

REPORT OF THE
State-of-the-Art (SOTA) Course
for
USAID Population, Health and Nutrition Officers
June 12 - 23, 1995

Prepared by:
Mary Beth Moore, SOTA Course Facilitator

REPORT CONTENTS

	page:
Introduction	2
Course Design	2
Course Methodology	4
Course Outcomes	4
Facilitator's Recommendations	5
Attachment A: SOTA Course Participants	7
Attachment B: SOTA Presenters and Participants	8
Attachment C: SOTA Course Schedules:	12
● At-A-Glance	
● Daily	14
Attachment D: Facilitator's SOTA Course Status Report	28
Attachment E: SOTA Logistics Management: Reminders and Recommendations	31
Attachment F: Summary of Individual SOTA Session Evaluations	36
Attachment G: PHN SOTA 1995 Full Course Evaluation	38
Attachment H: Highlights from Sota Presentations	(1-59)

INTRODUCTION

USAID's Center for Population, Health and Nutrition (PHN), with the assistance of cooperating agencies, held a State-of-the-Art (SOTA) training course for mission PHN officers. The SOTA course was held June 12-23, 1995, in the Hyatt Arlington at Key Bridge, Rosslyn Virginia. The course was intended to provide PHN officers with a stimulating update both in health technologies as well as changes underway in USAID programs and emphases.

The course was organized by the following SOTA Planning Team:

- Sigrid Anderson, PHN/POP/FPS
- Frances Davidson, PHN/HN/CS
- Melody Trott, PHN/HN/CS
- Ellyn Ogden, LAC/RSD/PHN
- Steve Landry, PHN/HN/EH
- Karen Nurick, PHN/FPS
- Vathani Amirthanayagam, IDI

Training Office support was provided by:

- Lisa Carlisle,
- Lucy Sotar,
- Jocelyn Rodriguez

Course facilitator, Mary Beth Moore, was assisted by Marcia Laing and Hanna Dagnachew.

Forty five PHN representatives of 35 missions attended the course (see Attachment A, SOTA Participants). Their experience varied from 3 months to over 20 years with USAID. Since the last SOTA technical update held in 1991 there had been limited group training for PHN officers. They were notified of the opportunity to attend the course in April and provided with schedule and content updates through the use of E-mail in advance of the course.

COURSE DESIGN

The course was designed to cover the state-of-the-art in population, health and nutrition, at a reasonable cost, and using resources found in-house and within various cooperating and other agencies. The course also included re-engineering, evaluation, policy reform, donor coordination, and integration concepts. The ten working days between June 12 and June 23 were divided into sessions of two or three hours between 8:00 AM and 5:00 PM. Luncheon presentations were minimized and evening and weekend time was not scheduled.

Topics were reviewed by the planning team and a point person (session coordinator) was identified to proceed with session design and preparation (See Attachment B, SOTA Presenters & Participants). A form entitled "SOTA Meeting Planner" was circulated to the point person for each session with a request for return in early May. The form requested information on session presenters, objectives, outline, topics for group discussion, handouts, format, audio visual needs, and rapporteur.

As planning proceeded, a "schedule-at-a-glance" (see Attachment C) was formulated and revised to accommodate time requirements and scheduling concerns of the point persons. This was later replaced by a daily schedule for participants.

The facilitator joined in the planning sessions during the final four weeks prior to the course and utilized a "status report" to track session planning (see Attachment D, Facilitator's SOTA Course Status Report).

Among the 45 sessions included during the ten-day program were the following:

- Opening overview from Dawn Liberi, Associate Assistant Administrator, PHN, Robert Clay, Deputy Director, Office of Health and Nutrition, and Margaret Neuse, Deputy Director, Office of Population.
- A "town meeting" convened by Duff Gillespie, Deputy Assistant Administrator, PHN, to discuss re-engineering, the budget process, contracting, and the connections between missions, bureaus, country teams and cooperative agencies.
- Jonathan Mann, Harvard U., speaking on health and human rights.
- Communication for Behavior Change with William Smith, AED, Phyllis Piotrow, JHU, Rick Sullivan, JHU, Claudia Fishman, Emory U., and Erma Manocourt, UNICEF.
- Applications of Communications Technologies for Program Action with Kaye Gopen, Morino Institute, Craig Fischer, IRM, and Virginia Yee and Gayle Gibbons, APHA.
- Reproductive health sessions covering new approaches, safe pregnancy, post-abortion care, STD/HIV, maternal nutrition, breastfeeding, maximizing access and quality, and technology, tools and research.
- Health and nutrition technology, tools and research as well as health quality, and emerging diseases.
- Child health sessions focusing on prevention strategies, integrated management of treatments for child health, and environmental influences on health.
- A series of sessions on NGO-PVO partnerships, work with the commercial sector, and social marketing advancements.
- Special presentations on Children as Agents of Change, by Linda Pfeiffer, INMED, Refugees by Deirdre Wulf, AGI, Lactational Amenorrhea Method by Miriam Labbok, Georgetown U., and Congressional Update by Dottie Rayburn.
- Sessions related to the state-of-the-art for 1) logistics related to building sustainable programs, 2) applying gender planning, 3) outcomes of recent world conferences, 4) vaccine initiatives, 5) serving hardly-reached groups such as young adults, males, street children, refugees, and those at high risk for HIV/AIDS.

One fifteen minute coffee/tea break was scheduled for each morning and afternoon. Otherwise sessions ran continuously except for open lunch periods on 5 days.

COURSE METHODOLOGY

Point persons were encouraged to plan their sessions with participant interaction and involvement. It was recommended that they limit lectures and utilize brief presentations, case studies, games, video presentations, demonstrations, panel discussions, breakout sessions, and other stimulating formats. Straight information exchange was intended to be done through handouts. Several presenters utilized the assistance of the course facilitator to plan exercises that utilize the participants energy and keep their attention.

For a detailed review of SOTA course logistics see Attachment E, SOTA Logistics Management: Reminders and Recommendations.

COURSE OUTCOMES

Given the brief (two-month) planning period, the SOTA course was a remarkable achievement. Many of the implementation snags and problems were the result of time constraints for planners and presenters.

During the first session, participants stated their individual expectations. Repeatedly, they mentioned their desire to 1) share practical information and field experiences, 2) learn the state-of-the-art in PHN, particularly as it applies to their field work, and 3) explore the latest progress in cross-sectoral linkages.

Sessions tended to be over-filled and frequently the interactive time was shortchanged. Several two-hour sessions included four or more presenters leading to the inevitable series of "talking heads" instead of an interactive exchange of technical and practical information.

In some cases the presenters were skillful lecturers and the audience remained attentive. In other cases the dim light and over-use of detailed projections were deterrents to learning. Time was so tightly scheduled there was no opportunity to reflect and absorb information between sessions.

The varied levels of participant experience made it difficult for presenters to determine the appropriate level of technicality for their sessions. Frequently information presented was simplified for the least experienced member of the audience. This was dissatisfying for experienced participants.

Participants evaluated individual sessions on a half-page form that included a comparison of participant expectation and outcome. On a scale of one (poor) to four (very good) each session was rated for a) learning more about this topic; b) providing information that was applicable to work; c) allowing opportunities to express ideas and make suggestions; and d) the overall value of the session. The averages of the "overall value" ratings are listed in Attachment F, Summary of Individual SOTA Session Evaluations.

Overall evaluation (see Attachment G, PHN SOTA 1995 Full Course Evaluation) results indicated the majority of the participants received adequate advance information although more details on the course plans and presentations may have been useful. They expressed a strong preference for fewer lectures and more interactive sessions including case studies, group exercises and questions and answers.

Highlights of the course included Jonathan Mann's presentation on Health and Human Rights, the opening and closing remarks by senior USAID staff, the update on reproductive health technology and research, the policy session, any session where the actual state-of-the-art was covered, and opportunities to talk with other participants and share experiences.

Beyond the SOTA course, participants would like SOTA-type information (including updates from organizations other than cooperating agencies) shared with PHN officers frequently. Utilization of E-mail seems appropriate. Also desired are more reports from the field on what works and what doesn't, in the form of case studies.

In response to the question about how often training in the state-of-the-art should be provided it was indicated that every two years would be desirable.

The participants rated the value of the overall course on a scale of one (low) to ten (high) with a group average of 7.4. They expressed concern over the volume of information and unforgiving schedule. However they concluded the course with an expression of great appreciation for the efforts of the planners, presenters and organizers.

FACILITATOR'S RECOMMENDATIONS

Consider offering the course to a group of 20 (or fewer) PHN officers following a complete redesign that would minimize classroom learning and maximize participation by PHN officers and the SOTA experts. I suggest the following design option:

- **Week One:** Participants (working in pairs) are given responsibility of presenting the state-of-the-art information on their chosen PHN topic. Identification of topic preferences would be done in advance so that course planners could assure full coverage of PHN topics. Participants would receive background materials and a list of individuals that are available for contact. Approximately 3 days in Washington would be allowed for pairs to do their research and prepare their presentation for the full group. They would be given guidance from the facilitator and allowed to include experts during their presentation to the full group.

Also during the first week, 2 or 3 short, group sessions would be held to cover over-arching topics such as policy development, donor coordination, evaluation, and communication for behavior change. A day may be needed to focus on individual problem solving and appointments, but this could be woven throughout their research days.

- **Week Two:** Participants would have a two-hour time slot during the first 3 days of the week to present their findings on the state-of-the-art for their topic. Their audience could be expanded to include relevant USAID staff along with the PHN officers. Three presentations a day would allow a daily 1-2 hour period for the facilitator's recap and the identification of linkages and opportunities or collaboration in the field.

The final 2 days of the course could include sessions of general interest and a briefing for G/PHN staff by the field PHN officers.

I believe this self-education design leads to greater adult learning. It minimizes the burden on USAID staff to prepare formal presentations and materials. It would lessen the expense of meeting facilities. The facilitator would be able to spend more time actually facilitating rather than managing logistics. If the cost were reduced, a different group of 20 PHN officers might participate on alternate years.

The facilitator's recommendations regarding logistics management are detailed in Attachment E, SOTA Logistics Management: Reminders and Recommendations.

Session notes, as prepared by rapporteurs, have been compiled in Attachment H, Notes from SOTA Presentations.

Overall, the course accomplished its goal to provide PHN officers with an update in health technologies as well as changes underway in USAID programs and emphases. The planners made every effort to encourage presenters to be participatory and stimulating. This was hampered by the tightness of the schedule, the volume of information, and the increased number of participants.

All those involved in the SOTA course deserve positive recognition. The facilitator especially appreciates the support provided by Sigrid Anderson, Vathani Amirthanayagam, Hanna Dagnachew, Marcia Laing and the POPTECH staff.

Anderson, Sigrid

D.C

USDH

	Participants	Post	Agency
1	Ababio, Benedicta	Ghana	FSN
2	Adamczyk, Christine	D.R.	USDH
3	Amirthanayagam, Vathani	D.C.	USDH - IDI
4	Andriamitantsoa, Benjamin	Madagascar	FSN
5	Ashley, Jeff	D.C.	USDH - IDI
6	Awantang, Felix	Nigeria	USDH
7	Balakrishnan, P. E.	Amman - Manila	USDH
8	Betemariam, Wuleta	Ethiopia	Fellow
9	Bogulavsky, Victor	Kiev	FSN
10	Braunstein, Arthur	Mali	USDH
11	Carpenter-Yaman, Carol	Egypt - Manila	USDH
12	Charlotin, Marlene	Haiti	FSN
13	Cohn, Rebecca	Barbados	USDH
14	Crawford, Katherine	D.C.	USDH-IDI
15	Curtin, Leslie	Indonesia	USDH
16	Dabbas, Rabiha	Jordon	FSN
17	de Estrada, Maricarmen	El Salvador	FSN
18	Habis, Charles	Niger	USDH
19	Jansen, William	Rabat	USDH
20	Kearns, Laura	Malawi	USDH
21	Klin, Maria	Brazil	FSN PSC
22	Kreis, Katherine	D.C.	USDH - IDI
23	Lawrence, Earle	Bolivia	USDH
24	Lins, Maria Luiza	Brazil	FSN PSC
25	Losk, David	Honduras	USDH
26	Matta, Nahed	Egypt	FSN
27	McLeod, Marie	Mexico	PSC
28	Micka, Mary Ann	Bucharest	USDH
29	Mize, Lucy	Mali	TAACS
30	Moloney, Michele	D.C. - Cambodia	USDH - IDI
31	O'Connor, Pat	Guatemala	USDH
32	Oldwine, Eilene	Manila - Jordon	USDH
33	Piet, David	Bangladesh	USDH
34	Pokhrel, Puru	Kathmandu	FSNDH
35	Rahmaan, Carl Abdou	Egypt	USDH
36	Rippey, Helene	Guinea-Conakry	TAACS
37	Robb-McCord, Judith	Kenya	Fellow
38	Rogers, Roxana	Zimbabwe	PSC
39	Sarcar, Shiril	Bangladesh	PSC
40	Seminario, Luis	Peru	FSN
41	Sinnitt Meri	D.C. - El Salvador	USDH - IDI
42	Snyder, Shelley	D.C. - Egypt	USDH - IDI
43	Ved, Rajani	India	FSNPSC
44	Vogel, Dana	Tanzania	USDH
45	White, Mark	D.C. - Zambia	USDH - IDI

auditors

1	Ken Farr	Indonesia	USDH
2	Claudia Allers	Bolivia	Fellow
3	Deborha Caro	Bolivia	West Consort

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ATTACHMENT B: SOTA PRESENTERS AND PARTICIPANTS

LastName	FirstName	Country
Ababio	Benedicta	Ghana
Abdou Rahmaan	Carl	Egypt
Adamczyk	Christine	Dominican Republic
Allers	Claudia	Bolivia
Allison	Adrienne	CEDPA
Amirthanayagam	Vathani	Washington, D.C. - IDI
Anderson	Sigrd	USAID/PHN/POP/FPS
Andriamitantsoa	Benjamin	Madagascar
Ankrah	Maxine	Family Health Interantional
Anthony	Susan	USAID/G/PHN/HN/NMH
Ashley	Jeff	Washington, D.C. - IDI
Awantang	Felix	Nigeria
Baird	Vicki	The Futures Group
Balakrishnan	P.E.	Amman - Manila
Barnes	Victor	USAID/G/PHN/HN/HIV/AI
Bartlett	Al	USAID/G/HN/CS
Bates	Jim	MSH
Beattie	Karen	Association for Voluntary Surgical Contraception
Betemariam	Wuleta	Ethiopia
Black	Bob	Johns Hopkins University
Block	Bernie	USAIDG/PHN/FPS
Bloom	Gretchen	ANE/ME
Bogulavsky	Victor	Kiev
Boni	Anthony	
Brady	Dr. William	Family Health International
Braunstein	Arthur	Mali
Brown	Lisanne	EVALUATION Project
Brown	Alex	Population Services International
Busquets-Mora	Maria	USAID/G/PHN/POP/CMT
Buzy	Jeanine	USAID/G/PHN/HN/HIV/AI
Campbell	Kent	IHPO/CDC
Carlson	Craig	USAID/G/PHN/POP/FPS
Caro	Deborah	Bolivia
Carpenter-Yaman	Carol	Egypt - Manila
Carrino	Constance	USAID/G/PHN/HN/PSR
Carroll	Dennis	USAID/G/PHN/HN/EH
Charlotin	Marlene	Haiti
Chung	Eunyong	USAIDG/PHN/HN/NMH
Clarke	Mari	WID/W
Clay	Robert	USAID/G/PHN/HN
Cleason	Marian	
Coffey	Trish	USAID/G/PHN/POP/R
Cohn	Rebecca	Barbados
Conly	Shanti	Popaction Internation
Cornelius	Dick	USAIDG/PHN/POP/PE
Crane	Barbara	USAID/PHN/POP/PE
Craven	Sarah	CEDPA
Crawford	Kate	Washington D.C. - (IDI)

LastName	FirstName	Country
Curtin	Leslie	Indonesia
Dabbas	Rabiha	Jordon
Dabbs	Carol	LAC/DR
Dagnachew	Hanna	USAID/Intern
Dallabetta, MD	Gina	Family Health International
Darnton-Hill	Ian	OMNI Project
Daulaire	Nils	PPC/SA
Davidson	Frances	USAID/G/PHN/HN/CS
Davidson	Frances	USAID/PHN/HN
Davis	Sara	USAID/G/PHN/POP
Davis	Sarah	USAID/G/PHN/POP
de Quadros	Ciro	
de Zalduondo	Barbara	USAID/G/PHN/HN/HIV/AI
de Estrada	Maricarmen	El Salvador
Deravello	Lori	Centers for Disease Controls
Destler	Harriet	PPC/CDIE
Dickins	Kate	Manoff Group
Diggs	Carter	USAID/G/PHN/HN/EH
Farr	Ken	Indonesia
Feeley	Rich	
Feinberg	Lloyd	USAID/G/PHN/HN/EH
Fields	Rebecca	BASICS/PATH
Fischer	Craig	IBM
Fisher	Andy	
Fishman	Claudia	Emory University
Flanagan	Donna	Family Health International
Fluty	Holly	AA/M/ROR
Gapen	Kaye	Morino Institute
Garber	Larry	PPC
Gibb	Dale	USAID/G/R&D/H/RCSS
Gibbons	Gayle	APHA Clearinghouse
Gillespie	Duff	USAID/PHN
Gordon	Catherine	USAID/G/PHN/PSR
Grosz	Ron	USAID/G/HDC/PP
Guilkey	David	EVALUATION Project
Gupta	Gita Rau	ICRW
Haaga	John	National Academy of Science
Habis	Charles	Niger
Hart	Carolyn	John Snow, Inc
Hassig	Susan	Family Health International
Hausdorff	William	USAID/G/PHN/HN/CS
Hawkins	Steve	USAID/G/PHN/POP
Heiby	Jim	USAID/PHN/HN/PSR
Helitzer-Allen	Deborah	BASICS Project
Hemmer	Carl	USAID/G/PHN/POP/CLM
Holfeld	Joyce	USAID/G/PHN/FPS
Horn	Marge	USAID/G/PHN/POP/R
Huque	Zahidul	MotherCare Project
Jansen	William	Rabat
Jensen	Eric	
Johnson	Cate	USAID/G/PHN/HN/NHM
Jones	Sally	BHR
Kamenga, MD	Claudes	Family Health International

LastName	FirstName	Country
Karra	Mihira	USAID/G/PHN/POP/R
Kearns	Laura	Malawi
Kleinau	Eckhard	BASICS Project
Klin	Maria	Brazil
Koblinsky	Marge	MotherCare
Koek	Irene	USAID/G/PHN/POP
Kosar	Kathy	USAID/G/PHN/FPS
Kreis	Katherine	Washington, D.C.
Labbock	Miriam	Georgetown University Medical Center
Laing	Marcia	SOTA Assistant Facilitator
Lampthey, MD	Peter	Family Health International
Landry	Steve	USAID/G/PHN/HN/EH
Lawrence	Earle	Bolivia
Levy	Don	The Futures Group
Liberi	Dawn	AA/G
Lins	Maria Luiza	Brazil
Loeb	Robert	USAID
Losk	David	Honduras
Maddox	Ashley	USAIDG/PHN/POP/PE
Maguire	Liz	USAID/G/PHN/POP/Director
Mann	Jonathan	Harvard
Manoncourt	Erma	UNICEF
Matta	Nahed	Egypt
McCloud	David	AA/M/ROR
McGuire	Liz	USAID/G/PHN/POP
McLeod	Marie	Mexico
McNeil	Erin	G/PHN/POP/R
Micka	Mary Ann	Bucharest
Miller	Caryn	USAIDG/PHN/HN/CS
Mitchell	Susan	
Mize	Lucy	Mali
Moloney	Michele	Washington, D.C. (IDI)- Cambodia
Moore	Mary Beth	SOTA Course Facilitator
Morita	Karen	USAIDG/OHN/HN/HIV/AI
Morris	Tom	/G/PHN/POP/FPS
Nell Wegner	Mary	
Neuse	Margaret	/G/PHN/POP
Nicholson	Don	Deloitte & Touche
O'Connor	Pat	Guatemala
O'Gara	Chloe	USAID/G/PHN/POP.CMT
Ogden	Ellyn	LAC/RSD/PHN
Oldwine	Eilene	Manila - Jordon
Oot	David	USAID/GPHN/HN
Pedersen	Bonnie	USAID/G/PHN/POP/FPS
Pfeiffer	Linda	INMED
Piet	David	Bangladesh
Piotrow	Phyllis	Johns Hopkins University
Pitas	Cecilia	/M/HR/POD/CD
Plowman	Beth	USAID/G/PHN/HN/PSR
Pokhrel	Puru	Kathmandu
Pond	Bob	BASICS Project
Preble	Elizabeth	Family Health International
Pressman	Willia	USAID/POP/RCD/G/PHN/FPS

