521-0086 ②
PD-AAB-766-B1

UNCLASSIFIED

8/24/77 185 p.

DEPARTMENT OF STATE
AGENCY FOR INTERNATIONAL DEVELOPMENT
Washington, D.C. 20523

PROJECT PAPER

HAITI

STRENGTHENING HEALTH SERVICES II

Project Number: 521-0086

LA/DR:77-8

UNCLASSIFIED

APR 24 1980

ACTION MEMORANDUM FOR THE ACTING ASSISTANT ADMINISTRATOR (LAC)

FROM : LAC/DR, Marshall D. Brown

Problem : Your approval is required to amend the Project Authorization for the Haiti Strengthening Health Services II project (521-0086) to provide additional funds for technical assistance to the Department of Public Health and Population (DSPP) and the National Service for Endemic Diseases (SNEM).

Discussion: The Strengthening Health Services II Project Agreement was signed on August 30, 1977. Grant funds of $7.525 million were approved for the life-of-the project to: (1) assist DSPP in designing a rural health delivery system for Haiti while strengthening its capability to manage it, and (2) to provide assistance to SNEM to reduce the incidence and prevalence of malaria throughout the country. The proposed amendment pertains solely to the SNEM component of this project. SNEM is a semi-autonomous agency under the DSPP, and currently operates with the assistance of AID and the Pan American Health Organization (PAHO).

Initial AID-supported efforts to reduce malaria in Haiti had their origin in the early 1960's, and were quite successful. However, a dramatic resurgence of the disease was experienced throughout the 1970's, and the SNEM program has, to date, been unable to reverse this trend. The seriousness of this problem is illustrated by the travelers' warning on malaria issued January 3, 1980, by the Center for Disease Control (CDC), which may detrimentally affect Haiti's growing tourist industry.

In light of the resurgence of the disease and the operational problems of SNEM, a high level team of malaria experts was established last May to conduct an in-depth evaluation of Haiti's malaria control program. The team included experts from the World Health Organization, PAHO, CDC, AID and the Government of Haiti (GOH). The evaluation resulted in an extensive set of technical and managerial recommendations, nearly all of which were accepted by the tripartite (AID/PAHO/GOH) SNEM Executive Committee. The Memorandum of Understanding, which sets forth the respective responsibilities of each party, was revised accordingly, and USAID/Haiti agreed, subject to AID/W concurrence, to respond to recommendations of the evaluation report for improving the management advisory services being provided to SNEM. The USAID also indicated a willingness to provide some of the short-term assistance required for the proposed field trials, and to extend the contract of its current adviser to SNEM for one year. PAHO agreed to provide an additional malaria sanitarian to SNEM to help carry out the technical recommendations, and PAHO is also assigning a senior malariologist to SNEM. The GOH has increased its budgetary support to SNEM, to enable it to carry out the Plan of Action approved by AID and PAHO.

The attached amendment to the Project Authorization and Request for Allotment of Funds (PAF) will provide an additional $275,000 for 24 person-months of long-term management advisory services, 7-10 person-months of additional short-term technical advisory services recommended by the evaluation, and a one-year extension of the current AID adviser's contract. No new funds are required as these funds will be reprogrammed from funds already allocated to the Haiti Rural Health Delivery System Project (521-0091) in the FY 1980 OYB.

An Advice of Program Change for this project was submitted to Congress on April 11, 1980. The 15 day waiting period expired on April 26, 1980.

Recommendation: That you approve an increase of $275,000 in project funding for the malaria component of the Haiti Strengthening of Health Services II project by signing the attached PAF amendment.

Attachment:

Amendment No. 1 to PAF

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

ASSISTANT
ADMINISTRATOR

PROJECT AUTHORIZATION AND REQUEST FOR ALLOTMENT OF FUNDS (AMENDMENT NO. 1)

Name of Country: Haiti

Name of Project: Strengthening Health Services II

Number of Project: 521-0086

Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, the Strengthening Health Services II project for Haiti was authorized on August 26, 1977 (the "PAF"). The PAF is hereby amended as follows:

1. The second paragraph of the Preamble to the PAF is hereby deleted in its entirety and the following paragraph is hereby substituted in lieu thereof:

> "I approve the total level of A.I.D. appropriated funding planned for the Project of not to exceed Seven Million Eight Hundred Thousand United States Dollars ($7,800,000) of Grant funding, including the funding authorized above, during the period FY 1977 through FY 1980. I approve further increments during that period of Grant funding up to $700,000, subject to the availability of funds in accordance with A.I.D. allotment procedures."

