISSION	2712			
JORDAN/MISSION 2	2733			
JORDAN/CENTRAL	2732			
JORDAN/BREASTFEEDING	2754			
PAPUA NEW GUINEA/CENTRAL	2741			
PAPUA NEW GUINEA/MISSION	2744			
PAPUA NEW GUINEA/BREASTFEEDING	2753			
PHILIPPINES/CENTRAL	2729			
PHILIPPINES/MISSION/IEC	2730			
PHILIPPINES/MISSION/ORT	2756			
YEMEN/CENTRAL	2742			
YEMEN/MISSION	2745			
YEMEN/ASIA	2706			
LATIN AMERICA REGIONAL				
LATIN AMERICA REGIONAL	2726			
ECUADOR/CENTRAL	2721			
ECUADOR/MISSION	2705			
GUATEMALA/CENTRAL	2709			
GUATEMALA/MISSION	2711			
GUATEMALA/MISSION II	2761			
GUATEMALA/CENTRAL II	2762			
HAITI/MISSION	2714			
HAITI/MISSION	2713			
HONDURAS	2702			
HONDURAS/CENTRAL	2759			
HONDURAS/MISSION2	2760			
HONDURAS/ORT	2710			
MEXICO/CENTRAL	2708			
MEXICO/MISSION	2722			
MEXICO/MISSION 2	2734			
MEXICO/CENTRAL 2	2748			
PARAGUAY/MISSION	2720			
PARAGUAY/BREASTFEEDING	2752			
PERU/CENTRAL	2724			
TOTAL		11,904		

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FY90 EXPENDITURE ANALYSIS
HEALTHCOM II
CONTRACT No. DPE-5984-Z-00-9018-00
THE ACADEMY FOR EDUCATIONAL DEVELOPMENT
EFFECTIVE DATES: August 31, 1989-August 30, 1994

FUNDING SOURCE	NO.	CENTRAL S&T/H EXPENDITURES FY90	CENTRAL BUY-IN EXPENDITURES FY90	MISSION BUY-IN EXPENDITURES FY90
HOME OFFICE	9800	449,403		
DIFFUSION/DOCUMENTATION	9810	8,389		
WORLD HEALTH ORGANIZATION	9811	8,106		
SUBCONTRACTORS	9800	125,625		
AFRICA REGION				
AFRICA REGIONAL	9805	48,635		
LESOTHO/CENTRAL	9808	134,505		
ZAIRE/CENTRAL	9809	178,432		
ASIA/NEAR EAST REGION				
ASIA/NEAR EAST REGIONAL	9807	6,422		
INDONESIA/CENTRAL JAVA/CENTRAL	9801	176,065		
INDONESIA/CENTRAL JAVA/FVA	9812		14,800	
PAPUA NEW GUINEA/CENTRAL	9804	137,561		
LATIN AMERICA REGIONAL				
LATIN AMERICA REGIONAL	9806	62,381		
MEXICO/CENTRAL	9803	5,287		
TOTAL		1,340,812	14,800	

Note: HEALTHCOM II expenditures began in October 1990.