LastName	FirstName	Country
Pryser-Jones	Suzanne	SARA Project
Quain	Estelle	USAID/POP/CMT/G/PHN/POP/CMT
Radloff	Scott	USAID/G/PHN/FPS
Rahmaan	Carl Abdou	Egypt
Ralston	Elizabeth	USAIDG/PHN/POP
Rau	Bill	Family Health International
Rayburn	Dottie	LPA
Rippey	Helene	Guinea -Conakry
Rizzuski	Daniel	PPC
Robb-McCord	Judith	Kenya
Roberts	Mathew	Family Health International
Rogers	Roxana	Zimbabwe
Ross	Jay	Academy for Educational Development
Saade	Camille	BASICS Project
Sarcar	Shiril	Bangladesh
Seminario	Luis	Peru
Shelton	Jim	USAID/G/PHN/POP/R
Shelton	Sally	USAID
Simon	John	Harvard University
Sinnit	Meri	Washington, D.C. (IDI)- El Salvador
Smith	Bill	Academy for Educational Development
Snyder	Shelley	Washington, D.C. (IDI)- Egypt
Spicehandler	Joann	USAID/G/PHN/POP/R
Spiegler	Jeffrey	USAID/G/PHN/POP/R
Spieler	Jeff	USAID/G/PHN/POP/R
Stanton	Mary Ellen	USAID/G/PHN/HN/NHM
Starbird	Ellen	USAID/G/PHN/POP/PE
Stark	Nancy	USAIDG/PHN/POP/FPS
Steele Verme	Cynthia	Association for Voluntary Surgical Contraception
Steinglass	Robert	BASICS Project
Stewart	Krista	USAID/G/PHN/POP/PE
Stolzfus	Rebecca	Johns Hopkins University
Storms	Dori	Johns Hopkins University
Sullivan	Rick	Johns Hopkins University
Tomaro	John	USAID/G/PHN/HN/PSR
Trostle	Jim	Harvard University
Trostle	Murray	USAID/G/PHN/HN/CS
Trott	Melody	USAID/G/PHN/HN/CS
Tulloch	Jim	WHO/CDR
Van Vleck	Michael	Deloitte & Touche
Vareldzis	Basil	USAID/G/PHN/HN/HIV/AI
Ved	Rajani	India
Vogel	Dana	Tanzania
Waldman	Ronald	BASICS Project
Weiss	Ellen	ICRW
West	Keith	OMNI/Johns Hopkins University
White	Mark	Washington, D.C. (IDI)- Zambia
Wilson	Anne	USAID/G/PHN/POP/FPS
Wulf	Deirdre	AGI
Yee	Virginia	APHA Clearinghouse
Zeitz	Paul	USAID/G/PHN/HN/CS

	MONDAY - 12th	TUESDAY - 13th	WEDNESDAY - 14th	THURSDAY- 15th	FRIDAY - 16th
8:00 - 10:00	ADMINISTRATION (registration, finance, coffee, overview of the course, phn directory) -course coordinator	RE-ENGINEERING	8:00-9:00 SAFE PREGNANCY 9:00-10:00 SAVING WOMEN'S LIVES THROUGH POST ABORTION CARE	8:00-9:00 FEED THE MOTHER- Maternal Nutrition & Reproductive Health 9:00-10:00 LACTATIONAL AMENORRHEA METHOD	MAXIMIZING ACCESS & QUALITY IN FAMILY PLANNING AND REPRODUCTIVE HEALTH SERVICES
10:00 - 10:15	B	R	E	A	K
10:15 - 12:30	10:15 - 11:00 OPENING REMARKS dawn liberi robert clay margaret neuse 11:30 - 12:30 UPDATE : STATUS OF PHN IN THE WORLD	EVALUATION: THE SCIENCE OF DEMONSTRATING RESULTS	STD/AIDS	NGO-PVO PARTNERSHIPS	HEALTH QUALITY
12:30 - 2:00	L	U	N	C	H
2:00 - 5:00	COMMUNICATION FOR BEHAVIOR CHANGE IN PHN PROGRAMS	speaker - In reproductive health (NAS) 2:00-3:00 WHAT IS REPRODUCTIVE HEALTH 3:00-5:00 Family Planning: A New Look at Familiar Topics	individual appointments	2:00-5:00 WHERE IS THE COMMERCIAL SECTOR? & SOCIAL MARKETING	2:00-4:30 PHN CENTER BUDGETING PROCESS BUREAU SUPPORT SOCIAL GATHERING 4:30-6:30
5:00-7:00	COCKTAILS				

12

ATTACHMENT C 1 : A+-A-GLANCE

	MONDAY - 19th	TUESDAY - 20th	WEDNESDAY - 21st	THURSDAY - 22nd	FRIDAY - 23rd
8:00 - 10:00	8:00-10:00 TECHNOLOGY & TOOLS UPDATE Family Planning	CHILD HEALTH	POLICY REFORM AND PARTICIPATION IN PHN	8:00 - 9:30 HEALTH AND HUMAN RIGHTS 9:30-10:15 HARDLY REACHED POPULATIONS: Young Adults	LINKAGES-INTEGRATION-PARTNERSHIPS: CHANGING PARADIGMS
10:00 - 10:15	B	R	E	A	K
10:15 - 12:30	10:15-11:15 Research in Family Planning & Reproductive Health 11:15-5:00 Technology, Tools and Research for Health and Nutrition	CHILD HEALTH	PERSONNEL SYSTEM & ISSUES 11:30 - 12:30 CONGRESSIONAL UPDATE	HARDLY REACHED POPULATIONS: breakout sessions 1. male involvement 2. refugees 3. street children 4. high risk behavior (std/hiv)	APPLICATIONS OF COMMUNICATIONS TECHNOLOGIES FOR PROGRAM ACTION
12:30 - 2:00	L speaker - diedre wolf refugees	U	N		H Closing Remarks
2:00 - 5:00	Technology, Tools and Research for Health and Nutrition (con't)	CHILD HEALTH	2:00 - 3:15 DONOR COORDINATION plenary 3:15 - 5:00 BREAKOUT SESSIONS 1. Retooling for logistics management 2. vii and vaccine procurement 3. report on world conferences 4. applying gender planning	2:00-5:00 EMERGING DISEASES & MALARIA INITIATIVE	individual appointments

SOTA - DAILY SCHEDULE

Monday, June 12

<p style="text-align: center;">Welcoming, Introduction & Administration 8:00-10:00</p>
<p style="text-align: center;">Presenter(s): Mary Beth Moore</p>
<p>Topics of Presentation:</p> <ul style="list-style-type: none">• Overview of SOTA course• Participant Expectations• Opportunities for Session Interaction
<p style="text-align: center;">Opening Remarks 10:15-11:30</p>
<p style="text-align: center;">Presenter(s): Dawn Liberi, David Oot, Margaret Neuse</p>
<p>Topics of Presentation:</p> <ul style="list-style-type: none">• Welcome• USAID's new challenges• Vision of PHN Center for the Future• Opportunities under the new USAID structure• Importance of the SOTA course
<p style="text-align: center;">Update: Status of PHN in the World 11:30-12:30</p>
<p style="text-align: center;">Presenter(s): Dick Cornelius, John Tomaro, Scott Radloff</p>
<p>Topics of Presentation:</p> <ul style="list-style-type: none">• PHN Strategic Objectives and Outcome• Where we have come, Where we are, Where we are going• Where do we focus our attention?• How do we work together in achieving our goals?
<p style="text-align: center;">Communication for Behavior Change in PHN 2:00-5:00</p>
<p style="text-align: center;">Presenter(s): Bill Smith, Phyllis Piotrow, Rick Sullivan, Claudia Fishman, Erma Manoncourt</p>
<p>Topics of Presentation:</p> <ul style="list-style-type: none">• New perspectives on Communication for Behavior Change• Ten Lessons Learned from Family Planning Communications• Competency-Based Training: Sustaining Behavior Change• Ethnographic Issues in Nutrition Communication• Community Mobilization for Health Behavior Change

SOTA - DAILY SCHEDULE

Tuesday, June 13

<p style="text-align: center;">Re-Engineering 8:00-10:00</p>
<p style="text-align: center;">Presenter(s): David McLoud, Holly Fluty, Pat O'Conner</p>
<p>Topics of Discussion:</p> <ul style="list-style-type: none">• Prisms vs. Results framework• Customers, participation and conflict of interest• Country teams and the role of Global and the Field• Experience from the Field
<p style="text-align: center;">Evaluation: The Science of Demonstrating Results 10:15-12:30</p>
<p style="text-align: center;">Presenter(s): Lianne Brown, Bill Jansen, David Guilkey, Eckhard Kleinau, Susan Hassig</p>
<p>Topics for Discussion:</p> <ul style="list-style-type: none">• Evaluation Innovations• Program Evaluation/Morocco case study• Measuring Program Impact/ Tanzania case study• Update on the RHIG Indicators• Monitoring and Evaluation of AIDS/HIV/STD
<p style="text-align: center;">Luncheon Presentation Reproductive Health (Intro & Case studies of three Reproductive Health priority areas) 12:30-2:00 Presenter(s): Dana Vogel, Bonnie Pedersen, Judith Robb-McCord</p>
<p style="text-align: center;">What is Reproductive Health? 2:00-3:00</p>
<p style="text-align: center;">Presenter(s): Bonnie Pedersen, Elizabeth Ralston</p>
<p>Topics for Discussion:</p> <ul style="list-style-type: none">• Present definitions of Reproductive Health and Conceptual Framework• Brief Overview of the Reproductive Health Agenda

SOTA - DAILY SCHEDULE
Wednesday, June 14

Safe Pregnancy 8:00-9:00
Presenter(s): Marge Koblinsky
Topics for Discussion: <ul style="list-style-type: none">• Lessons Learned from USAID/MotherCare Project• Behavior Change & Improving Services• Scaling-Up: From demonstration projects to provincial/state and national projects• Integration in Reproductive Health• Measuring the Results of Safe Pregnancy Programs
Post Abortion Care 9:00-10:00
Presenter(s): Anne Wilson, Trish Coffey
Topics for Discussion: <ul style="list-style-type: none">• Post Abortion Care video• USAID priority areas & resources• Field Questions/Discussion
STD/HIV 10:15-12:30
Presenter(s): Peter Lamptey, Bill Rau, Claudes Kamenga, Elizabeth Preble Mathew Roberts, Maxine Ankrah, Donna Flanagan
Topics for Discussion: <ul style="list-style-type: none">• What is working? What is not?• Behavior Imperatives (research and intervention)• Improving the Diagnostic link to STD case management• How to integrate STD services with other sector activities
Individual Appointments 2:00-5:00

SOTA - DAILY SCHEDULE
Thursday, June 15

Feed the Mothers: Maternal Nutrition and Reproductive Health
8:00-9:00

Presenter(s): Jat Ross, Cate Johnson

Topics for Discussion:

- Maternal Height and CPD
- Pre-Pregnancy Weight and Birthweight
- Weight gain during Pregnancy
- Micronutrients: Iron, Vitamin A, Iodine
- Focus on Adolescents
- Cost-Effectiveness/Strategies for Sustainable Programs

Feed the Baby: Lactational Amenorrhea Method
9:00-10:00

Presenter(s): Miriam Labbock

Topics for Discussion:

- Introduction
- Usefulness/Effectiveness of LAM
- Importance of Breastfeeding

PVO/NGO Partnerships
10:15-12:30

Presenter(s): Willa Pressman, Dori Storms, Sally Jones, Danielle Roziewski
Lloyd Feinberg, Maurice Middleberg

Topics for Discussion:

- Overview: Expanding current successful activities with PVOs/NGOs
- New partnership Initiatives
- US-based PVOs
- Is there need for further support to US-based PVOs for Family Planning & STD/HIV activities
- NGO/PVO funding mechanisms

**Where is the Commercial Sector?
&
Social Marketing
2:00-5:00**

**Presenter(s): Don Nicholson, Michael Van Vleck, Camille Saade, John Tomaro, Craig Carlson,
Catherine Gordon, Vicki Baird, Alex Brown**

Topics for Discussion:

- Introduction and Overview
- Summary of USAID's commercial sector interventions
- What Works? Viable USAID Strategies and Lesson Learned
- Social Marketing: Methodology & Marketing
- Case Studies
- Where do we go from here?

SOTA - DAILY SCHEDULE

Friday, June 16

Maximizing Access to Quality in Family Planning & Reproductive Health
8:00-10:00

Presenter(s): Jim Shelton, Cynthia Steele Verme, Karen Beattie

Topics for Discussion:

- Quality and Access components and their Programmatic Implications
- COPE (Client-Oriented, Provider Efficient): a clinic-level problem-solving tool to increase quality

Health Quality
10:15-12:30

Presenter(s): Jim Heiby

Topics for Discussion:

- The Concept of Quality in Health Services
- Quality Assessment
- Quality Improvement
- Organization of Quality Assurance Programs
- Research and Development Issues
- Resource Organizations and Publications

Luncheon Presentation:
Children as Agents of Change
Presenter: Linda Pfeiffer
12:30-2:00

PHN Center Field Trip & Social Gathering
(@ 1601 Kent Street)
2:00-5:00

Presenters: Duff Gillespie, Irene Koek, Kathy Kosar, Carl Dabbs, Joyce Holfield

Topics for Discussion:

- Welcome Remarks
- Budgeting & Implications
- Issues from Mission perspective
- Bureau Information

Social Gathering
(@ 1601 Kent Street) 7th Floor
4:30-6:00

SOTA - DAILY SCHEDULE

Monday, June 19

Technology & Tools for Family Planning 8:00-10:00

Presenter(s): Jim Shelton

Topics for Discussion:

- Latest technology for contraceptive methods, especially OC's, IUD's, barrier methods and Depo Provera
- Programmatic and service implications for these methods

Research in Family Planning & Reproductive Health 10:15-11:30

Presenter(s): Jeffrey Spieler, Marge Horn

Topics for Discussion:

- Cutting edge issues in biomedicine
- Contraceptives for the 21st Century
- Operations research in family planning and reproductive health

Luncheon Presentation Refugees

Presenter: Dierdre Wolf
12:30-2:00

Technology, Tools and Research for Health & Nutrition 11:30-12:30/2:00-5:00

Presenter(s): Robert Black, Rebecca Fields, Bill Hausdorff, Caryn Miller
John Simon, Rebecca Stolfus, Jim Tulloch

Topics for Discussion:

- HIV/AIDS: Syndromic approach to STD management; STD diagnostics and HIV dipstick; TIR behavioral research
- Micronutrients
- Vitamin A: impact and delivery
- Parasites
- Diarrheal diseases: ORS and its limitations, Low Osmolarity, promise of vaccines
- Acute Respiratory Infections: Case management & Prevention
- Immunization
- Cross-cutting themes

SOTA -DAILY SCHEDULE

Tuesday, June 20

Child Health (CH) - Introduction
8:00-8:30

Presenter(s): Al Bartlett

Topics for Discussion:

- Pathway to Child Survival
- Organization

CH - Prevention Strategies EPI, Nutrition & Environmental
8:30-12:30

Presenter(s): Murray Trostle, Paul Zeitz, Robert Steinglass, Frances Davidson.
Ian Darnton-Hill, John Tomaro

Topics for Discussion:

- EPI Program Strategy/Sustainability
- EPI coverage for Disease Control Initiative
- Nutritional Interventions and the Private Sector
- EPI Plus/Vitamin A issues
- Environmental Health

Informal Luncheon: Latin America/Carribbean
participants will meet outside the hotel at a restaurant TBA.

CH - Treatment: Integrated Management of Child Health
("The Sick Child Initiative")
2:00-5:00

Presenter(s): Jimm Tulloch, Suzanne Prysor-Jones, Ron Waldman, Nils Daulaire

Topics for Discussion:

- The WHO Algorithm
- Malnutrition/Cough/Fever/Diarrhea
- Discussion
- Expanding the initiative
- Motivational Tools/Assistance areas

SOTA - DAILY SCHEDULE

Wednesday, June 21

Policy Reform & Participation in PHN 8:00-10:00

Presenter(s): Constance Carrino, Bob Emory, Ellen Starbird, Scott Radloff

Topics for Discussion:

- Case study in PHN Policymaking
- Population policy project resources
- Health policy project resources
- Discussion

Personnel System & Issues 10:15-11:30

Presenter(s): Cecilia Pitas, Bernie Block, Dale Gibb

Topics for Discussion:

- Career management information and strategies
- New Hires - Conversion of non-DH to DH positions
- Personnel situation in Agency

Congressional Update 11:30-12:30

Presenter(s): Dottie Rayburn

Topics for Discussion:

- Current congressional issues related to USAID

Donor Coordination 2:00-3:15

Presenter(s): Liz Maguire, Judith Robb-McCord, Karen Marita, David Piet, Eileen Oldwine
Dana Vogel, Robert Clay

Topics for Discussion:

- Why is Donor Coordination Important?
- Case Study: US/Japan & from the field
- Open discussion

Breakout Sessions
3:15-5:00

Breakout A.
Retooling for Effective Logistics Management

Presenter(s): Caroline Hart, Carl Hemmer, Laurie Dearavello, Jim Bates

Topics for Discussion:

- What USAID/PHN can learn about supply logistics from the commercial sector
- How field PHN staff can strengthen local institution support to logistics improvement
- What logistics tools are available to identify priority actions that contribute to sustainability

Location: Ravenworth West

Breakout B.
Beginning to Apply Gender Planning to PHN

Presenter(s): Mari Clarke, Ellen Weis or Gita Gupta

Topics for Discussion:

- Introduction on the prominence of gender/women's empowerment in Agency Mandates
- Group Discussion
- Case examples: Honduras, Uganda and Malawi
- Women and AIDS

Location: Room 611

Breakout C.
Cairo, Copenhagen and Beijing: What Happened? So What?

Presenter(s): Sarah Craven, Richard Cornelius, Barbara Crane
Ashley Maddox, Earle Lawrence

Topics for Discussion:

- Review of the main points of these three summits
- Discuss conferences as catalysts and roles of the NGOs in the process
- Review national experiences
- Roles of NGOs

Location: Room 711

**Breakout D.
Vaccine Independence Initiative (VII)**

Presenter(s): William Hausdorff, Ciro de Quadros, Joyce Holfield, Bill Jansen

Topics for Discussion:

- UNICEF's new vaccine supply strategy
- Case studies: Morocco, Burundi, Philippines and Bangladesh

Location: Room 911

SOTA - DAILY SCHEDULE

Thursday, June 22

Health and Human Rights 8:00-9:30
Presenter(s): Jonathan Mann, Larry Garber, Ellyn Ogden
Topics for Discussion: <ul style="list-style-type: none">• Applicable Human Rights Conventions• Agency policy on Human Rights• Health and Human Rights• Child Health Rights•

Young Adults 9:30-10:15
Presenter(s): Jeanine Buzy, Anne Wilson
Topics for Discussion: <ul style="list-style-type: none">• Description of Global needs and Priorities• Description of USAID response• Questions

Breakout Sessions: Hard to Reach Populations 10:15-12:30
Presenters: A.-Barbara de Zalduondo, B.-Mary Nell Wegner & Cynthia Steele Verme, C.- Lloyd Feinberg, D.- Steve Hawkins
Breakout A. (Room 611) <ul style="list-style-type: none">• High Risk Behavior - STD/HIV Breakout B. (Room 711) <ul style="list-style-type: none">• Male Involvement Breakout C. (Room 911) <ul style="list-style-type: none">• Street Children Breakout D. (Ravensworth West) <ul style="list-style-type: none">• Refugees

Emerging Diseases & Malaria Initiative
2:00-5:00

Presenter(s): Steve Landry, Caryn Miller, David Piet, Basil Vareldzis, Dennis Carroll

Topics for Discussion:

- Introduction: Definitions of ENHI
- Case Studies
- Technical updates on: Surveillance, Antimicrobial resistance, TB
- Explaining new strategies for Malaria control

SOTA - DAILY SCHEDULE

Friday, June 23

Linkages-Integration-Partnerships: Changing Paradigms
8:00-10:00

Presenter(s): Robert Clay

Topics for Discussion:

- Relationships between Environmental Health-Child Health-Maternal Health Reproductive Health & TFR
- Relationships between Population-Health-Nutrition-Education-Poverty-Environment
- USAID case studies: Manila, Kingston
- Worlds Bank case studies: Bangladesh
- Realities of Linkages: Constraints and Opportunities

Applications of Communication Technologies for Program Action
10:15-12:30

**Presenter(s): Ron Grosz, Susan Anthony, Maria Busquets-Mora, Craig Fisher
Virginia Yee, Kaye Gapen, Gayle Gibbons**

Topics for Discussion:

- Presentation on state-of-the-art technologies
- Internet Demo
- How can these technologies serve you?
- Applications and Discussion

Closing Remarks

12:30-1:00

(Nils Daulaire, Liz Maguire and David Oot)

Individual Appointments

2:00-5:00

Thank You for Your Participation!!