2. Except as expressly amended or modified hereby, the PAF remains in full force and effect.

Edward W. Carter
Acting Assistant Administrator
Bureau for Latin America
and the Caribbean

April 28 1980
Date

Clearances:

GC/LAC:JLKessler: JLK/JK date 4/24
LAC/CAR:RDelaney: [illegible] date [illegible]
LAC/DR:LArmstrong: [illegible] date 4/23
LAC/DR:MBrown: [illegible] date 4/23

GC/LAC:GMWinter:ckg:4/23/80/ext:29182

AUG 26 1977

ACTION MEMORANDUM FOR THE ASSISTANT ADMINISTRATOR (LA)

FROM: LA/DR, Charles B. Weinberg

Problem: Authorization of Haiti Strengthening Health Services II Grant (521-0086).

Discussion: The Strengthening Health Services II project, originally submitted by USAID/Haiti in June 1977, requested a total of $10.5 million in AID funds - $6.0 million was to be provided to Haiti's malaria control organization, SNEM, and $4.5 million to the Ministry of Health (DSPP). Included in the DSPP portion were funds to develop a supply, transportation and communication system for the DSPP. The DAEC review of the project concluded the DSPP portion of the project did not reflect sufficient planning to permit project approval. The major issues were (a) timing and planning for SNEM integration into the DSPP and (b) the basic design of the model, particularly those aspects dealing with the requirements for medical supplies, transportation, storage facilities and communication support. The DAEC requested USAID/ Haiti revise the Project Paper, addressing the two major issues and several minor points.

Rather than a revised PP, USAID/Haiti submitted a 15 page supplement to the PP on July 25. On August 1, 1977, the LA Bureau reviewed the PP supplement and concluded that many of the original concerns still were not adequately answered. Accordingly, the medical supplies, transportation, and communications elements of the project were eliminated, a total of $3.0 million. It was decided to provide only $1.525 million for the DSPP (over a two year period, not five years as requested), and focus on institutional strengthening and further design of the RHDS model - with follow-on funding for replication of the model to be provided with future FY 78 or 79 funds.

The revised $7.525 million grant ($7.1 million in FY 77 and $425,000 in FY 78) will assist in financing Phase II of an ongoing program aimed at improving the rural health care delivery system of the Government of Haiti (GOH). The project will assist in reducing the incidence of malaria, as well as strengthening the capacity of the DSPP to plan, design, and manage a rural health delivery system.

The Phase II project will build upon the accomplishments of the Strengthening Health Services I project (521-0070), which provided budget support assistance to SNEM and through a technical assistance contract began to establish an administrative capability in the DSPP. This project goes beyond the earlier project, however, and further strengthens the personnel, training and

analytical capabilities of the DSPP so it can design and manage a rural health delivery system which will eventually reach 70% of the rural population of Haiti. Further, the project will attempt to bring the incidence of malaria down to a level where Haiti's malaria control program can be integrated with the rural health system. The GOH will take over complete administrative and financial responsibility for SNEM by the end of this project.

Project components and related costs are:

SNEM (A.I.D. and the GOH will provide $11.6 million over five years)

- Personnel and Operating Costs: A.I.D. will fund a decreasing share ($5.7 million) and the GOH an increasing share ($5.6 million) of personnel and operating expenses for SNEM, over the five year life of project.

- Commodities: A.I.D. will fund fuel and lubricants for SNEM operations ($332,000).

- Technical Assistance: A.I.D. will fund a medical entomologist for two years to advise the Director of SNEM on the proper use of DDT and Malathion ($60,000).

DSPP (A.I.D. will provide $1,525 million over two years)

- Personnel and Operating Costs: A.I.D. will fund personnel and operating costs for the administrative, planning, and statistical sections of the DSPP ($371,000).

- Training: Training programs will upgrade the administrative, planning, and statistical capabilities of the DSPP ($567,000).

- Technical Assistance: Approximately $320,000 in technical assistance will be provided to further strengthen the DSPP's planning and managerial capabilities. The remaining $20,000 will be to assist in planning the integration of SNEM and the DSPP.

- Commodities: Office equipment and supplies totaling $36,000 will be provided.

The Pan American Health Organization will contribute $952,000 to SNEM for technical assistance plus short and long term participant training.

A Negative Determination and a Negative Declaration for the environmental aspects of this project were approved on August 25, 1977. An Advice of Program Change was forwarded to Congress on August 12, 1977 and no objections were raised by the August 26, 1977 expiration date. Pursuant to the guidance provided in AIDTO CIRCULAR A-268 dated July 15, 1977, you have the authority to approve projects which do not exceed $10 million.

Recommendation: That you approve the proposed Haiti Strengthening Health Services II Project by signing the attached project authorization.

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT AUTHORIZATION AND REQUEST FOR ALLOTMENT OF FUNDS PART I

1. TRANSACTION CODE: A (A ADD, C CHANGE, D DELETE)

PAF

2. DOCUMENT CODE: 5

3. COUNTRY/ENTITY: Haiti

4. DOCUMENT REVISION NUMBER:

5. PROJECT NUMBER (7 digits): 521-0086

6. BUREAU/OFFICE: A. SYMBOL: LA; B. CODE: 05

7. PROJECT TITLE (Maximum 40 characters): Strengthening Health Services II

8. PROJECT APPROVAL DECISION — ACTION TAKEN: A (A APPROVED, D DISAPPROVED, DL DEAUTHORIZED)

9. EST. PERIOD OF IMPLEMENTATION: YRS. 05 QTRS

10. APPROVED BUDGET AID APPROPRIATED FUNDS ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. 1ST FY 77		H. 2ND FY 78		K. 3RD FY	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	I. GRANT	J. LOAN	L. GRANT	M. LOAN
(1) PH	534	510		7,100		425			
(2)									
(3)									
(4)									
			TOTALS	7,100		425			

A. APPROPRIATION	N. 4TH FY		Q. 5TH FY		LIFE OF PROJECT	
	O. GRANT	P. LOAN	R. GRANT	S. LOAN	T. GRANT	U. LOAN
(1)					7,525	
(2)						
(3)						
(4)						
TOTALS					7,525	

11. PROJECT FUNDING AUTHORIZED (ENTER APPROPRIATE CODE(S)) 1 - LIFE OF PROJECT; 2 - INCREMENTAL, LIFE OF PROJECT

A. GRANT	B. LOAN
2	

C. PROJECT FUNDING AUTHORIZED THRU FY 81

12. INITIAL PROJECT FUNDING ALLOTMENT REQUESTED ($000)

B. ALLOTMENT REQUEST NO. 2

A. APPROPRIATION	C. GRANT	D. LOAN
(1) PH	7,100	
(2)		
(3)		
(4)		
TOTALS		

13. FUNDS RESERVED FOR ALLOTMENT

TYPED NAME (Chief, SER/FM/~~POD~~) FCS

SIGNATURE: [signature]

DATE: 8/28/77

14. SOURCE/ORIGIN OF GOODS AND SERVICES: [ ] 000 [X] 941 [X] LOCAL [ ] OTHER

15. FOR AMENDMENTS, NATURE OF CHANGE PROPOSED

FOR PPC/PIAS USE ONLY	16. AUTHORIZING OFFICE SYMBOL	17. ACTION DATE (MM DD YY)	18. ACTION REFERENCE (Optional)	ACTION REFERENCE DATE (MM DD YY)

AID 1880-6 (7-76)

DEPARTMENT OF STATE
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

ASSISTANT ADMINISTRATOR

PROJECT AUTHORIZATION AND REQUEST FOR ALLOTMENT OF FUNDS

PART II

Name of Country:	Haiti
Name of Project:	Strengthening Health Services II
Number of Project:	521-0086

Pursuant to Part I, Chapter 1, Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize a Grant to the Republic of Haiti (the "Grantee") of not to exceed Seven Million One Hundred Thousand United States Dollars ($7,100,000) (the "Authorized Amount") to help in financing certain foreign exchange and local currency costs of goods and services required for a project which will improve the capability of the Department of Public Health and Population ("DSPP") to plan and administer a rural health delivery system, design a rural health delivery system for Haiti and fund a decreasing share of the operating costs of the malaria control program administered by the National Society for Endemic Disease ("SNEM") ("Project"). $7.1 million of the A.I.D. financing herein authorized and approved for the project will be obligated when the Project Agreement is executed.

I approve the total level of A.I.D. appropriated funding planned for the Project of not to exceed Seven Million Five Hundred Twenty-Five Thousand United States Dollars ($7,525,000) of Grant funding, including the funding authorized above, during the period FY 1977 through FY 78. I approve further increments during that period of Grant funding up to $425,000, subject to the availability of funds in accordance with A.I.D. allotment procedures.

I hereby authorize the initiation of negotiation and execution of the Project Agreement by the officer to whom such authority has been delegated in accordance with A.I.D. regulations and Delegations of Authority, subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate:

A. Source and Origin of Goods and Services

Except for Ocean Shipping, goods and services financed by A.I.D. under the Project shall have their source and origin in Haiti or countries included in A.I.D. Geographic Code 941 except as A.I.D. may otherwise agree in writing. Ocean Shipping financed under the Grant shall be procured in any eligible source country except Haiti.