SESSION TITLE	Point Person Ready	Presenters Ready	Rap	Out line	AV Needs	Badge Needs Listed	Hand-Outs Ready	Other Notes
Monday, June 12								
Welcoming, Introductions & Administration 8:00 - 10:00	MBM	MBM		D	✓	✓		
Opening Remarks 10:15 - 11:30	SiA MN	DL RC						talking points
Update: Status of PHN in the World 11:30 - 12:30	JT SR	JT +	AM	D	✓	✓	TBP	
Communication for Behavior Change in PHN 2:00 - 5:00	MT	ok	tba	F	✓	✓	✓	Reception 5-7pm
Tuesday, June 13								
Re-Engineering 8:00 - 10:00	HF	HF DMcC	tba	D	✓	✓	✓	
Evaluation: The Science of Demonstrating Results 10:15 - 12:30	KS BP	✓	tba	F	✓	✓	✓	✓
Luncheon Presentation - Reproductive Health, including intro & 3 case studies 12:30 - 2:00	ER	BP			✓			
What is Reproductive Health? 2:00 - 3:00	ER	BP +	AE?	D	✓		Y	
Family Planning: New Approaches for Familiar Topics 3:00 - 5:00	MH	ShC EJ JHa	SD	F	✓	✓	✓	✓
Wednesday, June 14								
Safe Pregnancy 8:00 - 9:00	MES	MK			✓		Y	lm 6/7
Post Abortion Care 9:00 - 10:00	AW TC	AW	TC	F	✓		Y	copying
STD/HIV 10:15 - 12:30	VB JB	!		D	✓		-Y	!!
Individual Appointments 2:00 - 5:00	Participants to set appointments as needed							
Thursday, June 15								
Maternal Nutrition/Feed the Mothers/BF 8:00 - 9:00	CJ MES	CJ JR	!	D	✓			Add BF
Lactational Amenorrhea Method/BF 9:00 - 9:45	MK CJ	ML	MK	F	✓	✓	✓	Add BF
Integrating Repro. Health Interventions (Wrap Up) 9:45 - 10:00	WP	WP	TC	✓	✓	✓		✓

SESSION TITLE	Pt. Pers.	Prestr.	Rap	Outl	AV	Badge	HndO.	Notes
PVO Partnerships/Relationships 10:15 - 12:30	WP	SJ DS	tba	?			**	booklets on arrival
Where is the Commercial Sector? 2:00 - 3:15	CWC JT	ok	CG	F	✓	✓	✓	
Social Marketing 3:15 - 5:00	TM	ok	CG	F	✓	✓	✓	
Friday, June 16								
Looking at Quality: MAQ in FP & RH 8:00 - 10:00	EQ	JSh	SD		✓		Y	attend next session
Health Quality 10:15 - 12:30	JH	JH	!	D				attend previous
Luncheon Presentation: Children as Agents of Change, Linda Pfeiffer, INMED 12:30 - 2:00	EO	LP	!!	F	✓	✓	✓	
PHN Center/Budgeting Process (2:00-4:30) Social Gathering 4:30 - 6:30 1601 N. Kent, Rm. 520	IK KK	DG CD	TL	D	✓**	✓	Y	will provide AV
WEEK TWO								
Monday, June 19								
Technology & Tools Part 1: Family Planning 8:00 - 10:00	JSh	JSh	SD	D	✓	✓	**	**may include on arrival
Research in Family Planning 10:15 - 11:15	JSp MK	JSp MK		D	✓			!! ct BdZ
Technology & Tools: Health & Nutrition 11:15 - 12:30	WH	✓						
Luncheon - Deidre Wolf 12:30 - 2:00	SH	DW	!		!			AGI?
Tech. & Tools: H & N (cont.) 2:00 - 3:00	WH							
Research: Health & Nutrition 3:15 - 5:00	CM WH	✓		D				
Tuesday, June 20								
Child Health (CH): Introduction 8:00 - 8:30	MT	AB		D				
CH - Prevention Strategies/Environmental 8:30 - 12:30	MT	MT FD		D				Lat. Am. lunch
CH - Treatment: Integrated Management of Child Health ("The Sick Child" Initiative) 2:00 - 5:30	MT	JT		D	✓**			set in rounds
Wednesday, June 21								
Policy Reform and Participation in PHN 8:00 - 10:00	BE	CoC	RM	✓	✓			7 rounds w/ stands

SESSION TITLE	Pt. Pers.	Prestr.	Rap	Outl	AV	Badge	HndO.	Notes
Personnel System & Issues 10:15 - 11:30	BB CP	BB CP		D	-		No	
Congressional Update 11:30 - 12:30	DR	DR	!!					lms 6/1,5&7
Donor Coordination 2:00 - 3:00	DC	LM DC	AM	F	✓	✓	Y, AM	?add? R. Clay
Breakout Sessions - 3:15 - 5:00	Sessions are to be presented once, beginning at 3:15. Length may vary.							
A. Retooling, Effective Logistics Mgmt(R-W)	CH	TB		D	✓			lms T/C
B. Applying Gender Planning to PHN (611)	EMc	✓	✓	F	✓	✓		✓
C. Summits: What happened? So what? (711)	AM	BC	AM	D	✓			lms B/A
D. Vaccine Independence Initiative (911)	WH	WH		D			NC	lm WH
Thursday, June 22								
Health and Human Rights 8:00 - 9:30	EO	JM LG	JoS	D	✓		**	sign up for copies
Young Adults 9:30 - 10:15	AW	JB AW		D	✓		Y	
Breakouts: Hard to Reach Populations 10:30 - 12:30	Sessions A, B, & C are to be presented twice; 10:30 and 11:30. Session D will be presented once; 10:30 only.							
A. High Risk Behavior - HIV/STD (611)	BD							
B. Male Involvement (711)	JR	MNW		F	✓	✓	✓	AVSC
C. Street Children (911)	LF							
D. Refugees (10:30-11:30) (Ravensworth-W)	SH	NS	tba		✓			ok
Luncheon Topics: Ebola Outbreak 12:30 - 2:00	SL	PZ RW	tba	F	✓	✓		✓
Emerging Diseases 2:00 - 4:00	SL	CM DP	tba	F	✓	✓		✓
Malaria Control: An Integrated Strategy 4:00 - 5:00	DC						///	DC out til 6/20
Friday, June 23								
Linkages-Integration-Partnerships: Changing Paradigms 8:00 - 10:00	RC AM	RC	AM	D ₂	✓		Y	
Applications of Communications Technologies for Program Action 10:15 - 12:30	MB-M SuA	RG	RT	D	✓	!	NC	
Closing Remarks 12:30 - 1:00	SA MT	?						

Attachment E

SOTA TRAINING COURSE LOGISTICS REMINDERS AND RECOMMENDATIONS

The 1995 Population, Health and Nutrition (PHN) State-of-the-Art (SOTA) training course was conducted with a compressed planning phase and a minimal amount of expense. The following recommendations are intended to save planning time when similar meeting arrangements are required.

ADVANCE PREPARATION

Advance Planning Form

Six weeks before the course, a form labeled "SOTA Meeting Planner" was sent to each session coordinator requesting information on the session's content and logistics. Responses varied in format and completeness. Many were late or unanswered. This caused delays in advance preparation and inaccuracies in the course agenda.

Recommendation: Give enough time for coordinators to respond, but set firm deadlines and replace coordinators who fail to pull sessions together in advance.

Hotel Reservations and Per Diem Arrangements

The participants were provided advance materials via E-mail, including information on per diem arrangements, hotel reservations and course schedule. If different reservations were requested, they were submitted through USAID and a rooming list was submitted to the hotel with date of arrival and departure and payment plan for each participant guest. Corrected rooming lists were provided to the hotel periodically until 48 hours prior to arrivals. The facilitator was impressed by the ease with which the reservation lists and complicated guest billings were handled by the reservation and front desk staff.

Unfortunately, per diem distribution was less timely and efficient. Several participants waited 3-4 days after arrival to receive their per diem. While this was the responsibility of the training office, the facilitator was frequently asked to assist with the financial "logistics". (Note: The training office did provide attractive participant certificates of accomplishment.)

Recommendations: Utilize a hotel with strong systems and experienced staff. Those processing participant expense advances must meet deadlines.

Badges and Arrival Materials

Presenter names and affiliations were not available from many session coordinators. Preparation of badges and the daily schedule was delayed until the last day. Badges were prepared for all participants, USAID staff planners and presenters, and known outside presenters. Participant badges included name and country. Presenter badges included

USAID division affiliations or cooperating agency name. It was necessary to have additional stick-on badges available for unexpected presenters, visitors and for reception guests.

Delayed session coordinator information made it difficult to assemble the advance notebooks for arriving participants. Notebooks, individually labeled with participant names, included the following:

- Cover page (slipped in notebook's outside front pocket) including course name, mini-schedule and participant's name
- USAID contact page (slipped in notebook's outside back pocket) with listing of USAID staff names and phone numbers
- General information sheet
- Two-page course-at-a-glance schedule
- Daily schedules with presenters names and topics for each session
- Participant list
- Handouts for the Reproductive Health Technology & Tools session
- Rosslyn map and visitor's guide

Notebooks were delivered to the hotel on Friday, June 9, alphabetized and in boxes. The front desk personnel were asked to give each participant their personalized notebook upon arrival. The remaining notebooks were retrieved on Monday morning and distributed at the meeting room to the participants not staying at the hotel.

Transporting notebooks, meeting materials, audio-visual equipment and supplies to the hotel was done by the facilitator, making several car trips to the hotel during the weekend before the course.

Recommendation: Allow three days for final preparation of daily schedules, badges and arrival notebooks. This requires cooperation from all session coordinators.

Audio-Visual Equipment

Despite repeated attempts to determine audio-visual (AV) needs for each session, gaps remained prior to the course. Contractors, POPTECH, Jorge Scientific, HTI, and JSI supplied equipment. Unfortunately contractors did not have the full capacity for SOTA equipment needs or delivery. When contractors fell short, the hotel company AVI provided last-minute equipment. Although more costly, AVI was efficient, responsive and their equipment was reliable. The value of using the hotel AV service is the tremendous savings in facilitator time and energy.

Recommendation: Uninterrupted service is worth the cost of hotel AV equipment.

Originally the course was to include 35-40 people, but the final size of the audience was 50-60 each day. Although a speaker's microphone was not provided until the last day, it would have been a benefit for the larger group throughout the course.

Recommendation: Provide a movable microphone for the head table if the audience exceeds 35 people.

COURSE IMPLEMENTATION

Conference Facilities & Services

The selection of the Hyatt Arlington hotel was fortunate due to its proximity to USAID PHN offices and its professional service to guests and visitors. Since two weeks were spent in the same conference room, it would have been better to have a larger space, windows and fresh air. The room set-up was changed between schoolroom and banquet style but other alternatives would have required a larger room. Guest seating was restricted.

Additional hotel arrangements included:

- Registration table and chairs outside the room entrance
- Message bulletin board near registration
- Materials tables at the rear of the room
- AV table for overhead and slide projectors
- Guest chairs
- Heavy duty extension chord
- Frequently refreshed drinking water on tables, pads, pencils
- Evening security for materials left in the conference room
- Headquarters room for equipment storage, onsite work, small meetings/interviews

Breakout rooms (3) were used on two days. It was agreed during contract negotiations that breakout rooms would be provided free if guest room use was over 22 rooms per meeting day. Use of the main conference room cost \$150/day. The hotel staff relieved the burden of set up and clean up. They were prompt and courteous. Requests for interim billing information and assistance with necessary adjustments was professionally handled.

Recommendation: Select a hotel with proven support services and arrange for a room that can handle at least twice the number of expected meeting participants, preferably with windows that open for fresh air.

Breaks and Luncheons

The hotel agreed to provide a morning coffee/tea service within the price of the conference room. The afternoon breaks and welcoming reception were sponsored by cooperating agencies. Morning and afternoon breaks were absolutely necessary and should have been lengthened to allow time to network, refresh, and set up for upcoming presenters. Sessions were tightly scheduled and the 15 minute break was often consumed by question and answer segments at the end of sessions. Interim stretch breaks were needed.

Recommendation: Plan for 20-30 minute breaks between all sessions for refreshing, networking and providing a buffer period for the sessions that run long.

In order to conserve participant per diem, catered luncheons were not required. Three days had luncheon sessions scheduled and the hotel allowed (hesitantly) restaurant buffet meals to be carried to the meeting room. Individual billing was expedited. Overall, this self-service required less time than most conference meal arrangements. Extra trays on stands were provided outside the room for self-busing of luncheon dishes.

Recommendation: Regardless of how economical and efficient luncheon sessions can run, they are not recommended. Participants need a break and the presenters deserve full-group participation and attention.

Course Materials

At the beginning of the course, divided storage envelopes (file wallets) were provided to each participant to store their accumulated materials. Handouts were copied by presenters whenever possible. Copies remaining at the end of sessions were left on material tables. Ultimately, left-over copies were returned to USAID for distribution to interested staff. If copies were limited, sign-up sheets were prepared for participant requests.

At the end of the course, boxes were provided to store and ship course materials. Participants boxed, labeled and taped boxes for shipping. A pouch address list and approximately 15 rolls of strapping tape were needed. The final day, 35 boxes were prepared and moved, by courier service, to USAID offices for mailing.

Recommendations: Provide at least three large materials tables in the meeting room. Distribute boxes to participants at the end of the first week and ask that they be packed, taped and addressed before they are given to staff for mailing. Provide strapping tape and an address list. Arrange for a courier service to pick up the accumulated boxes on the last day. Determine the place for delivery within USAID and mailing room procedures.

Communications and Business Services

Telephone services for participants, presenters and staff were limited to the pay phone in the public space near the room entrance. It provided poor support for an active group of callers. Incoming calls were difficult to receive and presented a burden to hotel staff (in the nearby executive offices) who delivered 15-20 messages a day for SOTA participants.

Recommendation: A private incoming phone line for the conference would improve access and relieve telephone burdens especially for hotel staff, facilitators and participants.

The listing of USAID staff and phone numbers proved very helpful during the course. The PHN directory was unavailable until the last day.

Recommendation: A full directory of PHN staff, cooperating agencies, and other related individuals should be provided with the participant's advance materials.

Recommendation: A common software application should be agreed upon early in course planning. Converting files cause lengthy delays in final schedule and list preparation.

Recommendation: Use a hotel with available business services. Utilizing the business service room at the Hyatt made it possible to produce last-minute transparencies, computer printouts, and last-minute, limited copies.

Flight confirmation assistance was requested. A helpful mechanism might be a simple list of airline phone numbers, a travel agency, or an assistant during a set time period.

Emergency Plans

Midway through the course a participant became ill and needed medical attention. He was visited in the hotel by other participants who are physicians. The hotel did not have a physician on call. Eventually the ill participant was accompanied to a hospital for care. The hotel provided a wheel chair for use within the hotel. Had this been an emergency, procedures would have been clear and an ambulance called.

Recommendation: Determine hotel capacity to handle medical care and emergencies. Remind participants of emergency procedures and be sure they have accurate insurance information.

Recommendation: Emergency contact information was collected at the beginning of the course, but should be available prior to participant travel and updated, if necessary, upon arrival.

POST-COURSE ACTIVITIES

Final Housekeeping

At the end of the last session the remaining handouts and course materials were boxed and transported to USAID offices. AV equipment was picked up by, or delivered to, the various lending agencies. Undelivered messages were sorted, delivered or destroyed. Evaluations were sorted and analyzed. Session coordinators were called to remind them when rapporteur notes were due.

Recommendation: Check for participant messages and items before the last session ends to assure nothing of value is left behind.

Rapporteur Notes

Each session was to have a rapporteur who would provide a summary of the session for the course record. Several sessions had no rapporteur. Whenever possible the facilitator's assistants took notes. The notes were submitted to the facilitator in a variety of forms and some were significantly delayed.

Recommendations: Identify assigned rapporteur for each session prior to the course. Provide written directions to each rapporteur for the preparation and submission of the session notes. Suggest that the notes be limited to one page and provided on diskette in a uniform software application.

Overall Recommendations: Increase planning time, think ahead, don't panic, and admit mistakes.

Attachment F

SUMMARY OF INDIVIDUAL SOTA SESSION EVALUATIONS

TITLE	*# of RESPONDENTS	**AVG. SCORE
Opening remarks	31	2.5
Update: Status of PHN in the World	40	2.9
Communication for Behavior Change in PHN	39	3.3
Re-Engineering	36	3.1
The Science of Demonstrating Results	23	3.0
Reproductive Health	18	2.8
What is Reprod. Health	-	-
FP:A New Look at Familiar Topics	22	2.9
Safe Pregnancy	22	3.1
Saving Lives thru. Post Abortion Care	13	3.2
STD/HIV	20	2.9
Feed the Mother	23	3.0
Feed the Baby	22	3.8
PVO/NGO Partnerships	20	2.8
Where is the Commercial Sector & Social Marketing	32	3.0
Maximizing Access to Quality in FP & RH	33	3.1
Health Quality	25	3.3

SOTA COURSE EVALUATION TALLY/Page 2

TITLE	*# of RESPONDENTS	**AVG. SCORE
Children as Agents of Change	9	3.3
Technology & Tools for FP	30	3.5
Research in FP & RH	33	3.2
Refugees	3	2.0
Tech., Tools & Research	33	3.1
Child Health	10	2.9
CH-Prev. Strategies EPI, Nutrition & Environment	2	3.0
CH-Treatment Strategies: Integrated Manag. of CH	-	-
Policy Reform & Partic. in PHN	22	3.2
Personnel Systems & Issues	7	1.8
Congressional Update	3	3.6
Donor coordination	3	3.0
Health & Human Rights	22	3.9
Young Adults	3	2.3
Emerging Diseases	2	3.5
Malaria Initiatives	-	-
Linkages-Integrat. Partnership	7	2.7
Application of Comm. Tech. for program Action for Health & Nut.	9	2.3

* out of 47 participants

** rating: 1-poor 2-fair 3-good 4-very good

**PHN SOTA 1995
FULL COURSE EVALUATION**

Consider the entire SOTA course, June 12-23, 1995, as you respond to the following questions. This information will be combined with the individual session evaluations for a report to the PHN SOTA Course Committee.

It has been a pleasure working with you,

Mary Beth Moore
1995 SOTA Course Facilitator

GIVEN:

- The large amount of important PHN information available;
- The economies required for USAID-supported training; and
- The limits of any person's capacity to absorb new information...

Please provide your suggestions and comments about the 1995 PHN SOTA Course according to the following categories:

ADVANCE PREPARATION

What additional advance information from the course organizers would have helped you prepare for the course?

COURSE IMPLEMENTATION

Knowing that people learn in different ways, what are your recommendations for improving the actual course sessions? Please check the appropriate box:

Presentation Style	More	Same	Less	Comments:
Lectures				
Slides & Overheads				///
Videos				
Case Studies				
Questions & Answers				
Group Exercises				
Written Materials				
Luncheon Speakers				
Social Events				
Individual Appointments				
Informal Conversations				
Other:				

What were the highlights of the course?

BEYOND THE SOTA COURSE

What additional PHN information would you find useful for your work in the field? Please be specific.

FUTURE SOTA TRAINING

How often should training in the state-of-the-art be provided?

What other comments or recommendations do you have for the future planners of SOTA courses?

Rate your overall course experience on a scale of 1 (poor) to 10 (very good) _____

Please add any comments or suggestions for the course facilitator here:

Thank You

HIGHLIGHTS OF 1995 PHN SOTA COURSE PRESENTATIONS

SOTA course presentation highlights are presented in the original text as provided by individual transcribers.

Monday, June 12

WELCOMING SESSION

Participants were welcomed by facilitator, Mary Beth Moore, who also provided course information and a review of the two-week schedule. Participant and staff introductions included individual interest areas and expectations for the course. Each participant selected a session for which they agreed to be the "key participant". Key participant responsibilities included:

- Prepare 1 or 2 questions for the session
- Organize others to participate
- Participate during the session

OPENING REMARKS

Dawn Liberi, Robert Clay and Margaret Neuse welcomed all participants and discussed current PHN Center issues including budget cuts and the effect on the PHN Center.

The political environment was discussed, particularly the threats of cuts to foreign aid assistance. Budget cuts will have a direct effect on USAID and thus the PHN Center. The speakers asserted that a challenge is ahead for all. Although, for example, child survival and HIV programs will be protected, other programs are threatened.

The PHN Center must report on the benefits of development assistance and the efficiency and effectiveness of USAID programs. Information should be provided on the value of foreign population and health assistance to the well being of the American public. The Agency's strategic objectives are:

- a) reduce unintended pregnancies
- b) decrease maternal mortality
- c) decrease child/infant mortality
- d) decrease STD transmission with a focus on HIV

PHN Center strategic objectives:

- a) need or problem identification
- b) product/program development
- c) field testing and validation
- d) diffusion and marketing
- e) market and refinements
- f) implementation and scale
- g) stabilization

Field missions are especially key to the latter as they are in position to give feedback as to what is going on in trying to reach these objectives.

The SOTA course is to keep field mission people informed of the latest technical and programmatic information in PHN, while engaging them in participatory discussion on all aspects of the PHN Center.

COMMUNICATION FOR BEHAVIOR CHANGE

Presenters and their topics:

- Bill Smith (AED) - New Perspectives on Communication for Behavior Change
- Phyllis Piotrow (JHU) - 10 Lessons Learned from Family Planning Communication
- Rick Sullivan (JHU) - Competency-Based Training: Sustaining Behavior Change
- Claudia Fishman (Emory University) - Ethnographic Issues in Nutrition Commun.
- Erma Manoncourt (UNICEF) - Community Mobilization for Health Behavior Change

Melody Trott of the Office of Health and Nutrition introduced the session by saying that USAID wanted to tie communication into management and training. She said the office wanted to know how it can support its people in the field in a more integrated way. Today there is more emphasis on social mobilization and private/public sector cooperation while in the past communication activities had been focused on setting up facilities and getting people into them. She was followed by Chloe O'Gara from the Population Office who said that the office was issuing a new IEC RFP with a ten-month overlap with PCS.

New Perspectives on Communication for Behavior Change (Bill Smith)

Calling his presentation "What's New, What's Hot, and What is Not," Bill said that an individual getting the message out along is out and that the feedback model works but has limitations. The exciting model today is audience driven and part of the community planning movement. Technologies are put into the hands of the community, ranging from an epidemiologist to a HIV-positive women.

Lesson No. 1 - Start with behavior. It is the implicit link between programs and health benefit.

Lesson No. 2 - Behaviors are different. Communication must match behaviors and deal with compliance, choice, and lifestyle.

What are the best practices? Those that are simple, show a community benefit and integrate policy decisions with services. They are audience centered and the process links demand, program, and service.

Accepted principles include segmentation and targeting. These principles are reached through triangulated research which involves surveys, observation and quality? Does it work? Sometimes--when it is used right and done correctly. There is a lot of excellent experience and data. Reasons for failure include the right channel wasn't used or it was done wrong (e.g., pretesting wasn't done).

Descending effects of behavior: aware of, concerned about, knowledgeable, attitudes towards, first trial, assessment, repeat use. Remember, though, good communication can't

compensate for other problems such as a poor distribution system.

No-no's include: single shot campaigns, mass media only, poor audience research, no integration with policy or service.

What is hot? Shift away from consequences to benefits; sustaining consequences in developing countries is hard to maintain; antecedent mapping--what are the triggers? E.g., what is it that triggers a woman to take her child in for immunization?

Social science determinants model: applied to AIDS prevention programs and deals with social norms, self-sufficiency, and perceived consequences (e.g., if a MD doesn't feel comfortable with counseling, not likely to do it). If you can make things easy, fun, and popular, people will do it.

Compare doers and non-doers. Doesn't matter how many you look at, but compare who is doing it and who is not. Focus on the differences.

Sustainability and costs. Tough issue. What do people want to sustain? Focus on differences. Unfortunately there is not good work on cost effectiveness for communication efforts.

Teach skills for condom use, not how to use condoms.

Questions/points raised by participants: Why call it behavior change? This has a lot of baggage. Wouldn't it be better to call it behavior practice?

Behavior change is what the literature calls it. Language is often a problem in social marketing. Behavior practice is fine if that is what communications.

HCOM provided posters in Honduras, but cultural norms prevented people from reading them.

Lessons Learned from Family Planning Communication: Phyllis Piotrow

Behavior change is a step-by-step process as programs identify and meet unmet communication needs. Steps for behavior change framework:

Knowledge - recall family planning messages; understands what fp means; can name methods; knows supply source

Approval - responds favorably to fp messages; discusses messages with network

Intuition - recognizes that fp can meet a personal need; intends to consult a provider; intends to practice fp

Practice - goes to provider; uses fp

Advocacy - acknowledges personal benefit of fp; advocates practice to others

Meeting communication needs means meeting the needs of influentials and service providers. Provide reassurance - fp is a community norm. Create confidence and encourage people to speak out

Informed choice must be the basis of sustained behavior change.

1. Information
2. Choices (availability, access, communication)



Example in Ghana - amount of IEC material is correlated with number of new acceptors.

Good communication must have an emotional as well as a rational basis. Emotion carries a powerful message.

Mass media, especially entertainment, are powerful and cost-effective changes.

Eight Ps: persuasive, popular, personal, passionate, practical, profitable, proven effectiveness for enter-education project. Value added.

Quality costs less. Quality is a new buzz word. Can't justify developing quality health programs overseas while cutting programs in the US. Must use quality people.

Cost effectiveness needs to be documented better.

Advocacy is the last step in behavior change and the first step to community mobilization.

Perfect program - spiral of silence (practice stops because no one talks about it); spiral of acceptability ("I do it, do you?") Successful behavior--know how, when and where they were successful because they are based on data. Egyptian success.

IEC training transfers skills and builds the team to carry out the program. Process for communication: trained through scope, a complete program. Based on data from Turkey for a highly participatory process. Communication is a process.

Competency-Based Training: Sustaining Behavior Change: Rick Sullivan

Rick started off by asking participants about the components of the best training course. Replies included: clear, funny, personally relevant, high energy level, well prepared, interactive, draws from real-life examples.

Competency-based training moves away from the old approach of the donor's representatives comes in, scatters thoughts and materials and leaves.

A training system has to be part of a context, i.e, the national program. It works best to grow trainers. People go to a course and are trained to provide a service. Prepare some of these people to be master trainers. This helps to standardize skills, update methods, and provide training and clinical practicum. It leaves behind trained people when donor-financed trainers leave.

New providers are then trained by master trainers. Master trainers participate in advanced training skills course. By doing training of trainers, the MOH is becoming self sufficient in training expertise. Individuals are able to grow to master trainers within the country to keep the system functioning.

Question: How do you blend in management of training with training? Is master trainer managing the training?

Central training team which includes master trainers manages process of planning, monitoring and evaluation.



What sustains change:

- conduct needs assessment
- design course based on real needs
- develop training packages
- select participants
- send information to participants

Question: How can you affect change if the wrong people are sent to the training?

You can't. This happens all the time.

- conduct highly interactive and participatory training
- develop skills using anatomical models
- coach participants in the classroom and clinic
- use video to give participants feedback
- develop follow up plans
- conduct follow up observations and evaluations

Question: How do you know if they are trained?

Try to assess skills during training. Have participants do presentations during training. Co-train with them. This will help you see if the training is sticking.

Most trainers in-country have other jobs. Often they go off to the private sector or want per diem to go into the field. Own behavior of master trainers is sometimes a problem. Please don't want to become trainers.

[the last two presentations were telescoped somewhat because of time pressures and projector problems]

Ethnographic Issues in Nutrition Communication: Claudia Fishman

Anthropologists want to understand who eats. If low consumption because of lack of food availability or social rules for who eats, when and where. (West Africa used as the model for the presentation.) What are the preparation methods? How is the food served and who is served first?

Vitamin A decision tree: Are foods available? Are the diets of women and children inadequate? Are social rules for consumption flexible? Field work was done to establish what food is being sold; what utensils are used; what food was available when. It was determined that the answer to the first three questions was "yes." The program would try to motivate mothers to eat more when they are pregnant. This would be culturally appropriate. To target audience, good food is food that tastes good. Don't have a concept of healthy food. Culture, though, has a conception of night blindness. Women see it as a first sign of pregnancy. Don't want people to see them tripping in the dark. Can you get liver to pregnant women? Make gender specific recommendation of liver for mothers and children. Who has the money to buy liver and who does not.

What forces are available for the intervention? Participants were given 15 minutes to come up with a mobilization plan. Forces were identified as cultural, gender-related, seasonal, perceptive, and based on a hierarchy. Who influences the decision makers: mother in-laws, market women, husbands.

Community Mobilization for Health Behavior Change: Erma Manoncourt

As communicators trying to mobilize communities, why are you looking at this information? Because it is orienting, empowering, need to understand possible incentives, and important to use limited resources well.

Community members are the stakeholders. Their attitudes need to be understood so they can do most of the work for your intervention.

Need to understand what factors contribute to your "competition."

Communication messages are often given too early. Larger issue is mobilization. Communities' views and perceptions are essential to whether they will change their behavior.

Possible community partners: work with pre-existing groups; do role models using community theater groups; parents/elders; opinion leaders (traditional and political); clinic themselves; PVOs, NGOs, ministries, local government.

USAID's involvement in communities is through surrogates. These intermediaries change the group dynamics. Women need help sometimes in being put in a position where they feel they can act. This is capacity building in an environment which may be hostile.

Ask yourself whether you as USAID are most effective at the policy level or within the community itself?

It is unrealistic and unfair to talk about community mobilization without talking about social mobilization. USAID can help set the environment that affects change at the community level. E.g., in a town where the mining company calls the shots, the mayor may become less of a "yes" man if a participatory planning process is underway.

Important to have a goal and ask if changes will make a big difference. What differences would a strong demand make?

Tuesday, June 13

EVALUATION: THE SCIENCE OF DEMONSTRATING RESULTS

The main theme of the session entitled "Evaluation: The Science Of Demonstrating Results" was that the current emphasis throughout USAID on "Performance Monitoring" has led to the development and refinement of quantitative methods for showing program impact. The session featured presentations by evaluation specialists from several USAID projects in the health and population sector concerned directly with helping Missions monitor programs in that sector. The most striking feature of this series of presentations was that great strides have been made in taking various theories of evaluation, theories which has been written and talked about for decades, and applying those theories with promising results in actual settings in the field.

Lisanne Brown, of the Evaluation Project, briefly highlighted the conceptual notions guiding the work of that project -- a commitment to clear definitions applied within carefully constructed conceptual frameworks, the need to distinguish program monitoring (periodic review of program progress by observing trends in selected indicators) from impact assessment (the attribution of observed change to program components) and the importance of applying sound methodologies (for example, randomized experiments and multi-level regression methods), especially in doing impact assessments.

Bill Jansen, of USAID Morocco, offered a case study example from Morocco where an evaluation framework was constructed as an integrated part of the Mission's PRISM plan and used to identify specific activities and outcomes to be delivered by participating contractors operating under performance based contracts. When USAID introduced the notion of results packages, the Morocco PRISM plan had already defined those packages and the means by which they were to be realized.

Lisanne Brown introduced EASEVAL, a computer software tool to allow ordinary people to do simple, custom analyses of DHS Survey data. Using EASEVAL, an analyst can easily compute simple frequencies and crosstabs on variables categorized according to the needs of the analyst.

David Guilkey, also of the Evaluation Project, described a case study from Tanzania in which a series of surveys paced throughout the life of a relatively large family planning project and designed to facilitate the measurement of change in key variables in the sampled geographical areas give strong evidence of program impact -- and not just change in outcome variables.

The last input from the Evaluation Project was a description by Lisanne Brown of the process underway to define Reproductive Health Indicators. Currently, draft reports of the various subcommittees formed to consider indicators in substantive areas related to reproductive health are under review by technical experts. Once the reports are finalized, the next step is field testing.

Eckhard Kleinau, of the BASICS project, after recognizing that the Child Survival indicators have been generally accepted by the health community for a number of years now, focused on three new tools for estimating the values of those indicators. The first, the Preceding Birth Technique, offers an alternative to periodic national surveys for the measurement of infant mortality. Based on a few simple questions asked of a mother about the survival of her next oldest child during a visit to a health facility for antenatal care, at an attended birth, or when the newborn is first brought to a clinic for vaccination, it is possible to estimate short term trends in infant mortality. The second, a mortality survey (the example being one in Bolivia), uses the verbal autopsy technique to identify not only the causes of death in children but also the factors at household, community and health facility level which contribute to those deaths. The third, a Rapid Facility Assessment, is useful to measure process and outcome variables for a health intervention implemented through facilities. This third tool is based on the WHO facilities survey; however, it modifies that survey by expressly considering many diseases rather than just one.

Zahidal Huque, of the MOTHERCARE project, introduced the course to the sometimes subtle behavior of indicators with an example drawn from Mongolia in which the Maternal Mortality Ratio (the most commonly recommended indicator of maternal mortality) showed

enormous negative change while the Maternal Mortality Rate did not. This "paradox" arose because the fertility (number of live births) of women declined and, therefore, the deaths per live birth rose but the proportion of women who died did not. The speaker went on to note that in the aspect of health intervention aimed at reducing maternal mortality, the tools of evaluation are not as well developed as in the more established areas of family planning and child survival. Tools which show promise but need more work include: the measurement of births in which complications are present, the analysis of "near miss" episodes, and the study of why full-grown, full-term newborns die. This segment of the session ended with another illustration of the methodological problems confronting evaluators where a patient is classified as having or not having a condition -- the problem of gross mis-estimation resulting from a relatively small amount of misclassification.

The final speaker, Susan Hassig of the AIDSCAP project, accelerated her presentation by referring the class to a recent article on HIV/AIDS indicators published by the GPA program at WHO and moving quickly to some of the newer avenues of exploration at AIDSCAP. One such tool, a Behavioral Surveillance Survey (BSS) has an objective of providing reliable measures of which population groups exhibit what potentially dangerous behaviors for the purpose of indicating the next area of intervention for a project. Also, a spreadsheet model is being developed to convert information on a target population, its HIV prevalence and its sexual behavior (and changes in that behavior) into projections of program impact. Finally, a manual for "Targeted Intervention Research (TIR)" has been produced elaborating on a technique to help program designers and managers to better understand a community's perceptions of sexually transmitted diseases and services for addressing them.

The brief question and answer period following the formal presentations identified a provocative problem for the "evaluation experts"; specifically, the need to use evaluation methods not only to measure and understand what has happened due to intervention but also to enable program managers to set reasonable targets for the future. Lastly, the disconnect between reporting/monitoring and in-depth evaluation was identified as a problem while working in the field. It was suggested that the in-depth interpretive processes of the kind discussed throughout this session be somehow transformed into an ongoing process for program managers and not just a tool applied once during a project or at its conclusion to fulfill requirements that projects be evaluated.

LUNCHEON PRESENTATION - REPRODUCTIVE HEALTH

Tanzania's National Family Planning Program: Dana Vogel

Tanzania's Logo: Happy two child family including breastfeeding and literacy.

Factors for Tanzania's success:

- Higher than expected demand
- Improvements in service delivery system
- Availability of adequate resources and strong NFPP management
- Government commitment
- USAID's special role

Handouts provide details.

Female Genital Mutilation and Reproductive Health in Kenya: Judith Robb McCord

How did FGM get on the agenda in Kenya?

- Proposal from AMREF on prevention and design intervention. Did not go with this proposal, but there was a lot to learn on FGM.
- An NGO, Maendeleo Ya Wanawake, conducted a survey on FGM which also looked at early marriage and traditional taboos
- Pathfinder will do a survey on FGM- 4 districts on Kenya surveyed. This will also cover early marriage and traditional taboos in women fourteen years old and older.

Results: 90% of women in 4 districts were circumcised. 51% of women 15 years of age are circumcised. There may actually be a slowing down of use of the practice

Regions: Meru has the lowest % of women circumcised (73%). Religion is not a determinant. There is a high prevalence in refugees; Kisi has 51% of girls circumcised before age 10

- Definitions of types of circumcision:
Sunna: partial removal of clitoris
Excision: Clitoris and labia minora removed
Infibulation: Clitoris and both labia removed and vaginal opening is sewed up leaving an opening not wider than a pencil.
- Equivalent for men would be removal of penis, testicles and scrotal tissue
- Women were asked to list common reasons for doing this:
 - Good tradition
 - Sign of maturity
 - Increases chance of marriage
 - Reduces promiscuity
 - Being recognized in community
 - Easy childbirth
 - Female dependency
- Where practiced?
 - 61% -- village
 - 14% -- bush
 - 16% -- home
 - 4% -- health center
 - 1% -- hospital

The hospitals and health centers are more often becoming involved- more educated people want this done in a safe setting

- 68% of the procedures are done without washing the instruments
- In 70% of the girls, the same instrument was used on all the girls

48

- Fat and urine are local substances that are put on the wound to stop the bleeding

Side effects:

- Hemorrhage (about 50%)
- Scarring
- Urine retention

Change of attitudes among women: The elders say, "It's ok if they want to stop the practice" and the women say, "The elders don't want this to stop". But if the practice was stopped, the women fear they wouldn't get married

WHAT IS REPRODUCTIVE HEALTH?

Within reproductive health, there are three priority areas for USAID: Family planning and related fertility services; safe pregnancy, improvement of maternal nutrition and promotion of breastfeeding; and STD/HIV/AIDS prevention and management.

In small groups, participants prepared a group drawing that represented reproductive health without the use of words. Drawings were shared with the full group. This was followed by a brainstorming on what is reproductive health, resulting in the following list of issues and concerns:

- Define and deal with according to country context
- Vertical projects mix within the field. Questions: How can have the highest impact? How do they relate to existing programs? What are the costs involved?
- Integration of other RH activities can compromise FP
- In Romania, which has different problems, 70% of the maternal deaths are prevented if used family planning because it results from unsafe abortion
- Emphasis on the importance of integration
- Mostly women
- Supportive environment necessary
- Good nutrition
- Literacy
- Policy
- Penis and condom
- Male and female
- One child
- Choice
- Ecology
- Access
- Holistic
- IEC
- Empowerment
- Need to get back to MCH model
- Share responsibility (ie. male partners)
- Effect on family planning
- USAID's comparative advantage
- Opposition to "RH"
- Unsafe abortion

Elizabeth Ralston presents on the RH Coordinator's function: Elizabeth coordinates among different working groups in the Center. She provides technical guidance on a variety of issues and serves as the focal point through which information gets passed.

- The RHTF is the vehicle through which issues are discussed and technical guidance is given. There are several other working groups that do their own activities and provide technical guidance within their own area.
- The reproductive health communications plan: gets information to the field and also vice versa. Involves information dissemination:

How should information on reproductive health be disseminated? There is a lot of information out there and it needs to be channeled appropriately and selectively.

The Reproductive Health Communications Plan:

Information Dissemination Strategies for Reproductive Health

How should information on reproductive health be disseminated? There is a lot of information out there which is not channeled appropriately and selectively.

Solution: The Reproductive Health Communications Plan:

This plan outlines ways in which information is disseminated or compiled to be used easily and effectively by USAID staff and other partners.

The Reproductive Health Task Force:

- Provide technical guidance in reproductive health programs
- Serve as a forum for continuing education
- Coordinate reproductive health activities within the Center

PHN Center working groups:

- Provide technical guidance and serve as a resource within a particular reproductive health category (i.e. STD, Breastfeeding, Post Abortion Care, etc.)

Reproductive health electronic discussion forum:

- Promotes discussion of a wide range of reproductive health issues
- Demonstrates the power of the internet

The Reproductive Health Materials Working Group

- Compile a database/resource of reproductive health materials produced by Cooperating Agencies
- Reduce duplication of effort among Cooperating Agencies

Information packets:

- Develop packets of information on activities in the different components of reproductive health (i.e. Adolescents, STDs, etc.)

50

- Develop a packet on the Center's activities in reproductive health

Resource list of who does what in Reproductive Health

- Serve as a guide for where to find information on a particular subject

FAMILY PLANNING: NEW APPROACHES FOR FAMILIAR TOPICS

Thirty Years of Family Planning Experience: Shanti Conly

- A. Lessons Learned from 30 years of FP experience
 1. access is critical
 2. pluralistic approach works best ("no magic bullet")
 3. successful programs have client-orientation
 4. strong management, supervision and political backing makes a difference
- B. Post-Cairo
 1. individual at center
 2. FP provided in larger context of reproductive health
- C. Three "Pearls"
 1. keep eye on public health impact (cost, etc.)
 2. be less paranoid about integration
 3. avoid blanket prescriptions

Community-Based Distribution: John Haaga, National Academy of Science, National Research Council

- A. CBD: no single definition (variations in agent selection and compensation, in agents' connection to clinics, etc.)
- B. Role in new FP programs: CBD can serve as kickstart, yet there are common obstacles
 1. safety fears (not grounded)
 2. acceptability fears (not ungrounded; can be opposition)
- C. Role in mature programs: CBD can greatly increase contraceptive prevalence (CBD especially effective where there is high density of settlement, e.g., Bangladesh)
- D. Sustainability: Role of CBD can decline (as women become more mobile, demand for CBD can lessen)
- E. Management Challenge: Supervision
 1. geographic dispersion makes workers difficult to observe
 2. common mistake: supervisors who have never been CBD workers

Situation Analysis: Andy Fisher, Population Council

- A. Definition: rapid appraisal of a sample of family planning service delivery subsystems to determine quality of care received (e.g. supervisory visits, technical competence,

equipment on site, training received, client provider interaction, etc.)