B. First Disbursement

Unless A.I.D. otherwise agrees, prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee will furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(1) An opinion of counsel acceptable to A.I.D. that the Project Agreement has been duly authorized and/or ratified by, and executed on behalf of, the Grantee, and that it constitutes a valid and legally binding obligation of the Grantee in accordance with all of its terms; and

(2) Evidence that the Grantee has duly and lawfully established a department for administration within DSPP.

C. Additional Disbursement.

Unless A.I.D. otherwise agrees, prior to disbursement under the Grant, or to issuance by A.I.D. of documentation pursuant to which disbursement will be made, for any purpose other than to finance the technical advisor to SNEM, the Grantee will furnish to A.I.D. in form and substance satisfactory to A.I.D. an implementation plan containing a time phased work schedule for SNEM's activities during the first year of the Project and a similar schedule for DSPP, which schedules describe the activities to be carried out, the goals and targets to be achieved, and the offices or individuals responsible for each activity.

D. Disbursement for Operating and Personnel Expenses

Unless A.I.D. otherwise agrees, prior to disbursement under the Grant, or to issuance by A.I.D. of documentation pursuant to which disbursement will be made, to finance operating or personnel expenses of SNEM or DSPP, the Grantee will furnish to A.I.D. in form and substance satisfactory to A.I.D. a plan including:

(1) An itemization of the specific operating and personnel expenses for SNEM and DSPP during the first year of the Project for which Grant funds will be used; and

(2) A staffing plan for SNEM and DSPP showing the organization and position necessary for the Project, the schedule for establishing and filling these positions, the salaries for these positions, and the source of funds for paying the salaries.

E. Disbursement for Training

Unless A.I.D. otherwise agrees, prior to disbursement under the Grant, or to issuance by A.I.D. of documentation pursuant to which disbursement will be made, to finance training, the Grantee will furnish A.I.D. in form and substance satisfactory to A.I.D. a training plan for the Project including:

(1) Proposed long and short term training;

(2) The schedule and estimated costs of the proposed training;

(3) The criteria used in selecting participants; and

(4) Measures to be taken for insuring that trainees continue to work in the positions for which they receive training.

F. Disbursement for SNEM after December 31, 1979

Unless A.I.D. otherwise agrees, prior to disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made,

after December 31, 1979, to finance any SNEM activity, the Grantee will furnish to A.I.D. in form and substance satisfactory to A.I.D. a plan for the integration or merger of SNEM and the DSPP.

G. Grantee's Covenants

Grantee shall covenant that:

(1) During this Project and thereafter, the Grantee will continue to give the extension of health services to rural areas high priority as a national goal and will coordinate the activities of A.I.D. and the Pan American Health Organization ("PAHO") relating to DSPP's extension of health services to rural areas to insure that A.I.D.'s and PAHO's efforts complement and reinforce each other without wasteful duplication or inconsistency.

(2) Unless A.I.D. otherwise agrees, the Grantee will furnish A.I.D. in form and substance satisfactory to A.I.D. annually during the Project a revised, updated version of the training plan submitted by Grantee under Section F and of the implementation plans submitted by Grantee under Section D.

(3) The technical advisor to SNEM for the Project referred to in Section C will be a medical entomologist capable of monitoring the effectiveness of the pesticide spraying.

Edward W. Coy
for Assistant Administrator
Bureau for Latin America

August 26 1977
Date

Clearance:

GC/LA,JLKessler JMC Date
LA/DR,CWeinberg Date 8/26/77
LA/DR,PBittner Date 8/26/77
LA/CAR,WRhoads WR Date 8/26/77

GC/LA,TLGeiger:lb:8/25/77
TLG/lb

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT PAPER FACESHEET

1. TRANSACTION CODE: A (A = ADD, C = CHANGE, D = DELETE)

PP

2. DOCUMENT CODE: 3

3. COUNTRY/ENTITY: Haiti

4. DOCUMENT REVISION NUMBER:

5. PROJECT NUMBER (7 digits): 521-0086

6. BUREAU/OFFICE: A. SYMBOL: LA; B. CODE: 05

7. PROJECT TITLE (Maximum 40 characters): Strengthening Health Services II

8. ESTIMATED FY OF PROJECT COMPLETION: FY 82

9. ESTIMATED DATE OF OBLIGATION: A. INITIAL FY 77; B. QUARTER 4 (Enter 1, 2, 3, or 4); C. FINAL FY 78

10. ESTIMATED COSTS ($000 OR EQUIVALENT $1 = 5 G)

A. FUNDING SOURCE	FIRST FY B. FX	FIRST FY C. L/C	FIRST FY D. TOTAL	LIFE OF PROJECT E. FX	LIFE OF PROJECT F. L/C	LIFE OF PROJECT G. TOTAL
AID APPROPRIATED TOTAL						
(GRANT)	(993)	(6,107)	(7,100)	(993)	(6,532)	(7,525)
(LOAN)	( )	( )	( )	( )	( )	( )
OTHER U.S. 1.						
OTHER U.S. 2.						
HOST COUNTRY	731	189	920	2,282	3,318	5,600
OTHER DONOR(S) PAHO	186		186	852		852
TOTALS	1,910	6,296	8,206	4,127	9,850	13,977

11. PROPOSED BUDGET APPROPRIATED FUNDS ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE C. GRANT	PRIMARY TECH. CODE D. LOAN	E. 1ST FY 77 F. GRANT	E. 1ST FY 77 G. LOAN	H. 2ND FY 78 I. GRANT	H. 2ND FY 78 J. LOAN	K. 3RD FY ___ L. GRANT	K. 3RD FY ___ M. LOAN
(1) PH	534	510		7,100		425			
(2)									
(3)									
(4)									
			TOTALS	7,100		425			

A. APPROPRIATION	N. 4TH FY ___ O. GRANT	N. 4TH FY ___ P. LOAN	Q. 5TH FY ___ R. GRANT	Q. 5TH FY ___ S. LOAN	LIFE OF PROJECT T. GRANT	LIFE OF PROJECT U. LOAN
(1) PH					7,525	
(2)						
(3)						
(4)						
TOTALS					7,525	

12. IN-DEPTH EVALUATION SCHEDULED: MM 08 YY 78

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN THE PID FACESHEET DATA, BLOCKS 12, 13, 14, OR 15 OR IN PRP FACESHEET DATA, BLOCK 12? IF YES, ATTACH CHANGED PID FACESHEET.

1 (1 = NO, 2 = YES)

14. ORIGINATING OFFICE CLEARANCE

SIGNATURE: Parke Massey

TITLE: Parke Massey
Acting Director
USAID/Haiti

DATE SIGNED: MM 08 DD 24 YY 77

15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM 08 DD 24 YY 77

AID 1330-4 (3-76)

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ANNEXES

Legal Exhibits
Technical
Institutional
Financial

1. Summary and Recommendations

B. Recommendations

1. Terms of Assistance:

In accordance with the official request from the Government of Haiti (Annex I), it is proposed to provide $7,525,000 in capital grant funds to the Government of Haiti for a project to be called Strengthening Health Services II. These funds will be authorized in Fiscal Year 1977, contingent upon congressional notification (Section I-D, Issues), and will be obligated through a Project Agreement to cover a 5-year life of project, an additional $425,000 will be obligated in FY 1978. The A.I.D. grant funds will provide for technical assistance; participant and other training; costs of Government of Haiti personnel and some operating expenses of the central Health Ministry (DSPP) and malaria control program (SNEM). The project is to assist the central Health Ministry (DSPP) to design a rural health delivery system; strengthen the DSPP to administer a nation-wide rural health delivery system; and phase out A.I.D. support to the GOH (SNEM) malaria control program in preparation for integrating malaria control within the DSPP.

This project has been found to be technically, financially, and socially sound. The respective analyses are contained elsewhere in this paper. The project is consistent with the A.I.D. strategy for development of Haiti's health sector (see the revised DAP submitted June, 1977, and Sector Assessments of June 1975 and September, 1976 respectively.

Recommendation: That the Assistant Administrator of A.I.D. for Latin America authorize the Mission Director of U.S.A.I.D./Haiti to enter into a five-year $7,525,000 FY 1977 grant Project Agreement with the Government of Haiti (GOH) for a project entitled Strengthening Health Services II.

2. Special Conditions and Covenants

The Project Agreement, Article 4, Conditions Precedent to Initial Disbursement, will contain the standard conditions to first disbursement contained in the model Project Agreement format issued via AIDTO Circular A-503 (Handbook 3 - Project Assistance: Chapter 10) of September 11, 1976. These cover Grantee provision of (a) opinion of counsel that the Agreement has been duly authorized; and (b) names and signature of authorized representatives. In addition, a Condition Precedent to initial disbursement will be added requiring submission to AID of proof that a Bureau for Administration has been established in the DSPP. Up to 90 days from Project Agreement signature will be allowed for satisfaction of these initial conditions precedent (although the AID Mission Director reserves his right to extend this terminal date up to another 120 days in accordance with AIDTO Circular A-268-7/15/77.