- B. Measurement objectives
 - 1. policy vis-à-vis quality of care
 - 2. readiness of system to deliver quality of care
 - 3. services received
 - 4. impact measured at client level
- C. Sampling: all staff members and all clients receiving services on day of Situation Analysis
- D. Utilization of Data
 - 1. rapid data processing
 - 2. national seminars held where results are disseminated
 - 3. data used to research and/or develop interventions to improve programs or policy
- E. Conclusions
 - 1. strong interest by program managers
 - 2. rare opportunity to collect program-level data
 - 3. results extensively used

Cost Analysis: Eric Jensen, East West Center

- A. Joint costs: crux of the problem for cost analysis definition: costs shared over multiple activities (e.g. costs of buildings, training, etc.)
- B. Measurement problem: "cost measurement is more complicated than you'd think!"
 - 1. service statistics: doubtful quality
 - 2. field observations (sampling and field visits): in calculating joint cost on per-visit basis, under-utilization of staff drives up cost
- C. Cost-effectiveness: a comparison
 - 1. Definition: a cost-effective program is one that delivers a given output with fewer inputs than an alternative program providing comparable outputs.
 - 2. Advantage: clear conclusion
 - 3. Disadvantages
 - a) expressing social benefits/outcomes not always straightforward
 - b) cannot compare projects with different units of output
 - c) difficult to take into account quality of facilities and of users
- D. Sustainability
 - 1. definition: a sustainable program is one in which revenues exceed costs
 - 2. relationship to cost-effectiveness: Cost-effective programs need not be sustainable, and vice versa.
 - a) if commodities are donated and users receive commodities free of charge, program delivers highest output at lowest cost to program (therefore is cost-effective); yet because no revenue flows in, program is not sustainable.
 - b) if program has high cost per unit of output, but users pay for services such

that revenues exceed costs, the program is sustainable; yet program is not cost effective because it does not deliver output with lowest cost.

Wednesday, June 14

SAFE PREGNANCY

Pathway to Survival

Life threatening Illness
*
Recognition of Problem
*
Decision Making to Seek Care
*
Logistics to Reach Quality Care
*
Quality Care
*
Survival

Safe Pregnancy is one of the areas where IEC (Information, Education and Communication) for behavior change seems to be making a lot of headway.

The question we are trying to address when we talk about promoting safe pregnancy is Where do women with complications deliver?

Keep in mind that the set-up of IEC programs should be among the first programs initiative in any comprehensive set of development programs. Once IEC programs are in place, behavior change will be easier to effect.

Case Study: Indonesia

A formal study conducted in Indonesia taught a valuable lesson which can be applied in many developing country settings.

The most important point that was gathered from the study was that it was not the TBAs (traditional birth attendants) that were making the decisions of whether or not to move a women to a hospital setting if complications arose, rather it was family members themselves who decided.

Therefore, the IEC work needed to be conducted at the household level, contrary to belief.

In addition, there was seen to be a large amount of work to be done with the physicians themselves, so that upon arrival at the hospital, the newest techniques were employed to ensure the quality of care being given.

A new technique called the Perinatal Audit was used to gather all the participants in a birth together (where there was a mortality) to encourage peers to discuss what problems could have been avoided. At the onset, however, this program created suspicion and finger-pointing among the participants and tended not to be constructive.

Final Findings:

- The most expedient way to encourage Safe Pregnancy is by extensive IEC via several means
- Training of community workers (TBAs and local physicians)

SAVING WOMEN'S LIVES THROUGH POST ABORTION CARE

Anne Wilson

- Objectives:
- To define post abortion care
 - To describe the work of the Post Abortion Care Consortium
 - To describe and discuss post abortion care as a USAID priority in PHN programs
 - To provide an opportunity to clarify/discuss PHN field questions

Handouts provided:

Contact information for each of the Post Abortion Care Consortium members

USAID technical info packet on Saving Women's Lives Through Post Abortion Care

Monograph on Complications of Unsafe Abortion in Africa
(Executive summary of paper by Lynne Gaffikin)

IPAS Advances issues:

"Post Abortion Care: A Women's Health Initiative to Combat Unsafe Abortion"

"Post Abortion Family Planning: Factors in Individual Choice of Contraceptive Methods."

Field Issues:

1. What are the reactions in the U.S. to USAID programs?

Response: The general response of Congress to information regarding the mortality and morbidity of women in the developing world has been that the U.S. has problems as well and must focus on addressing domestic health. Countries that identify mortality and morbidity as an issue need to reallocate funds from other programs, such as nuclear armament development to health. As resources diminish there appears to be less interest in using them internationally.

As compelling as the data is, it has not persuaded Congress to support funding in this area. The human and financial costs of septic abortion are staggering. We also have inexpensive, low tech technologies available to prevent loss of lives and chronic disabilities.

54

2. What is the current USAID policy regarding MVA (manual vacuum aspiration) kits?

Response: No USAID equipment can be purchased for the purpose of providing abortion as a method of family planning; however, treatment of complications of septic abortion is permitted. Such humane treatment was also supported by the Vatican at the Cairo conference. The difficulty has been USAID concern that the MVA equipment may also be used to provide abortion services. Although this is not and has not been the intent of USAID supported programs, concern about misuse of the equipment persists even though the same concern does not extend to other kinds of equipment. USAID is discussing with other donors how to work more collaboratively to provide post abortion care.

3. In Zimbabwe a study was done on women recuperating after abortion. Women who had been treated with MVA recovered faster. Are there other studies like that?

Response: Yes. Use of general anesthesia in the standard treatment of complications markedly increases the risk. This is why MVA is so important. It does not require general anesthesia. This may also facilitate family planning counseling post abortion. Women who have emergency treatment using general anesthesia are too sick to be able to receive family planning counseling immediately post care. There are studies from Mexico, Egypt, Kenya among others.

4. What are the efforts from organizations to get governments to look at the abortion laws and to change policies?

Response: There is much work being done at the policy level to identify effective ways to reduce mortality and morbidity. Some governments are beginning to look at the cost of emergency services and ways to reduce the costs. One way is to reduce the need for emergency services through better family planning access.

5. Are there statistics on repeat abortions from the developing countries?

Response: For countries which have adequate reporting systems, there is data. Unfortunately the reported cases represent only a small portion of the total.

6. In Eastern Europe 10% of women who get abortions in facilities get counseling and referral for family planning. This seems low. Is it this low worldwide?

Response: This is not an unusual percentage. Frequently facilities which provide emergency services do not have staff who are equipped to provide preventive counseling and family planning services. Where the emergency services and preventive care are separate, especially in different facilities, the percentage of women who actually make it to the referral services is lower. The linkages between emergency care and family planning need much greater attention.

STD/HIV
FHI/AIDSCAP staff

Policy : The Changing HIV/AIDS Epidemic

The following trends are evident in the nature of the epidemic:

- the spread into rural areas
- the increasing number of infected women and the vulnerability of all women
- HIV/AIDS is now observable in growing numbers of illnesses and deaths
- impact beyond the health system to developmental and economic structures
- inducing wider and deeper levels of poverty among house holds affected

The following trends are evident in the response to the epidemic:

- policy makers behind the curve of the epidemic
- low levels of self-advocacy by people affected by HIV/AIDS and by AIDS prevention activists
- community-/primary health-based approaches to prevention and care.
- cultural and legal structures are questioned

Lessons learned in stimulating policy development:

- A well-planned strategy is the most important factor/process
 - identification of issues
 - debate
 - advocacy
 - consensus building
- illustrating the impact is useful
- comparative examples are helpful--psapp
- experiences from the field must inform policy making process

Some Thoughts About Behavior Change Communication

There is an art to Behavior Change Communication (BCC)--to making messages and materials stand out, engage the emotions, resonate in memory, persuade to take action. But the art rest on a solid foundation of behavioral science including models of behavioral change, theories of communication and techniques borrowed from marketing.

Formative research and analysis tell us what the problem is, who has it, what they and others are (or are not) doing about it, and why. Audience research provided valuable clues to attitudes, motivation and behavior. And the resulting plan provides a structural blueprint to guide the entire communication process.

It is the audience research that helps us get at the determinants of behavior.

Here it may be interesting to tell you about a key finding from the behavioral sciences. Regardless of the number of theories describing the behavioral change process, (and there are many) it now seems clear that there are relatively few variables that serve as immediate determinants of intention and behavior.

There is a growing consensus that there are only a limited number of variable that need to be considered in our attempts to understand, influence and/or maintain behavior.

Eight variable appear to account for most of the variation in any given behavior. Generally

speaking, it appears that in order for a person to perform a given behavior, one or more of the following must be true:

1. The person has formed strong positive intention (or made a commitment) to perform the behavior;
2. There are no environmental constraints that make it impossible for the behavior to occur;
3. The person has the skills necessary to perform the behavior;
4. The person believes that the advantage (benefits, anticipated positive outcomes) of performing the behavior outweigh the disadvantages--i.e., in other words, the person has a positive attitude toward performing the behavior;
5. The person perceives more social pressure to perform the behavior than to not perform the behavior;
6. The person perceives that performance of the is more consistent than inconsistent with his or her self- image, or that its performance does not violate personal standards;
7. The persons emotional reaction to performing the behavior is more positive than negative;
8. The person perceives that he or she has the capabilities to perform the behavior under a number of different circumstances; in other words, the person has perceived self-efficacy to execute the behavior.

The first 3 factors (commitment, no environmental constraints and skills) are viewed as necessary and sufficient for producing any behavior. In contrast, attitudes, norms, self standards, emotional reactions and self-efficacy are viewed primarily as influencing the strength and direction of intention--and influencing the likelihood that one will act upon his or her intentions.

It appears that the most important implication of this is that it points out the necessity of research and in particular, measuring intentions prior to developing an intervention. For example, if a person has formed a strong intention to perform a given behavior, but is not acting upon that intention, the intervention should be focused upon improving skills and /or removing or helping one to overcome environmental constraints.

In contrast, if a person has not yet formed a strong intention to perform a given behavior, the goal of the intervention should be to strengthen the person's intention to perform that behavior.

A few other findings for the behavioral sciences.

1. Information can produce behavior change. Next contrary to popular belief, there is also abundant evidence that information in and of itself can produce behavior change. Although it is quite true that providing people with knowledge about a disease and how it is transmitted may have little or no impact on their behavior, other types of information (e.g., about the consequences of performing the behavior, about groups who support behavioral performance, and/or about ways to overcome barriers to behavioral performance) can be effective.

2. Interventions should attempt to change specific behaviors.

We have learned that the most effective intervention will be those directed at changing very specific behaviors. Just changing peoples intentions to reach goals (e.g. to avoid AIDS; to stay healthy) or their intention to engage in categories of behavior (e.g., to practice safe-sex; to negotiate condom uses) does NOT ensure change in any specific behavior. In contrast, changing someone's intention to perform (or not perform) a specific behavior (e.g., to always use a condom for vaginal sex with my main partner; to tell my main partner to always use a condom will usually be followed by a change in that behavior.

A few more thoughts about BCC...

1. Tinkering and tampering with people's private behavior or with a societies norms can be very sensitive--ticklish undertaking. When a BCC intervention focuses on individual behavior, the skills necessary for the preferred safer sexual behavior may be offensive to those who feel such activities or even discussions of them may threaten public morality. On the other hand, when the BCC focus is on broader social norms and/or environmental constraints, the forces promoting such a shift of norms may be viewed as meddlers in sacred customs. In this case, the BCC intervention must position itself to be seen to facilitate safer behavior rather than to change culture. The goal is not to replace traditions, but to complement and perhaps widely-reported ritual cleansing of a widow by sexual intercourse with a brother-in law has, in some places, been substituted by a non-sexual cleansing thus preserving the tribal tradition while making it safer.)

2. Another issue that you may have encountered is the skills/knowledge delay inherent in a field that is evolving as quickly at this. There is a wide range of competency--we find it in AIDSCAP projects but we find it too in the US. BCC is often seen as the responsibility of people trained as health educators. Clearly, health education skills are one necessary aspect of BCC. But, just as clearly, the skills required to undertake the strategic planning, the formative research, and the design and development tasks of BCC are often not part of the training of health educators. Effective BCC requires adherence to certain principles of communication which in turn requires certain technical skills. Unfortunately, in some countries, the title of BCC specialist precedes the knowledge and skills.

On to another point...

3. Behavior Change Communication is not static. It is tempting to believe that once a communication message or intervention or campaign is researched, created and tested, the desired results are guaranteed. It appears, however, that the results are time-bound. That is, a campaign that has proven its effectiveness in one year, may have lost its impact several years--or even months--later. Not only is there the predictable issue of audience fatigue, but there is the very success of the communication. Communication is developed to move the target audience from one stage of behavior to another. If it is successful, the audience will progress along the behavior change process, and the messages that were appropriate for one stage will no longer be of much consequences in the next.

finally, some thoughts about evaluation....

4. Measuring success of BCC interventions has been difficult for predictable reasons; baseline data is often inadequate; changes are not easily attributable to one specific intervention; self reported behavior may be unreliable; and anecdotal evidence is often not considered credible.

Given the relatively short time span of most AIDSCAP projects, BCC encourages

implementors, to look at intermediate indicators of success rather than absolute impact or outcome indicators. These indicators are able to detect movement in the direction of "influencing individual behaviors and the social context in which they occur." Examples of intermediate indicators for some project objectives might be: increased grassroots participation in campaign activities; increased discussion of HIV/AIDS policy issues in legislative bodies; increased press coverage of ethical and legal issues dealing with HIV/AIDS issues; more religious leaders and/or business leaders speaking out in a positive way about HIV/AIDS issues; and self-reported indicators such as: increase in self-reported ability to discuss safer sex options with partners; increase in women's self-reported ability to recognize STD symptoms, etc. Anecdotal evidence, and observation success include such observed evidence as: men and women leaving bars separately rather than together as in the past; or school girls speaking openly of rejecting "sugar daddies" can be considered indicators of positive and appropriate movement along the behavior change continuum. Anecdotal evidence and observation must be authenticated by further studies of a more critical nature when the interventions have been in operation for 4 or more years.

This whole process is often time consuming, frustrating and difficult. But it must be recognized that, just as one cannot simply "throw together" a vaccine, one also cannot simply "throw together" an intervention. If we want to develop effective behavior change intervention, we must be willing to put in the time and effort to conduct the research. Equally important, in evaluating or testing an intervention, we must be willing to give it time to have an effect; we must not look at behavioral interventions as a "quick fix." Behavior change is not an all-or-nothing, immediately occurring phenomenon. We must become more realistic in our expectations about the amount of behavioral change one can expect a given intervention to produce in a given time period.

Thursday, June 15

FEED THE MOTHERS: MATERNAL NUTRITION AND REPRODUCTIVE HEALTH
Cate Johnson and Jay Ross

Drs. Ross and Johnson examined two aspects of maternal nutrition: Protein-energy and micronutrient malnutrition.

Dr. Johnson emphasized the importance of a life cycle approach to nutritional needs. She stressed that low birth weight affects child growth failure which predicts low weight and height in teens and thus small adult women who often give birth to low birth weight babies. This vicious cycle is compounded when women become pregnant before attaining their adult weight and height.

Why do we need to focus on the nutritional status of the mother? Because women who have low pre-pregnancy weight and inadequate weight gain during pregnancy have a higher likelihood of giving birth to a LBW baby. Infant survival, later cognitive function and academic performance are all linked to LBW.

Anthropometric indicators for low birth weight are:

- Pre-pregnancy weight kg/ht² (BMI)
- Weight gain during pregnancy
- Arm circumference
- Height and weight

In 1990, the Institute of Medicine published guidelines on optimal weight gain during pregnancy.:

BMI	Recommended gain in kg
< 19.8	12.5-18
19.9-26	11.5-16
> 26 to 29	7-11.5
> 29	at least 6

Why do we need to look at the mother's iron status? Maternal anemia is another predictor of poor infant/ child outcomes such as a decrease in IQ, language skills, visual-motor skills, etc. Dr Jay Ross presented a computerized presentation entitled, "Profiles" produced by AED. This program, which deals with micronutrient malnutrition, is available for use by the missions and CA's.

"Profiles" looks at the three most important micronutrients for public health interventions: Iron, Iodine and Vitamin A. These nutrients are silent contributors to mortality and morbidity because they do not cause hunger and thus are easily neglected in the diet. Yet there are easy and inexpensive interventions to provide the daily requirements.

Iodine is required for the thyroid gland to produce thyroid hormone which controls the basal metabolic rate of the body. With inadequate thyroid hormone, mental function is slowed and a goiter may develop. If there is in utero deficiency, cretinism will result with severe mental retardation. World-wide 1.6 billion are iodine deficient. Supplementation before and after pregnancy is one strategy to avert cretinism, and fortification of salt an intervention to protect against hypothyroidism and goiter. These are inexpensive interventions.

Iron deficiency is the most common nutritional problem in the world. It is estimated that 1/2 of all pregnant women in developing countries are Fe deficient. Anemia decreases the brain's capacity to think and learn and lowers work capacity. It also increases the risk of maternal mortality due to hemorrhage. Infant Fe comes from the mother and thus her FE status directly affects childhood anemia.

One strategy for increasing Fe intake is dietary diversification. But Fe containing foods are often too expensive, not available or not acceptable. Supplementation for pregnant women and fortification of food (eg sugar, bread) are additional approaches. These interventions are highly cost/effective.

Vitamin A deficiency effects vision (from night blindness to ulceration of the cornea and blindness), the immune response and the health of tissues. A half million children are blind because of vitamin A deficiency worldwide, and 231 million have inadequate vitamin A intake which lowers resistance to infectious diseases such as diarrhea and measles. Interventions to increase vitamin A intake include the promotion of breast feeding (breastmilk is a rich source of vitamin A), diet diversification, supplementation and fortification. Again, these programs are highly cost/effective.

60

FEED THE BABY: LACTATIONAL AMENORRHEA METHOD (LAM)

Three areas to monitor to ensure efficacy of LAM method:

*

Menses (amenorrhea)

*

Supplementation (outside of breastfeeding) of infant's diet

*

Infant's age

LAM is not only a form of birth control -- it is also a method for promoting safe motherhood and a healthy baby.

LAM reduces post-partum hemorrhage.

Breastfeeding releases the hormone Oxytocin which in turn induces the let-down of colostrum and later milk and encourages uterine contractions post-partum. (FYI - This is also the hormone that causes orgasm).

LAM - relies on exclusive, frequent, on-demand breastfeeding.

Duration of breastfeeding and lactational amenorrhea are closely linked.

If these three rules are all followed LAM has been proven to be 98% effective:

1. Exclusively and nearly exclusively breastfeeding
2. Women is still experiencing amenorrhea
3. Infant is 6 mos. or younger

PVO/NGO PARTNERSHIP

- Main points covered in the presentation:
 - the administration's and the agencies interest in supporting PVOs/NGOs.
 - different mechanisms to support PVOs and NGOs and
 - experience in working with NGOs and PVOs.

Speakers:

Danielle Roziewski, a management intern on rotation to PPC, is working on the New Partnership Initiative (NPI) of the agency. D. Roziewski provided an overview of the NPI.

Sallie Jones, Chief of the Matching Grant Division in USAID's Office of Private and Voluntary Cooperations, explained that the program supports approximately 40 current agreements with U.S. PVOs in sectors and countries that coincide with USAID priorities. She provided an overview of the PVO Child Survival Support Program and its new approaches to activities.

Mary Ann Micka, HPN Officer/USAID Romania, gave an overview of USAID/Romania's

experience in working with local NGOs.

Maurice Middleberg, Director of CARE's Population Unit, directs the Cooperative Agreement with the Office of Population. This project is to integrate family planning into CARE's work overseas.

Major issues raised by the participants:

- The PVO Child Survival Support Program needs to insure that the US PVOs collaborate closely with the missions and work toward missions' strategic objectives.
- The difficulty of supporting local NGOs due to the red tape required by USAID regulations.
- The difficulty of working toward strategic objectives focusing on impact and outcome when working with NGOs which requires a great deal of institution building but which many not result in any impact in the near term.

**WHERE IS THE COMMERCIAL SECTOR
AND SOCIAL MARKETING?**

Craig Carlson

Where is the Commercial Sector?

Comment - The commercial sector is not a panacea, not going to serve everyone or meet every need. Varied. Diverse. Different players. Role that the private sector can play is complex.

The Commercial Sector Overall: Don Nicholson

What is the commercial sector? Everything from small business (e.g., Avon seller) to global giants (corporations)

The commercial sector can be formal or informal. It involves a diversity of players and sectors.