Section 4.2 of the Project Agreement will contain the following conditions to Additional Disbursement and covenants:

(a) Prior to any disbursement for other than extension of the SNEM technical advisor's contract or transportation technical assistance to the DSPP, an implementation plan shall be submitted containing time-phased work schedules for DSPP & SNEM respectively covering the first year's activities under the project. The plans should show actions to be carried out, targets to be achieved and officers or individuals to whom action responsibility has been assigned.

(b) Prior to any disbursement for budget support to either implementing agent, a support requirements plan shall be submitted by SNEM & DSPP showing the respective organization and staffing (positions) needed to carry out this project; the schedule for establishing and filling any new or vacant positions, the salaries to be paid existing or new incumbents; and the proposed source (s) of funds for these salaries. This plan should also indicate intended application of A.I.D. funds to itemized operating expenses.

(c) Prior to any disbursement for procurement of goods i) a list shall be submitted by DSPP showing goods to be procured and estimated costs; ii) a plan shall be submitted by SNEM showing amount of goods (POL) to be procured with project funds, estimated cost, origin, and proposed schedule.

A.I.D. must approve all plans, specifications, cost estimates and time schedules prior to any disbursement for procurement.

(d) Prior to any disbursement for training, a plan shall be submitted by DSPP showing long and short term training to be financed under the project; the schedule and the estimated cost of such training; criteria used in selecting participants; and provisions to insure trainees utilize the skills gained in the positions or service intended;

(e) Prior to disbursement to SNEM for year 3-5 of operations a plan for integration with the DSPP will have been prepared and approved.

The Government of Haiti shall covenant to:

(a) maintain a high priority on extension of health services to the rural areas; and

(b) coordinate A.I.D. and Pan-American Health Organization (PAHO) activities in support of the Department of Public Health and Population's (DSPP) rural health delivery and regionalization programs, so as to avoid duplication or conflict, and promote mutually reinforcing efforts in these related areas.

Section 4.4 of the Project Agreement will contain the following terminal dates for meeting Conditions Precedent:

(1) The terminal date for submitting to A.I.D. implementation and support requirements plans described Section 4.2 (a. and b.) will be 120 days from signature of the Project Agreement.

(2) The terminal date for submitting to A.I.D. the procurement plan (for goods not related to the rural health delivery system model) described in Section 4.2 (c) will be 180 days from signature of the Project Agreement. The terminal date for submitting to A.I.D. a plan for procurement of goods related to the rural health delivery system will be established in writing by U.S.A.I.D. as the DSPP's planning process produces sufficient information.

(3) The terminal date for Conditions Precedent described in Section 4.2 (d. through f.) above will be established in writing by A.I.D. as the DSPP's planning process evolves.

C. Project Description

1. Summary

The Government of Haiti lacks both the management and technical expertise and financial resources to implement any outreach program with a measurable impact on the health status of the population. Therefore, the A.I.D. project will provide the resources necessary to improve the planning and administrative capabilities of the DSPP while assisting in the planning of an integrated rural health delivery system (RHDS) which is intended to result in the extension of affordable health services to an estimated 70% of the rural population.

The RHDS concept is entirely consistent with the GOH "regionalization" plan under which the Directors of the six health regions are to have a high degree of autonomy for administration and operational decision making for all health, MCH-Family Planning, and nutrition activities in their respective regions. Each region will be a self-contained hierarchy with the hospital as the regional center for complex care and administration; the health centers as foci of intermediate care; and the basic level dispensaries as the primary care centers. The interface with the community should be the basic level health worker (agent sanitaire), who will be the key to effective delivery of rural health care. Supervision will be crucial to the effectiveness of this graduated referral system of care. Therefore, special training programs will be developed for supervisors who will in turn take part in the training of basic workers.

Two rural health delivery projects already exist at Croix-des-Bouquets and Petit-Goâve. The DSPP will study the possibility of synthesizing these two projects to design their prototype RHDS. The operating cost of the Petit-Goâve project would be assumed under this project about 12-18 months followings signature of the Project Agreement. At that time also, non-family planning activities of the Croix-des-Bouquets project would be transferred from Title X to project funding. Project funds would also assist on-going personnel training activities of the Department of Community Medicine at the Faculté de Médecine.

The DSPP feels that rural health delivery services should be integrated, i.e. that services should be provided in a uniform way through the same physical or human delivery point.

Under the RHDS, Maternal-Child-Health (MCH) and related services will be provided by the same basic level health worker for each health center area. This approach addresses the multi-causal nature of health problems in Haiti much more adequately than existing vertical systems of separate health care delivery.

Malaria continues to be a major cause of morbidity in the population. The increase in the slide positivity rate from a low of .2% in 1968 to 8% in 1972 is a result of many factors, (administrative, technical and policy). In 1975, AID took over funding the administrative side of SNEM's malaria control program, and PAHO supplied the technical backstopping (5 resident technicians). Agreement has been reached that a full-time resident entomologist will also work with the PAHO-SNEM technical team. Since this organization has been in place, SNEM's effectiveness in planning,managing, and delivering services has improved markedly, if somewhat slowly.

While AID does not wish to continue support for a solely vertical health program, it does recognize the importance of reducing the incidence of malaria to a point where it is no longer a public health problem.

Since the GOH has shown commitment to the program by steadily increasing its share of the contribution, AID phase-out support under this project is justified to bring malaria down to levels controllable by the DSPP within its RHDS program. When the DSPP is sufficiently organized and strengthened, it is expected that SNEM will be incorporate into the Ministry. Assuming the project schedules are realistic and are met by the implementing agents, integration should occur during the life of this project.

The project agreement includes a commitment on the part of the DSP/P to develop a course of action for the preparation of a detailed plan for the integration of SNEM into DSP/P. A working committee on integration will be set up prior to the end of FY 77. A suggested membership would be as follows:

2 representatives of the DSP/P
2 representatives of SNEM
The Westinghouse Health Systems team leader
The AID advisor to SNEM

The committee will start its works in January 1978. An outside consultant will be provided the integration committee for approximately 3 man months. By June of 1978 the committee will submit a draft plan of integration to the SNEM Executive Committee for approval. This draft plan will indicate what further actions need to be taken during the course of the following year and what technical assistance will be needed. By June of 1979 the plan of integration will be finalized and integration will commence. The development of this plan will be made a condition precedent for the 1980-1982 disbursements for SNEM.

$20,000 will be specified in the Financial plan of Project Agreement for the 3 months of technical assistance indicated, and any additional technical assistance will be funded under technical assistance funds for the DSP/P.

It is assumed that it will be necessary to continue technical assistance support to the DSPP during the transition to the nation-wide RHDS implementation phase. Therefore, a health planning contract will continue to be supported throughout this project to provide guidance and supervision during the transition phase, and to diagnose and deal with specific problems as they arise. The contractor for this latter phase of project implementation will be selected competitively.

AID's strategy is being implemented in three phases, of which this project is the second. Phase II will have three components. First, work will go on at the central level with the Department of Public Health and Population (DSPP) in strengthening its planning and administrative capability. This will be done primarily through the Westinghouse Health Systems technical services contract (funded through January, 1979, under Strengthening Health Services I; project number 521-11-510-070). Secondly, assistance will be given to the DSPP under Phase II in developing the infrastructure necessary to support the RHDS. This includes phase-out support to SNEM to bring the incidence of malaria to controllable levels so that control operations may eventually be incorporated into the rural health delivery system under the direction of the DSPP. Thirdly, resources will be provided under this project for the design, of a rural health delivery system to Haitian circumstances and needs. In Phase III (the final phase) of the AID strategy, this tested model will be expanded to give broad health services coverage to 70% of the rural population under the proposed Rural Health Delivery Systems project now scheduled for FY 1978 funding.

Currently, delivery of health services is fragmented administratively and logistically, resulting in duplication of effort and waste of scarce resources. Improvement of both GOH health planning and administrative abilities is a ncesssary prerequisite if any integration and extension of health services is to be achieved or economies realized. The Westinghouse Health Systems (WHS) team will work to, 1) improve the DSPP's personnel system; 2) establish a working linkage between the central financial (i.e. budgeting) system with the outlying health posts; and 3) create a more reliable and effective information and data collection system through the newly created Bureau of Planning and Evaluation (BHP/E) in the DSPP.

AID funds will support 1) manpower development and training (including task definition analysis for the RHDS); 2) necessary technical equipment to support the improved information systems; and 3) some operational cost support to the Ministry.