Key trends in the commercial sector:

- private investment - private investment is rising. Capital flight from LDCs is slowing down; being invested at home.
- trade barriers - breaking down.
- reform taking place in the public sector - Changes in government happening all over the world. Government is downsizing, redesigning itself. Throughout the world. Example: Brazil and Mexico allowing privatization of gas.
- Intellectual property rights given greater protection. Ashanti (goldmine) is example of good public-private partnership in a significant enterprise in Ghana.

62

- commercial sector - share of investment rising, share of family planning activity (as a percentage of all activity) is rising.
- resources - Private resources are needed to meet the gap between what we have (in health) and what we need. This is true in other sectors as well. Donor funding is declining. Five billion dollars less donor money in '93 than in previous year.

Some of the ways AID can relate to commercial sector

Commercial sector interested in:

profitability
 image
 sales
 TA
 Government contacts
 financing

In turn, the commercial sector can provide assistance to development efforts. Interests of commercial sector are donors and coming closer together. Managed care, equipment manufacturers interested in expanding abroad.

Summary of USAID Interventions: Michael Van Vleck

SOTA interventions and crosscutting interventions with private sector were described. Focusing on financing, M. Van Vleck discussed approaches in credit facilities.

Messages:

There is a clear rationale behind using commercial sector.
 Private sector not universally bad or good.

USAID - Commercial sector approaches:

- supply/distribution - local production, trade and regulation reform, social marketing, private providers
- financing of products, services - employer based programs, credit facilities, third party payers
- consumption - demand creation, social marketing.

Issue - Amount of USG resources going to private efforts is relatively small. Does USAID mobilize private resources as a complementary strategy to complement an overall strategy (that by inference is public sector)?

Example: Employer based programs - employers pay for health and for services.

Sulmac - flour producer in Kenya. Now have a clinic on premises without external support. Successful employer-based approach.

This approach has not been widely generalized. Tough to sell -- takes manpower to sell companies on the cost-benefit analysis. Health care is generally not the employer's primary business.

Newer approach to employer-based programs: Example - AAR/Kenya. PROFIT will provide loan for expansion of health services. Services provided on a capitated, per-person

basis. This allows purchase of insurance through means other than government.

To the degree that they (private primary care approaches) can become stronger, there will be a lower burden on the government.

Credit facilities provide opportunity to access large networks of private providers.

Provider loan fund - Indonesia Midwives Assn. 2,000 midwives. Using micro-loans for health objectives. Revolving loan type concept.

Critical Issues:

1. Sustainability of a business venture vs. the timing/amount of health outcomes. What sort of priority is accorded to sustainability?
2. Subsidy - Example: IUDs in Egypt -- price vs. coverage (of needy persons)? Which is more important? How much subsidy is important? How important are other price objectives?
3. Issue of control/ownership - donors are several steps removed.
4. Commercial sector's ability to reach low income populations. Can they do this?
5. Attention to approach is critically important - "selling ideas" to commercial entities.

Questions from the group:

- Subsidy--Commercial sector is dependent on public sector resources.
- Should the government charge NGOs for training? Subsidized service.
- What is the experience with types of subsidies to the private sector? Answer - Provide financial resources on a recuperative basis. Loans should be paid back. Leave the subsidy only for TA, training. Have private sector partner at economic risk.
- Employer with in-house health package. Managed care only becomes economically interesting if at risk for in-patient and (especially) out-patient care.
- How do you get the public sector to acknowledge and make accommodations to the private sector's contribution? Does the private sector change the way government operates?
- Potential role for HPN officers - (1) Honest broker role between government and private sector. (2) Regulatory reform needed to allow private sector to do better (example - non-physician health care provider). (3) Government as marketer of private services - e.g., Ecuador - Ministry encouraged people to buy bleach and soap (against cholera).
- Maybe the best time to move in (with the private sector) is after an AID project closes down. (ORS-Egypt)

64

Social Marketing: Camille Sade

What is the impact between private/public sector when we act to mobilize private sector.

Pyramid Diagram - Public sector provides services in a non-discriminatory way. They may reach people regardless of income. This is not necessarily the part of the population we want.

USAID's role is to encourage the private sector to fill in the void that the government can't, won't or shouldn't fill. This can help to better reallocate services to those who most need it.

BASICS will be developing a practical manual for working with the private sector (mobilizing the private sector for public health objectives).

What is social marketing?

"Marketing" beneficial exchange relationships. "Social" behaviors that are in the individual's and/or society's interest.

Focus of marketing - consumer oriented.

Marketing plan - Of what does it consist?

Market situation (evaluate). Company situation (evaluate). Define objectives.

What are Objectives:

S - specific

M - measurable

A - ambitious

R - realistic

T - time bound

4 Ps - price, product, place, promotion (+ public relations, politics + personnel)

How do we mix the four Ps? Marketing is using the same ingredients to fit the customer.

Approaches to market segmentation:

No market segmentation.

Complete market segmentation.

By income.

Age.

Education.

Geography.

Product strategy:

In Bolivia, developed product (ORS). How? Did basic market research with rural and semi-urban mothers. Asked them: "How do you perceive the ideal treatment for diarrhea?" "How do you describe the state of your child when he has diarrhea?" They answered: "Child is weak, want to make the child strong again." Positioning of the product is "to restore the strength of the child when he has diarrhea." Developed product identity as a visual concept as a result of focus groups. Came up with a name in keeping with product.

Distribution: In order to reach consumer, had to go through two layers. Manufacturer, wholesalers. Then on to pharmacies, private hospitals, doctors, government. Look at where does the consumer go?

Promotion: Has to be direct in terms of tangible products.

- advertising
- personal selling
- merchandising
- sales promotion

Advertising brings product to the consumer. Merchandising brings the consumer to the product.

Case Studies

Group I

Mission - Provide injectables to working/middle class populations of urban areas, simultaneously with condom marketing plans.

Why? Bad press regarding OCs and CPR of 30%.

Policy - Physicians

Price - One price, no subsidies

Promotion - one message (counseling) agencies

Place - urban clinics/hospitals, physicians

Product - commercial sources/condoms

Group II

Market services.

What to do to increase use of FP services?

Policy dialogue to use nurses/midwives, etc.

Train nurses.

Advertising campaign.

IUD insertion kits

Design logo

Baseline assessment

What role to use existing private health care infrastructure?

Learn characteristics of private sector

Professional associations

Continuing education

Work with pharmaceutical networks

Work with private insurance companies.

Work with industries.

How to promote services?

Develop message

Sell message

Group III

Design a social marketing program for ORS
Resources limited.

Where product might come from - define this.
Get a donation (UNICEF)
Entice pharmaceutical companies after product introduced.
Focus on packets.

Opportunities for private sector - through local market sellers. Get them interested in marketing ORS packets

Distribution - through traditional markets and midwives, later pharmacies.
Promotion - radio. Through midwives.
Training programs for midwives and end users of ORS. Pilot campaign: motto "buy or die"

Lack information - don't have info on message that will appeal to users. Also don't know who really has resources to purchase the packet or the mobility to go to marketplace.

Group IV

Objective: Design social marketing for OCP and condoms.

Need market research. Commodities would be donated. Assumption: there is an existing market distribution system. Would allow private distributors to take profit.
Select marketer to do market research (focus groups).
How to promote product? Hire experienced agency to do this.

Friday, June 16

MAXIMIZING ACCESS TO QUALITY (MAQ) IN FAMILY PLANNING AND REPRODUCTIVE HEALTH

Jim Shelton/Office of Population
Cynthia Steele Verme /Association for Voluntary and Safe Contraception

MAQ: Jim Shelton

Access and quality are both essential elements for successful programs. Offering advantages on individual and collective levels, improving access and quality benefits not only the user but programs as well. High-quality, accessible service encourages clients to use services longer and more effectively. It has been shown that family planning programs that ensure choice and good counseling have clients with higher rates of continuation.

I. Quality -- pulling the best flowers from the field

- A. choice
clients who receive the method they wished are more likely to continue
- B. side effects
clients who are counseled on method side effects are more likely to continue
- C. client provider interaction
not just medical advice, but dialogue in which there is two-way communication
- D. management and supervision
empowering providers to solve problems at the clinic-level and encouraging participatory approaches to supervision

II. Access

- A. barriers to family planning and reproductive health services
 - 1. social, cultural, religious, economic
 - 2. medical
 - 3. geographic, logistic
 - 4. regulatory, legal
 - 5. poor contraceptive image
 - 6. lack of trained providers
- B. Medical Barriers
"scientifically unjustifiable" practices that impede access to contraception
 - 1. Eligibility Barriers
most important: age and parity
 - 2. Process Barriers
 - 3. Provider Bias
 - 4. Medical Culture
hierarchical, conservative, curative, science-based
 - 5. How to Reduce Medical Barriers
sensitize, improve knowledge, mobilize medical hierarchy, promote change agents (champions)
 - 6. Tools to Reduce Medical Barriers
updating clinical guidelines and service policies:
 - 2 tracks for standardizing technical guidance
 - Improving Access to Quality Care in Family Planning. Medical Eligibility for Initiating Use of Selected Methods of Contraception* - WHO document providing eligibility criteria (forthcoming)
 - Recommendations for Updating Selected Practices in Contraceptive Use, Volume I* - document reflecting consensus of CAs and other agencies; designed to be basis for national guidelines; in both full and abridged versions

Cynthia Steele Verme

III. Client Provider Interaction

- A. importance
one study found that when analyzing the reason women did not come forward for treatment of obstetric complications, "attitudes of staff" ranked as important as "lack of supplies, blood and medicine"

B. definitions count

1. client provider interaction: the umbrella under which counseling falls (positive effect of counseling can be negated if the receptionist is rude)
2. counseling is distinct from other forms of communication such as promotion and information-giving
3. counseling is 2-way communication which helps the client make an informed decision and use method correctly

C. support -- to ensure the effectiveness and sustainability of counseling, programs need:

1. training
2. policies (e.g. supporting choice)
3. service support (e.g. adequate space and IEC materials)
4. supervision

D. counseling materials currently available

1. PATH Family Planning Counseling poster
2. AVSC Quality of Care poster on clients' rights and providers' needs
3. AVSC Family Planning Counseling notebook

HEALTH QUALITY

Jim Heiby

A definition of quality, particularly in the provision of health/clinic care is needed. In order to define quality or assess the quality of care, a "standard" must be set. Thus, quality is reached once the clinic, health facility or program has set a standard/guideline toward which the health providers, program facilitator, etc. work to reach. By pin pointing problems that arise, immediate attention and correction of the problem is possible. Heiby illustrates a quality assessment cycle which focuses on the following:

- 1) plan
- 2) set standard
- 3) communicate standard
- 4) monitor
- 5) identify and prioritize
- 6) define problem
- 7) identify who will work on the problem(s)
- 8) analyze and study problem
- 9) choose and design solution
- 10) implement solution

Heiby asserts that quality assessment is an on going process. Although the quality assessment cycle is given as exemplary illustration of the basic guidelines to assess the quality of a health programs, it is also essential to evaluate the program guideline on a regular basis.

LUNCHEON PRESENTATION: CHILDREN AS AGENTS OF CHANGE

Linda Pfeiffer/INMED

A new view has been recently voiced that "children can be active participants in their development." Key questions have been raised:

- Every mission needs a strategic plan which includes the role of CAs.

<p style="text-align: center;">WEEK TWO Monday, June 19</p>

CONTRACEPTIVE TECHNOLOGY UPDATE
Jim Shelton

A. Combined Oral Contraceptives (COC)

1. non-contraceptive health benefits: decreased monthly blood loss; improved anemia; decreased incidence of endometrial and ovarian cancer, ectopic pregnancy and acute pelvic inflammatory disease
2. COCs and breast cancer: no overall increase of breast cancer risk except possibly among younger women
3. change in estrogen dose
 - a) since the early 1960s, estrogen dose has decreased (from $> 50 \mu\text{g}$ to $30 \mu\text{g}$ found in USAID-supplied COCs)
 - b) lower risk of myocardial infarction and thromboembolism
4. failure rates: range from less than 1% (perfect use) to about 8% (typical use)
5. discontinuation: side effects #1 reason
6. common medical barriers
 - a) one pack at a time
 - b) inappropriate contraindications (thyroid, varicose veins, fibroids, diabetes, etc.)

B. Progestin-Only Pills (POP)

1. In countries where most women are breastfeeding: Should POPs be the primary OC?
 - a) very highly effective with breastfeeding
 - b) no reduction of breastmilk
2. disadvantages: changes in menstrual bleeding likely (NA with lactation), less effective than COCs (unless lactating)

C. Emergency Contraception (ECPs)

1. different forms: Emergency Contraceptive Pills (ECPs, which are COCs), POPs, IUDs, Mifepristone, others
2. regimen: 4 low-dose COC pills within 72 hours of unprotected intercourse, plus 4 COC pills 12 hours later

3. all mechanisms of action are pre-implantation: interferes with ovulation, egg transport, fertilization, timing of endometrial preparation
4. effectiveness - ECPs reduce the risk of:
 - a) pregnancy by about 75%
 - b) pregnancy from single unprotected act of intercourse from 8% to approximately 2%
5. potential clients include women who:
 - a) don't expect to be sexually active
 - b) run out of or experience mishaps with method
 - c) experience sexual assault
6. safety
 - a) dose too low to have long-term consequences
 - b) evidence that ECPs do not effect clotting or increase birth defects

D. DMPA

1. most common side effects: menstrual irregularities, weight gain, amenorrhea
2. DMPA in breastfeeding women: suitable for lactating women; initiation preferred after six weeks postpartum
3. DMPA *in utero*: although avoidance in pregnancy prudent, studies have found no toxic effects on fetus and no long-term developmental effects
4. no increased cancer risk (for breast, cervical, endometrial or ovarian cancer)
5. demonstrated health benefits
 - a) reduced risk of acute pelvic inflammatory disease
 - b) protection against endometrial cancer
 - c) reduced risk of ectopic pregnancy
6. DMPA program requirements
 - a) adequate training in counseling and provision
 - b) supervision of providers
 - c) sterile needles and syringes; safe disposal of contaminated disposables
 - d) steady supply

E. IUDs

1. variations in IUDs (cost, blood loss, effective life after insertion, pregnancy rate, expulsion rate)
2. Dalkon shield effect: while the Dalkon shield greatly increased the user's risk of pelvic inflammatory disease (PID), today's IUD's increase a woman's risk of PID only in the first month after insertion
3. ectopic pregnancy: among no method, diaphragm, condom, tubal sterilization, and oral contraceptives, IUDs (TCu 380A) have the lowest typical ectopic rate per 1000 (0.2)

11

4. Quality of Care: IUDs

- a) STD/HIV screening (by history and physical exam)
- b) correct insertion and disinfection procedures
- c) counseling (expected side effects, high-risk behaviors, when to return)

F. Barrier Methods

1. Male condom

- a) advantages: STD/HIV protection, male involvement, theoretical effectiveness
- b) disadvantages: use-effectiveness, acceptability

2. Female condom

- a) advantages: woman-controlled, STD/HIV prevention
- b) disadvantages: cost, use effectiveness, "squeaky"

3. Spermicide

- a) advantages: provide some protection against STD/HIV
- b) disadvantages: can be messy, can cause irritation

G. Norplant

Programmatic requirements:

1. informed choice
2. adequate number of providers trained in insertion AND REMOVAL
3. tracking system to ensure clients return after 5 years
4. counseling (choice, side effects, time for removal)
5. side effects management (for heavy bleeding)
6. strategy for removal (taking risk, medical guidelines and logistics into account)

RESEARCH IN FAMILY PLANNING

Jeff Speiler

LUNCHEON PRESENTATION: REFUGEES

Deirdre Wulf, AGI

The issues of refugees has suddenly/recently merged into other population issues. In a 1995 estimate, there were at least 20 million official refugees. There were 11 million in 1987. In addition, there are 24 million displaced people.

The UN only officially works with refugees who have crossed their home country borders, therefore, internally displaced refugees are not under UN jurisdiction. Eighty percent of all refugees are women and children. These are the populations most affected by civil strife and natural disasters.

Staffing differences between other relief workers and refugee workers:

- refugee work goes unreported, unanalysed and unrecognized

72

- workers are very different from more main-stream international health professionals

In 1989, the Women's Commission for Refugee Women and Children found that 60% of pregnancies in Bosnia were terminated because of refugee status.

This is a European example -- these are women that have for years used contraceptives (suddenly they have no electricity, potable water, basic hygiene, and therefore contraceptives)

UNHCR provides these 4 basic services during a refugee crisis:

- Shelter
- Clean/potable Water
- Food/cooking fuels
- Basic health care

There is no provision whatsoever for family planning/reproductive health services in particular.

Special engineers and health workers come to set up camps -- although they do incredible jobs, they are not trained to deal with the changing realities of these refugee camps. These experts are trained to address the initial crisis period. The conditions of most refugee camps change drastically in 6 months.

Many women arriving in the camps have not even menstruated for months, have had septic abortions, etc... because of malnutrition.

After 6 months and through 1 year, under the improved conditions of the four basic services provided by the UNHCR, womens' health status is improved and we see a baby boom.

Most camps witness a very high birthrate after 6 months through 1 year. Unfortunately rape increases this phenomenon.

Of course, studies of these issues are very difficult to conduct. Most women continue to give birth within their huts/compounds rather than in the health centers (which are always present in camps). Therefore it is extremely difficult to measure maternal mortality rate within the camps.

In all of the camps studied, not a single camp had available contraceptives. International relief organizations addressed this problem with the response that they felt it was inappropriate to discuss FP/RH under refugee conditions. This may be because they are not trained in the value of FP/RH activities on the health of both mother and child.

There must be pressure from somewhere to incorporate FP/RH IEC programs in these camps.

Are refugees another hard-to-reach population? Not really, they are all concentrated in one relatively small area; camps are highly organized; and health centers can be found in virtually all camps.

TECHNOLOGY, TOOLS, & RESEARCH IN HEALTH & NUTRITION

73

Tuesday, June 20

**CHILD HEALTH
PREVENTION STRATEGIES, EPI, NUTRITION AND ENVIRONMENTAL HEALTH**

Presenters and their topics:

Robert Steinglass (BASICS) - EPI Program Strategy/Sustainability
Murray Trostle and Paul Zeitz (USAID) - EPI Coverage for Disease Control Initiative
Ian Darnton-Hill (OMNI) - Nutritional Interventions and the Private Sector
Frances Davidson and Keith West (JHU) - EPI Plus/Vitamin A Issues
Andy Arata, Gene Brantly and Helen Murphy (EHP) - Environmental Health

Introduction

PHN has moved beyond vertical approach, even if this hasn't been made clear to the field as yet. Vertical interventions are important components, but they are part of a larger effort in integrated health. This approach is partly in response to a felt need from the field and part of AID's leadership role, particularly in generating demand—social marketing, IEC, behavior change programs. Standard approach now: focused interventions but emphasis on cross-cutting elements too.

There will be more collaboration with WHO/CDC as well as in AID.

Pathway was offered as one way to begin an analysis of the problems associated with child mortality.

EPI Program Strategy/Sustainability: Robert Steinglass

An overview of vaccine programs worldwide was presented. Who was where in sustaining vaccine coverage (see handout). What is needed besides vaccines is infrastructure support and help with recurrent costs. Who are the important players? UNICEF, but others are playing roles—some good, some bad.

Question HPN officers should ask about their own programs: Who has a place at the table; what is the role of the MOH, etc. USAID's comparative advantage is technical assistance.

Comment: There is the problem of UNICEF taking credit at the local level, "UNICEF is taking care of EPI." This is not true; the problem is too big.

Response: USAID needs to make the case that we are key players. UNICEF often is more political than technical. USAID has the technical edge. Perceived by the public health community, but not by MOHs in recipient countries. Process indicators are needed. Are things being done in a sustainable way?

74

EPI offers a vehicle to penetrate into the community. Important to piggyback on other activities. Important to look at countries that can't transition to a more sustainable approach. USAID has helped countries move away from a militaristic approach to EPI.

EPI Coverage for Disease Control Initiative: Murray Trostle and Paul Zeitz

Diphtheria

Diphtheria is rampant in the newly independent states. Had been under control until the breakup of the USSR. Causes of the epidemic:

- 1) low immunity levels in adults
- 2) low immunity levels in children
- 3) use of low-potency vaccines in children
- 4) large population movement
- 5) lack of vaccines
- 6) lack of drugs for follow-up treatment
- 7) general erosion of the public health service
- 8) lack of confidence in health services

Children are protected in post-vaccination era, but adults are susceptible. Eg., Jordan's two outbreaks: 1977—20% immunization rate with epidemic largely in children; 1983—epidemic largely in adults. Lesson: adults need to be immunized.

In the NIS, everyone is bringing an immunization strategy. Treat contacts with antibiotics and practice proper case management. Fatality rates as high as 23% in some NIS countries.

Real issue is vaccines. 180 million doses of vaccine are needed in the NIS. UNICEF is requesting donations to support the program. USAID's contribution - \$13.5 million. Potential of disease spreading to Central and Western Europe. Finland has stepped up immunization efforts. Most significant diphtheria since World War II. Emerging public health crisis. Serious service delivery problems, particularly with the cold chain.

Question: Are children or adults dying in the greatest number? Answer: Children

Question: Why doesn't diphtheria break out? Answer: Luck and a variety of other factors.

It is important to have boosters every 10 years. Sometimes three doses are required. Have to set up campaigns to immunize large populations. Problems with shortages of vaccines, antitoxins, and syringes/needles. Cases are higher among children, but numbers vary considerably by country.

Polio

Major push to sustainability and eradication. Two parallel processes. How can USAID reconcile a vertical program in polio and measles with sustainability?

Political support for eradication is uneven. World Health Assembly Resolution backs up global eradication by 2000.

Strategy:

- 1) routine immunization
- 2) national immunization days

- 3) effective surveillance
- 4) outbreak response in detected area

Implementation:

- 1) requires many workers; careful planning of vaccine supply; storage; public information
- 2) immunize all children under 5
- 3) provide other services (e.g., vitamin A capsule)

In Brazil, there was a rapid drop off in the number of cases after national immunization day.

Surveillance is the other cornerstone of eradication. ACP cases need to be investigated and confirmed. Very labor intensive. In the Americas, this is being done very effectively. Last case there was in August 1991 in Peru. Certified in 1994 that polio had been eradicated in the region. This has influenced other regions to undertake similar efforts.

Indian and the subcontinent have 70% of the world's polio cases (India - 50%) and are the major exporters of polio. Government of India has just begun an eradication effort.

Southern Africa is considered as an emerging polio-free zone. West Africa is where the problems are and some countries need intense help.

A positive spin off of global eradication has been the development of a network of global laboratories.

The following constraints are likely to delay polio eradication on a global scale:

- 1) shortage of sufficient vaccine
- 2) shortage of such other resources as technical support and surveillance capacity
- 3) insufficient political commitment
- 4) importation from different parts of the world (e.g., Americas have to keep a surveillance system active because of the problem of importation)

By year 2000, US\$500,000 million will be saved by the eradication of polio. Savings come from the discontinuation of the need to vaccine.

Measles

Measles eradication strategy is being implemented in the Americas. In part, helps to keep up surveillance strategy. Coverage in the 90% range for many Latin American countries. Some may need catch-up campaigns.

PAHO measles elimination campaign: children 9 months to 14 years regardless of previous immunization history.

Mop-up campaign. Increase age of routine measles vaccinations to 12 months. Achieve and maintain immunization rates. Respond to outbreaks.

Impediments:

- Mostly an urban issue
- Technical, emotional and political issues around eradication
- Highly vertical, expensive effort with most resources coming from the outside

Capture public health resources for sustainability. What is USAID's role here? To promote the dialogue.

Question: Is it irresponsible to push polio in poorest African countries where there is such a need to strengthen the infrastructure? Eg. Rotary International is really pushing polio, yet many more children are dying from measles in Nigeria.

What is USAID recommending be done? It is not selecting polio eradication. UNICEF, WHO, etc. programs pushing. Need to work this out on a country-by-country basis for eradication strategies. In some countries, measles or EPI should be the priority. Rotary International is now lobbying Congress for more polio money. Difficult decisions to be made on this issue. Consultations with CDC and WHO to work with bureaus and missions. USAID is in the game for polio eradication, but in a sustainable way. Difficult to reconcile issues--working on a paper to missions. Trying to classify countries by past performance.

Poorest countries: require system strengthening

Mid-level countries: develop immunization systems

Higher-level countries: Sustain immunization system; accelerate disease control efforts

Build system up around polio eradication: service delivery support; social mobilization; disease control.

Nutritional Interventions and the Private Sector: Frances Davidson, Ian Darnton-Hill, and Keith West

USAID's niche in nutrition is with micronutrients. Contribution of malnutrition to childhood deaths--underlying factor in many deaths. In the past, focus has been on the severely malnourished. Mild and moderate malnutrition also important:

- 1) Contribute to more than one half of child deaths worldwide; and
- 2) Risk of death for children who are mildly, moderately, and severely malnourished.

Vitamin A - USAID world leader; iodine deficiency - working with UNICEF on this. Simple kit is being developed to test salt for iodine content.

Micronutrient interventions

Criteria for success: Feasible, based on experience, will save lives, will enhance human potential, cost effective (World Bank has demonstrated this), proven economic advantage.

OMNI and its partners: USAID missions in-country; country counterparts/government departments; university/NGO partners (private sector); John Snow, Inc; USAID/Washington; other donor agencies (UNICEF, WHO, World Bank).

OMNI can help with advocacy for micronutrient interventions in-country. Also help with nutrition education, fortification and technical backup in such areas as monitoring and evaluation.

Strategic objectives of USAID/PHN

- 1) reduce unintended pregnancy
- 2) reduce infant and child mortality

is 14,000 pregnancies to focus on nutritional status. Just capsules are being provided; no nutrition education given. Supplement children through the period when they are most at risk (six months to age five).

Questions and research of the 1980s is driving today's programs and research which will create problems in the 21st century. Capsules versus food--a lot of research now going on with this. Capsules are cheap but delivery is expensive and difficult to sustain. Help buy time to put food-based strategies in place for:

- Maternal and child health
- HIV transmission--causal role?
- Food-based intervention--what works?
- Simpler assessment--tools needed
- Micronutrient linkages--progressive

Iron deficiency anemia (IDA):

- major contributor to maternal mortality
- important cause of impaired cognitive development in small children
- factor in low productivity in poor communities

IDA prevention and control:

- logistical problems; non-compliance
- interesting new developments
- short-term -- supplementation. Is it effective?
- medium-term -- fortification, nutrition education
- long-term -- fortification, dietary change, nutrition education

IDA goals and objectives - set at international conference

- mid-decade goal -- to have national programs in place
- end of decade -- reduce IDA by one-third

Iodine deficiency disorder (IDD)

- commonest cause of preventable intellectual impairment
- in extreme forms, irreversible intellectual and physical damage
- in milder forms, lower IQ
- leads to miscarriages and stillbirths
- mid-decade -- universal salt iodization
- 2000 -- virtual elimination of IDD as public health problem
- This will reduce infant and maternal mortality and unintended pregnancies.

Interaction of micronutrient deficiencies

Vitamin A deficiency has been the focus of considerable development experience. Goals:

- short-term -- capsule distribution
- medium term -- fortification and nutrition education
- long term -- home gardens, dietary changes, nutrition education
- mid-decade -- 80% of children have access to vitamin A
- 2000 -- elimination of vitamin A as a public health risk

Fortification appears to be one of the main interventions for sustainability.

Cost of micronutrient diseases: economists at the World Bank modeled typical country for 50 million people--20,000 preventable deaths. Micronutrient interventions are the most achievable international public health goal.

Discussion

What can USAID do in this area? Is a daily supplement for anemia control practical? Very difficult to manage.

Vitamin A doesn't mix well with other nutrients such as iodine. Can vitamin A be piggy-backed on EPI programs? Tie into national immunization days?

Concern expressed that in Africa it may be difficult to introduce micronutrients at the village level. Look at the problem in getting ORS accepted. Should micronutrients be introduced at a higher level such as fortified foods?

Washington needs help in identifying vehicles to introduce micronutrients at the field level.

Fortification takes time. Supplements can begin shortly.

How do you pull this together for an over-all mission or region level? Can't do everything well. Need more policy and programmatic guidance from Washington.

More cost effective to have a general mineral/vitamin (nutritional) supplement in the long run. One-a-day type of supplement is a long way off in most countries.

What about protein-based malnutrition. USAID won't handle this.

Capsules are an interim approach. Do you want to look at this year's deaths or deaths in five years, ten years. This is what you need to decide.

ENVIRONMENTAL HEALTH

John Borrazzo, Andy Arata, Gene Brantly, Helen Murphy

How do you think of environmental health? Lead, water, pollution, malaria, smoke/smoking, parasites, deforestation, traffic accidents, chemicals, radiation, energy

What links these things together? Impact on quality of life; impaired physical or mental health; man-made causes; modifiable through behavior or policy change; affects the broad community.

Environmental health is defined as a branch of public health devoted to preventing illness through managing the environment and changing peoples' behavior to reduce exposure to biological, physical, and chemical agents of disease and injury.

Events leading to exposure include production, transmission, exposure and events occurring after exposure include host factors (such as nutritional status, general health), illness, treatment and outcome.

Technical scope of project includes tropical disease control, water supply and sanitation,

waste water, solid waste, air pollution, occupational health, food hygiene, toxic and hazardous waste, and injury control. Skill areas include public health, epidemiology, engineering, risk assessment, finance, ID & HRD, social sciences, vector biology and HIS.

Five of the six top diseases in developing countries have environmental factors. They include respiratory infections, diarrheal disease, unintentional injuries, malignant neoplasms, and TB.

Highlights from environmental health activities:

Project is working in Ecuador on behavior-based cholera activities. A NGO trains people in 10 communities to observe behavior around water use and make suggestions for change. In Jamaica, NGO is designing water systems for communities and the project is improving the quality of the work.

In Nepal, technical assistance is being provided to in-country malaria research. A new training center and teaching lab has been set up. To fight urban air pollution in Romania, an occupational health curriculum is being developed and health promotion activities are encouraging people to change their behavior. In Tunisia, people are being helped to become more knowledgeable about the environmental problems they are experiencing and taught how they can have an impact on policy.

The project is helping governments and public institutions evaluate specific problems and move forward. Also doing research.

Discussion

Environment - here and population/health - over there -- not coming together. Project should deal more with people in the environmental section. Environmental health may fall 'through the cracks. PHN objectives are found elsewhere.

In the health sector, can the environment have a role to play in meeting health objectives? Think, for example, about leveraging indigenous NGO activities in smokeless cook stoves with ARI.

What are the environmental activities that can be added to case management?

TREATMENT STRATEGIES: INTEGRATED MANAGEMENT OF CHILD HEALTH "The Sick Child Initiative"

Presenters:

Jim Tulloch, Director, WHO/CDR
Ron Waldman, Technical Director, BASICS
Suzanne Prysor-Jones, SARA
Bob Pond, BASICS
Mark Rasmuson, BASICS

To begin the presentation, Al Bartlett introduced Jim Tulloch as the leader of the initiative to integrate vertical programs and include malaria and nutrition in "Integrated Case

80

Management" (ICM).

The starting point for ICM is the group of five major killers of children: ARI, CDD, measles, malaria and malnutrition. The argument for an integrated approach is clear when one considers that many of these killers have overlapping symptoms and can be misdiagnosed if a health worker is more significantly trained in one vertical area. This overlap is not entirely new as measles is mentioned in the ARI training materials and malnutrition is considered in the CDD training materials, among other examples.

ICM provides a more comprehensive approach for dealing with each condition in addition to covering for missed opportunities: immunization status and nutritional status are routinely checked in ICM.

The wall charts provide the technical guidelines for managing the sick child. Being used as visual teaching and consultation devices, they are separated vertically to show what needs to be done in each area when presented with a sick child, but the key technical content remains integrated. The charts are also formatted according to treatment steps: (1) assess and classify the child 2mo - 5yrs; (2) treat the child; (3) advise the mother; and (4) assess and classify the child 1 week -2mo.

They include a color coded triage system at each step: pink denotes referral; yellow indicates that the health worker should treat the child ; and green signifies that the health worker should send the child home for care.

The drug management aspect of ICM is approached by providing a list of 13 essential drugs including ORS, Vitamin A, Iron, and antimalarials among others. These are all fairly inexpensive drugs that WHO believes should be available at most front-line health centers.

Some process of adaptation of the ICM curriculum will be required in every country that decides to use the modules. The most adaptation will be necessary in the feeding instructions, though other area of adaptation might include the names of locally available antibiotics and antimalarials. The MOH and senior pediatricians will be included in every stage of the adaptation.

In addition to the wall charts, the training includes three videos, a guide for clinical instructors and a facilitators guide. The videos will be particularly useful in clinical situations where examples are not available.

One problematic area in the Tanzania field test was the diagnosis of anemia as the symptoms are not very obvious.

Integrated management of the sick child was rated the most cost-effective health intervention in the 1993 World Development Report by the World Bank.

Breakout Session

The SOTA group was divided into four sections to discuss different disease areas on the wall charts: diarrhea, fever, malnutrition and cough.

Feedback from the Breakout Session

Q: How can all that is necessary for ICM be fit into a short visit with the sick child?

A: Health workers trained in the field pre-test in Ethiopia were observed after training. While continuing to use the ICM process the visit was generally kept between 7 and 12 minutes depending on the complexity of care required. This time frame is not too long if the goal is to have a real impact on child mortality. The field test in Tanzania had similar results.

Q: What is the status of the 2 videos still in development? What is the status of translations?

A: The definitive English version will be ready for distribution in September. Individual translations are discouraged before then as the materials are still being reworked.

Q: The medical establishments will need documented impact in addition to technical assistance, how will this provided?

A: WHO, BASICS and UNICEF in addition to trained consultants will provide technical assistance and help with implementation and adaptation.

Q: Will the health workers with limited education be able to understand the flow chart format of the wall charts?

A: The training focuses heavily on how to read the wall charts. Once the ICM process becomes internalized they will not need to regularly refer to the wall charts.

Q: How will the training succeed without drug availability?

A: We believe that having a set list of 13 inexpensive essential drugs will reduce the tendency to spend a lot of funds on more expensive, less necessary drugs -- high level policy discussions have to take place to make this work. One possible model for drug purchasing is a district level revolving loan fund that would allow drugs to be bought in local currency. The fact that drugs may not be available does not diminish the need to train people -- where drugs are available without training they may be used improperly.

Q: How does ICM fit into a decentralized integrated system?

A: It fits reality in the field where health workers are responsible for everything. It gives them effective decision-making tools.

A: The system must be integrated before the front-line health worker using ICM can succeed. There must be a common support system, reporting mechanism and supervision system.

Al Bartlett introduced Suzanne Prysor-Jones

She and the SARA Project have developed a tool to help countries assess whether ICM is right for them and assist them in introducing it into their child health programs. It will be available in French and English.

The tool entitled "Integrated Case Management: A Preparatory Guide," attempts to raise questions in a systematic way. The guide is designed to be used in a session with a facilitator as it raises many answers but provides no concrete solutions as the solutions will be very country specific. It consists of eight sections, two of which are still in development.

The first section looks at the decision to introduce ICM into a health system. It provides basic information on ICM; how to organize a forum to examine its appropriateness for the country setting; and what are the influencing factors. It also plans for the next steps.

The second section is a rapid review. It includes protocols to look at systems issues. It

guides the collection of information needed to make decisions or recommendations regarding the planning of training and setting policies.

Section number three reviews the coordination of management. In this exercise, managers are identified to be responsible for ICM at national and regional levels. The coordination mechanisms for ICM are established.

The fourth section examines program policies and technical issues. Current policies are reviewed and technical issues are identified. These include possible changes in personnel and responsibilities.

Section five addresses the issue of drug availability. Drug availability is assessed; drug lists are reviewed; and recommendations are made.

The sixth section addresses training. It looks at how needs training; how training coverage can be increased; and what case management skills are most needed.

The seventh and eighth sections are still in development they include topics on monitoring and evaluation and communications issues.

The guide is being tested by the Haitian "groupe spécifique" on ICM which has been coordinated by donors. They have only looked at training so far, but they have found the guide to be quite useful. They will be creating task forces to work on each section.

Bob Pond of BASICS technical division.

Bob provided brief updates on 2 activities that BASICS is collaborating on with WHO-CDR that complement the course on integrated management of childhood illness.

With technical input from Dr. Richard Laing, WHO-CDR and BASICS have developed a course on **drug management for first level health facilities**. Just as the course Management of Childhood Illness aims to improve the clinical skills and the drug prescribing practices of primary care health professionals, this complementary course aims to improve drug ordering, inventory control and dispensing at the same facilities.

One of the most novel things about this 3 day course is that it is linked up with a one day visit to each health facility by the trainer to assure that the practices taught during the course are effectively implemented.

The training materials for the drug management course for first level health facilities have been completed. A field test of the course is planned for later this fiscal year and the course should be ready for wider use thereafter.

Bob next informed the SOTA participants about the plans of WHO-CDR and BASICS to develop an integrated version of the Health Facility Survey (HFS) which has previously been used to evaluate national CDD and ARI programs. The new survey instrument will be called the **Health Facility Quality Review (HFQR)**. According to Bob, "The Health Facility Quality Review will be a Health Facility Survey with a difference." One difference is that instead of being used 2 to 3 years after a national program has been launched, the HFQR is designed to be used by local supervisors immediately after training and perhaps quarterly thereafter. Like the HFS, the HFQR can be used by program managers to identify problems

across facilities. Such problems should be addressed by more system-wide or programmatic interventions, such as by improving drug distribution.

Supervisors can also act on the HFQR findings *during the same visit to solve problems* at the specific health facility, *through feedback, on-site training, and reorganization of the clinic*. Thus, the HFQR is designed to serve as a follow up to the in-service training course *Management of Childhood Illness*. To succeed, donor support will likely be needed at least for the first year after training. According to Dr. Pond "If ministries of health and donors are reluctant to fund such efforts, they should consider the alternative: years of experience have taught us that training without follow-up has very limited impact"

ICM Communication Issues: Mark Rasmuson

Primary issues are:

- Effective counseling by health workers
- Effective use of other channels and strategies to reach caretakers

Lessons learned from previous projects on the essential elements in counseling:

- Communication skills
- Appropriate concepts and vocabulary
- Motivation

Challenges in counseling:

- Health workers must master more material to communicate to client and decide what client needs to hear first

Important questions to consider when using other channels:

- How to apply lessons from previous (vertical) programs?
- Which messages cut across different disease interventions?
- How to organize available communication resources most effectively?

Possible ICM message strategies:

- Priority behaviors - promote symptom recognition and appropriate care-seeking
- Thematic - improved care for the "whole child"
- Tactical - take your child to the clinic

BASICS initiatives (in collaboration with WHO/CDR and SARA Project)

- Guide for planning and organizing national ICM communication efforts
- Guide for improving community-level behavior change interventions
- Training materials to improve health worker counseling in ICM programs

Cross-cutting issues pertaining both to caretakers and health workers:

- Motivation - what are benefits and barriers involved
- Maintenance - what strategic elements can help sustain new counseling or care-keeping behaviors?
- Marketing - what simple measures can be taken to make facilities more customer-oriented?

Wednesday, June 21

POLICY REFORM AND PARTICIPATION IN PHN

Topics of Discussion:

- Case study in PHN Policy making
- Population policy project resources
- Health policy project resources

SOTA course participants took part in a case study analysis in PHN policy making. Through role playing, the participants assisted the Minister of the Republic of Teri, a fictitious nation, create a reform plan. SOTA course participants represented the following stakeholder and concerns:

- government health bureaucrats/quality improvement needed
- PVO's/NGO's/Community needs
- women's groups/equity
- donors/cost effectiveness
- private practitioners
- over regulation
- political leaders/visible results

Furthermore, pending projects were discussed:

•Health Financing and Sustainability-II Project

As the flagship of G/PHN's health and nutrition policy and sector reform activities of child survival this project seeks to improve accessibility, quality, efficiency, and sustainability of child survival, reproductive health, and HIV/AIDS programs. HFS-II offers a package of services to USAID bureaus and mission in three areas: health and nutrition policy and management reform; health care financing; and health services improvement. Among the more active areas, HFS-II offers assistance with: cost recovery and user fees; health insurance and managed care; decentralized management systems; pharmaceutical management; quality assurance; and private sector cooperation in health.

•The Policy Project

The **Policy Project** is the centerpiece of G/PHN's population policy portfolio. The purpose of the five-year project is to help build a supportive policy environment for family planning and reproductive health programs through promotion of a participatory policy process and the development and implementation of population policies that are effective in responding to client needs. **POLICY** streamlines earlier population policy assistance efforts by combining successful element of the RAPID and OPTIONS project and embarks in new directions by incorporation research and participation elements.

DONOR COORDINATION

How USAID-Washington and various missions work together was addressed by Elizabeth Maguire, Director of the Office of Population, Robert Clay, Acting Director of the Office of Health, and Karen Morita.

Elizabeth Maguire discussed multilateral and bilateral assistance. She stated that USAID is

a lead PHN donor, and has great technical leadership and field presence. Population coordination with UNFPA, WHO, IPPF, World Bank, and OECD (DAC) were highlighted. Bilateral assistance with Japan is a key effort, as is with the UK, Germany, Canada, and France. USAID and UKODA jointly hosted 20 multilateral and bilateral donors at a workshop last week in New York on Integrating Reproductive Health Programs. The major donors agreed it would be desirable to meet periodically on policy and programmatic issues. In depth discussions have been held with Germany and UNICEF on PHN coordination.

Robert Clay discussed coordination with the WHO, UNICEF, PAHO, and the World Bank. WHO and UNICEF activities were discussed. The speaker mentioned the new capable director of UNICEF, Carol Hellam, and how her focus would be on the management side of budgets and there seems to be a lack of prioritization of activities. USAID feels it needs to interact more with the World Bank.

Karen Morita presented an overview of the US-Japan Common Agenda. The PHN Center has the lead on the population and HIV/AIDS initiatives of the Common Agenda and is a partner agency for the child health initiative. The Department of Health and Human Services is the lead agency on the child health initiative. The US is interested in working with Japan because they are the single largest donor in the world. Japan has increased its spending on population and health by \$3 billion over the next seven years. Japan is willing to work with the USAID and they recognize USAID's technical expertise. Parallel and complementary activities are easier to develop than jointly funded ones.

Open discussion with SOTA participants:

- 1) Kenya; example of USAID working closely with Japan on funding NGO's they have developed long-range goals together.
- 2) Tanzania; discussed logistics and donor coordination in contraceptive ordering. Because this is organized manner, new donors are attracted to the project and the mission has become more cost-effective.
- 3) Philippines; example of combining donor funds to support a common national IEC strategy; UNFPA playing a key coordination role.
- 4) Bangladesh; importance of donors working within the national program as development partners; personal relationships are critical.

BREAKOUT SESSIONS

Retooling, Effective Logistics Management

Facilitator: Carl Hemmer, Chief, Commodities and Logistics Management Division,
Office of Population

Presenters: Lori DiRavello, CDC
Jim Bates, MSH
Carolyn Hart, FPLM

Lori demonstrated a Presentation Package for Policy Makers, a tool developed recently by CDC to persuade policy makers in developing countries of the value of investing in good logistics systems. The full presentation consists of 55 slides with accompanying dialogue, and is adaptable to target various policy-making audiences. The presentation answers the questions: "Why contraceptive logistics?" "What is contraceptive logistics?" "What can go wrong?" and shows specific examples of improved logistics systems and the resulting benefits to family planning and aids prevention programs in two countries.

Jim explained the rationale of the RPM (Rational Pharmaceutical Management) Project, an assessment tool for pharmaceutical distribution programs. It is valuable to health programs for which pharmaceutical represent one of the largest budget items. The tool may be used by experienced evaluators or local personnel using the accompanying instructional manual. Some highlights of the assessment system include: 46 quantitative indicators, focus on eight areas of management, rapid assessment, good sample of sites and patient encounters, and identification of areas where the current system falls short. One of the key concepts of the system is the Indicator Drug List, a list of 20 - 50 essential pharmaceutical products with a range of therapeutic categories and dose forms used at all levels of the health system, and, importantly, the involvement of local counterparts in the process. The assessment results offer support to open policy dialogue for improving systems currently in place.

Carolyn offered a presentation, promotional as well as instructional, on state-of-the-art logistics, which was developed as part of the core FPLM Logistics Training Program. The trend in what is considered state-of-the-art logistics has moved from a military focus in the 40's and 50's, to 'Japanese-style' manufacturing of the 60's - 80's, to the current focus on retailing. Logistics has become one of the greatest commercial growth areas of the 90's, second only to information technology, which is closely related. In fact, the seamless flow of information along the logistics chain is the key to competitive logistics. In a field where customer service has become the norm, an open sharing of information at all levels in order to have the goods available when they are needed (the six 'rights'), is essential to a competitive status in the market. While logistics leaders, like Wal-Mart, want real-time data and electronic (paper-free) ordering and billing, a level of sophistication beyond the abilities of many public sector programs, the basic principles remain the same: data (MIS) and professional skill building to move the logistics managers from the back room to the board room are key.

Questions:

- 1. What is one key lesson learned form the private sector (like Motorola, for instance)?**
Focus on information. We are right to put LMIS in the center of the logistics cycle. Also, skill-building across management areas keeps logistics professionals on the front lines.
- 2. How much private sector experience can be applied to the public sector?**
This is a challenge since the 'bottom line' does not drive public sector programs. Nevertheless, the fundamental principles of data collection cannot be stressed enough. Even though public sector programs cannot expect to have daily updates, the private

sector feels that a 30% difference between forecasts and consumption is acceptable. With CPTs done twice yearly, and accurate data collection is stressed, we can get good data.

3. What about for pharmaceutical?

It's the same story: a well-designed LMIS and good reporting are essential.

4. Looking at local transportation only, is it possible to piggy-back essential drugs and family planning and AIDS commodities?

Yes, where there is a willingness to do so. Ideally, use the more efficient or better-established system and integrate the other into it. In Tanzania, the commodities are managed separately at the central level, but are transported by EPI from the regional level down.

5. The 'bottom line' isn't a driving factor in public sector programs, yet good logistics saves money. Is there any way to persuade the public sector to save money, or is the attitude that 'money is free' too pervasive?

In fact, any idea of making cost-effective decisions is undermined even further when commodities are donated. However, especially in the essential drug program where commodities are always in short supply, there is a convincing argument for effective LMIS because every bit you save means more drugs on the shelves.

6. The public sector, like the private sector, needs to focus more on the needs of the customer rather than the provider. A customer driven market is usually more efficient.

USAID has developed a customer-focused attitude, and Ministries would do well to adopt that stance. One way to motivate ministries to look at client or customer needs is to attach achievement to political benefit: serving the needs of the electorate and avoiding crises and resultant embarrassing publicity will motivate local politicians.

7. What is USAID's current stand on the promotion of US manufacturers vs. contraceptive self-reliance?

USAID encourages the speediest movement by programs to resupply themselves. This philosophy does not undercut a competitive American manufacturer. USAID supports and encourages American competitive bidding as countries move away from donor supply.

Applying Gender Planning to PHN

Cairo, Copenhagen, and Beijing: What Happened? So What?

This session reviewed the outcomes of recent global conferences, with special attention to their 1994 International Conference on Population and Development in Cairo. Moderator Barbara Crane discussed the role of conferences in focusing governments' attention, setting new agendas, opening new channels for communications on issues, creating new networks and coalitions, stimulating learning, and providing tools for policy dialogue. Key new

themes from Cairo were identified by Richard Cornelius, including population/development linkages, the role of women, the comprehensive concept of reproductive health, and the goal of universal access to family planning and other reproductive health services. Special presentations were also made on the 1992 International Conference on Nutrition (Andrew Swiderski), their Summit of the Americas (Carol Dabba), and the upcoming 4th World Conference on Women to be held in Beijing (Ashley Maddox). Attention was given by Sarah Craven of the Center for Population and Development Activities (CEDPA) to the key role of women's NGO networks that have been organized around recent conferences and that are having a major impact both on the conferences themselves and on follow-up at the country level. The case example of the effect of the Cairo conference process in Bolivia was presented by Earle Lawrence, showing the impact of the conference in deepening national support for family planning.

Vaccine Independence Initiative

The purpose of the session was to discuss the increasing tendency for developing country governments to pay for their own vaccine needs, and to review the advantage and disadvantages of various procurement mechanisms, based on experiences in Latin America, Morocco, and elsewhere. Ciro de Quadros of PAHO described the development of the PAHO vaccine purchases revolving fund in the late 1970's, noting that almost all Latin American countries have used the fund for years. Dr. de Quadros indicated that the development of this fund forced countries to come up with serious analyses of vaccine needs and immunization "action plans." Bill Hausdorff of Global's Office of Health and Nutrition pointed out that UNICEF's new Vaccine Supply Strategy calls for every country-- even the poorest and smallest-- to develop national vaccine supply plans, and to support the costs of their vaccine needs.

There was discussion of the various ways countries can procure vaccines--directly from vaccine producers, indirectly through UNICEF's "reimbursable procurement" mechanism, and through vaccine purchase revolving funds, including the Vaccine Independence Initiative (VII). Advantages of the VII include the fact that local currency can be used, that vaccines can be paid high quality vaccine for reputable producers. Extensive experience with VII in Morocco, "pilot" country, indicated that despite various logistical and billing difficulties, the fund operated well there, and that the Government viewed its participation in the VII as part of its regional leadership in the immunization area. Substantial benefits also accrued to USAID/RABAT, according to the three generations of HPN officers present at the session, including cementing an extremely productive relationship with the local UNICEF office. Finally, it was noted that sufficient local currency capitalization of the VII currently exists to allow the participation of many more countries interested in purchasing some or all of their vaccine needs.

Thursday, June 22

89

HEALTH AND HUMAN RIGHTS

Speakers:

Jonathan Mann

Francoies-Xavier Bagnoud Professor of Health and Human Rights, Harvard School of Public Health

Larry Garber

Advisor in Democracy and Human Rights
Global Bureau, Center for Democracy, USAID

USAID's Policy on Human Rights: Larry Garber

What is USAID's position on human rights? Since it is not one of the strategic objectives, where does it fit within the Agency?

-What the USAID strategic plan does is support human rights in its broadest context. Human rights is more than civil and political rights. It includes the right to education; information; economic social and cultural rights; rights of the child, various conventions dealing with the rights of women.

-In the US, there is explicit Congressional legislative prohibition to providing development assistance to countries violating internationally recognized human rights. This raises the challenge of how to work with these countries to improve these conditions when we are unable to have a direct presence.

-One can measure human rights performance

-Specific programming: the Global Bureau of USAID through its Democracy Center has mechanisms for access to court advocacy and training . These include initiatives in

- the legal empowerment of women
- research on efficacy of human rights monitors
- new partnership initiative:
- NGO empowerment
- small business
- democracy and local governance

Areas to be further explored include:

1. educating people about their rights
2. the issue of humanitarian assistance (the need for greater confluence between humanitarian assistance and human rights)
3. worker's rights: child labor, exploitation of certain categories of workers
4. victims of torture: there is move to highlight the need for responding to victims of torture
5. female genital mutilation (FGM)

There is a need to think holistically about development work. Also a need to develop performance indicators for human rights.

Health and Human Rights: Jonathan Mann

The WHO definition of reproductive health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Yet there is no consensus on measures of the above, although we do have measure for disease and mortality.

What is public health? The Institute of Medicine (IOM) definition defined public health as the work of ensuring the conditions in which people can be healthy.

What are these conditions?

-medical care (often in the US medical care is equated with heal, although only a small fraction of the variance of health status among population can reasonably be attributed to medical care)

-societal determinants are major determinants of health status

However, there is no coherent analysis of society or the conditions people need in order to be healthy. We in public health behave as if societal determinants are not major determinants of health status

Socioeconomic status (SES) is only one part of the answer. An example of a study done of the British civil service was given and clearly indicated that poverty is not the only explanation for health differentials found across different ranks of staff. Class differences played a significant role in the British context. The SES mode for health status fails on three counts:

1. taken alone, it is an inadequate explanation of the dynamic affecting health status
2. it is a crude form of measurement
3. once you determine this, what can be done to alleviate the situation (in other words, it is out of control as health care providers?)

What we are lacking in public health is the language and ability to describe more fully the essential conditions required for good health.

Hypothesis: Human rights provides a language and frame work for establishing the essential conditions for hale mores than the biomedical or medical models.

The modern human rights movement dates primarily from World War II and the holocaust. The protection of human rights was one of the major foundations upon which the United Nations system was built. The Universal Declaration of Human Rights was adopted in 1948, and the credit for the formulation and ratification of these principles was due in large part to the US delegation led by Ms. Eleanor Roosevelt.

Since that time, a number of international covenants have bee developed. These include the international covenants on civil and political rights, which was only ratified about three years ago by the US, and the international covenant on economic, social and cultural rights, which has not yet been ratified by the US. These various international rights documents.

The Universal Declaration of Human Rights represents the first time in history that a secular description of rights was agreed to by most of the countries of the world, an agreement with the status of international law.

The following are the basic principles of human rights:

- they inhere in us because we are human, they are therefore automatic
- they are inalienable in that governments cannot give them or take them away
- they are universal, intended for every human being, anywhere on the planet at all times-- they are inviolable, giving them a special value because of their ratification by countries of the world

How does the political process of human rights intersect with health:

The example of famine vs. food shortages was given. In a country such as India, with a democratic political process and free press, although dire circumstances some times lead to food shortages, the situation since democracy has never lead to famine. In China on the other hand, food shortages have become famines. What accounts for the difference? In countries with a democratic process and free press, the political consequences of a famine cannot be ignored. In an authoritarian dictatorship, however, famines are covered up and overlooked to protect the government and its policies.

What are some of the ways in which the human rights framework can be applied to health?

The World Development Report discusses the importance of improving the overall education attainment of women, not specifically health education.

The International Conference on Population and Development suggests a new paradigm for reproductive health: informed choice.

With regard to AIDS, a lot has been learned to document that health care interventions, including health and social services and IEC, cannot alone control the epidemic. It is critical that infected person not be discriminated against or the scope of the epidemic cannot be accurately defined. The AIDS situation made us recognize how essential the human rights approach is to controlling the epidemic.

The AIDS experience also helped us to recognize that the vulnerability of a particular group or group within a society defines as the existence or lack of the status of respect for the rights and dignity of a given group. No matter how an epidemic begins, whether with the well-educated as in the US with regard to the gay community, or the wealthy as was mentioned with regard to one of the East African country where the disease is prevalent, it is the margins of the society that within a decade will be the most prevalent population affected.

How do we connect the promotion and protection of health with human rights?

Unfortunately, those involved in human rights and those engaged in health have not traditionally worked together in the past. This poses some constraints. In addition, human rights emanates from a legal tradition, whereas health from a medical tradition; therefore there has been little intersection of these two areas in the past.

There has also been a changing view of public health. The old vision is one of diseases a dynamic events in a static society. The new public health vision suggest that society and disease are inextricably connected that a health problem cannot be controlled with simply a medical approach. There must be a search for the root or underlying causes that places some in a society a t higher risk due to their vulnerability with that society.

How might a more integrated health and human rights approach help us address specific health care issues?

- 1) It allows for a share common goal and for us to develop broader networks to address a health problem.
- 2) It allows us to join with others who are already involved in related activities and have an experience that can be shared.
- 3) It can contribute to our knowledge as health professionals.
- 4) It allows us to link our global understanding of rights and health with action ate the local level.

The fight to eliminate Female Genital Mutilation (FMG) as a practice provides rich examples of what can happen with the human rights and health communities link to address a critical health issue.

What are some it the limitations of working only with the medical community? The AIDS epidemic has shown us for example that "safe sex" is not more than a band-aid in terms of the real underlying causes of the strength of the epidemic among vulnerable populations. A strictly medical perspective is inadequate to deal with problems face by marginalized groups in society. Heise and Elias have written a paper that points to the role of sexual networking in providing some women with access to resources and the role of sexual violence in making it difficult for women to refuse sex.

In conclusion, it is critically important for health care to adopt a human rights frame work because it creates a vital link to understanding and addressing the societal determinants of health. Health is part of a larger picture, although it is a field that offer tremendous opportunities for connection with the community.

BREAKOUT SESSIONS ON HARD-TO-REACH POPULATIONS

High Risk Behavior - HIV/STD

Barbara deZalduondo

Male Involvement

Cynthia Steele Verme

Street Children

Lloyd Feinberg

Refugees

Steve Hawkins

EMERGING AND RE-EMERGING DISEASES

Steve Landry

- **EMERGING DISEASES** are either newly recognized diseases (e.g. hantavirus) or known diseases that occur in new geographic areas or within new populations (e.g. cholera in South America).
- **RE-EMERGING DISEASES** are diseases endemic in a given area, but which recently have shown a rise in incidence and/or prevalence (e.g. TB or drug resistant malaria)
- Though environmentally related illnesses can also be included in emerging diseases (e.g. non-infectious diseases such as cancers, trauma, nutritional problems, and iatrogenic problems)...USAID is focusing on infectious diseases.
- Philosophy of OHN is to address the problems of Emerging and Re-Emerging diseases by expanding/strengthening relevant activities within the existing PHN objectives (e.g. not to create new objectives which could dilute the impact of current activities)
- Current proposal is to focus on three areas:
 1. surveillance/epidemic preparedness
 2. anti-microbial resistance
 3. control and prevention of TB.
- The following questions were discussed in 4 groups: i) surveillance/epidemic preparedness ii) anti-microbial resistance, iii) control and prevention of TB iv) malaria (group added to further condense afternoon session)
 1. Do these priorities make sense in terms of your experience in the field?
 2. Are there major areas or issues that have been neglected?
 3. Are there institutions within your countries that with additional support could serve as focal points for emerging and re-emerging disease activities?

Surveillance/Epidemic Preparedness Group

Discussion group members suggest that USAID should continue support for global epidemic preparedness and response and that these efforts should be coordinated through USAID/Washington mechanisms to:

- focus institution strengthening at strategic regional and national institutions;
- coordinate and ensure South-South participation in epidemic response;
- coordinate global activities with CDC and WHO;
- utilize existing (electronic) surveillance systems (e.g., Famine and Early Warning System, FEWS).

A number of ongoing USAID-supported surveillance capacity building initiative were identified.

Anti-microbial Resistance

- Antimicrobial resistance to drugs used to treat a variety of diseases including malaria, pneumonia, shigella, TB, and STDs is accelerating world-wide due to overuse/misuse of drugs and the use of antibiotics for animal/fish husbandry.

94

- The importance of detecting drug resistance in LDCs in order to provide data for policy makers on drug selection and procurement was discussed.
- Low cost rapid assessment methodologies are needed. Also needed are low cost drug alternatives once resistance is confirmed.
- Research is being supported by a USAID grant to WHO to develop simple cost effective methods for sentinel surveillance and to test new drugs/regimens for pneumonia and shigella.
- Microbiology capacity is weak in many LDCs especially sub-Saharan Africa, so regional surveillance and reference centers should be considered.
- Efforts to promote rational use of drugs should be expanded.

TB Prevention and Control Group

The following points were discussed in the working group:

- TB is the leading infectious killer of young adults in the developing world, causing almost 3 million deaths in 1994. In addition, 8 million new cases of TB disease are estimated to occur each year by the WHO, with 20 million chronic cases. Untreated, 50% of the patients with TB will die within two years of developing disease. One third of the world's population is infected with the TB bacterium, with 10% of those infected developing disease in their lifetime.
- USAID is involved in operations research and development and field testing of new Diagnostics in TB. Currently, USAID funds TB activities in 8 countries worldwide.
- USAID and CDC are collaborating to develop a state of the art Operations Research Training Course for HIV/TB for developing country investigators
- World Bank is investing \$370 million for strengthening TB programs and drug supply in India, Bangladesh, China, and Zimbabwe
- Bilateral donors that are active in TB include: Japan, Netherlands, Norway, Sweden, Germany, Switzerland, and Finland.
- USAID is exploring possible funding for surveillance of Drug Resistant TB in several countries. In addition, USAID is exploring evaluation of cost effectiveness of various treatment regimens among HIV-infected TB patients, including replacing the 2 month inpatient initial phase with an outpatient phase that allows patients to go to work.
- Other USAID research areas include: modelling the impact of HIV on the TB epidemic; estimating the economic impact of TB in key developing country economies such as India.

Malaria Group

- The focus, purpose and approach of the Africa Integrated Malaria Activity were discussed:
- Focus- using existing institutions to improve malaria diagnosis and treatment, ii) prevention based on education (social marketing and training mothers on early detection and treatment)

95

and bednets: highly effective under ideal conditions but issues of implementation need to be demonstrated (example: distribution of bednets @ \$4.80 through the Bamako initiative in a village in Kenya)

- Purpose- to strengthen the prospects for sustainable, effective malaria control and prevention in Africa.
- Approach- to build upon USAID's experience and strengths in i) Maternal and Child health services, ii) partnerships between the public and private sectors, & iii) experience in social marketing, behavior change and communications.
- The USAID Malaria Vaccine Development Program's plans for trials in human volunteers of two experimental malaria vaccines in early 1996 were presented.

Other issues raised during discussions included:

- The need to address potential health impacts in the design of development programs in all sectors and the need to coordinate health programs with other sectors (e.g. agriculture, water supply, education)
- Important Emerging Infectious Diseases identified by the participants that were not included in this session: i) Kala Azar in Nepal, ii) Onchocerciasis in W. Africa, & iii) Hepatitis B in Egypt
- Institutions that could be useful in surveillance systems include: KEMRI (Kenya), Nogochi (Ghana), Egyptian Regional Reference Center, Vector Disease Control Center in Nepal (good example of multi-donor involvement), Institute Pasteur in Madagascar, and the Regional NIH supported center in Morocco.

Friday, June 23

LINKAGES-INTEGRATION-PARTNERSHIPS: CHANGING PARADIGMS

APPLICATIONS OF COMMUNICATIONS TECHNOLOGIES FOR PROGRAM ACTION

CLOSING REMARKS