2. Target Group; Project Benefits

a) Strengthening Health Services II Project

Within the strict confines of the Strengthening Health Services II project, direct beneficiaries will be persons receiving SNEM's malaria control services . Preliminary estimates (to be refined in their Annual Plan of Action) indicate SNEM's anti-malarial spraying should directly benefit, i.e., "protect", almost 1.5 million people over the 5-year project period. SNEM's chemotheraphy program is to cover almost 2 million individuals over that period . Some SNEM activities, e.g. anti-larval attacks, cannot readily be translated into numbers of direct beneficiaries, and some of SNEM's beneficiaries will be located in "urban" areas (e.g. Port-au-Prince and Jacmel) where unsanitary conditions and proximity to stagnant water make malaria a serious health threat. However, it is safe to say that combined AID and PAHO assistance under this project will help the GOH reach approximately 60% of the total population, with protection against malaria. Of these, the majority will be rural residents.

The target group of the DSPP's activities under this project is the same as that under the proposed FY 1978 RHDS project, i.e. 70% of the rural population. Clearly, a project designed primarily to develop the planning and administrative capacity of a central Government Ministry, will benefit directly only a fraction of that 70% of rural resident (i.e. individuals receiving services being tested for inclusion in an RHDS model). It is also recognized that as central-level delivery capabilities improve, existing urban-based health services will likely also improve. Therefore, the urban population will likely benefit to some extent from the FY 1977 project. However, such urban beneficiaries are apt to fall in the lower ranges of the economic scale (i.e. those who utilize public health services); and the FY 1978 project to replicate a nation-wide RHDS should remove the long-standing disparities between health benefits to urban and rural residents.

b) The Rural Health Delivery System

The target group for AID's 3-phase health sector program is the currently unserved portion (i.e. the great majority) of the rural population of Haiti. A detailed description of Haiti's rural poor, including socio-economic indicators, is included in the 1977 revised DAP.

More specifically, as health services will be designed to meet high priority health problems (defined by sound epidemiological data), the direct beneficiaries will become individuals or groups "at risk", i.e. currently suffering from these health problems. Epidemiological and sociological data to be collected in improved form under this project will serve as a major determinant in the design of the RHDS to be replicated nation-wide under the proposed FY 1978 (Phase III) project Westinghouse Health Systems' technical assistance being financed during the first year of project implementation is particularly aimed at assisting the DSPP to identify its rural health target group and priority beneficiaries based on good epidemiological and sociological data.

3. Implementing Agents

The Grantee will be the Government of the Republic of Haiti (GOH) and the principal executing agency for the project will be the Department of Public Health and Population (DSPP). The Service National des Endemies Majeures (SNEM) will collaborate with the DSPP in the execution of certain aspects of the project.

a. DSPP

The DSPP is headed by the Secretary of State for Health and Population, and is arranged in two major divisions -- Technical Services and Administrative Services. Operations of the DSPP at the central level are supervised by the Director General for Health and his staff in the present eleven Sanitary Districts. This structure will change and the number of Sanitary Districts will be reduced to five health regions when plans for decentralized regional operation are completed. Subentities of the DSPP, e.g. the Bureau of Planning and Evaluation (BHP/E), the Statistics Service, the Division of Education, and the Bureau of Administration, are discussed in greater detail in Part IV of this Paper.

b. SNEM

Formerly an international organization with a PAHO co-director, SNEM is now headed by a Haitian National Director (see Memorandum of Understanding, Annex II). At the central level, the Director oversees three divisions -- Administration, Epidemiology, and Field Operations. Field operations are carried out in a series of zones which are further divided into sectors. There is a SNEM Executive Committee composed of GOH, AID, and PAHO representatives which guides the policy and program direction of SNEM, and provides liaison with the DSPP. Technical assistance to SNEM is divided with PAHO providing all technical inputs through a 5-person team of malariologists, engineer

etc., and AID providing technical assistance in administration and management. Continued funding for the AID administrative advisor is included in this project.

The institutional and technical capabilities of these organizations are analyzed in greater detail in Parts II, III, and IV of this Project Paper.

4. Financial Summary

The project will provide $7.525 million in A.I.D. grant funds over a five-year period. The funds are to be authorized in FY 1977 and, subject to Congressional notification. Funds will be obligated via the standard grant Project Agreement format provided in Handbook 3 - Chapter 10.

The grant will help finance technical assistance ($399,000); participant and other training($308,000); costs of certain GOH personnel and some operating expenses of SNEM and the DSPP ($6,640,000); and $152,000 for contingencies and inflation.

The Pan-American Health Organization (PAHO) is expected to contribute approximately $852,000 in technical assistance to SNEM. This includes the cost of Master's Degree training in epidemiology and entomology necessary to strengthen SNEM's ability to reduce malaria incidence. The PAHO contribution constitutes approximately 6% of total project cost.

The Government of Haiti contribution is expected to be equivalent to approximately $5.6 million over the life of the project, or 40% of total project cost ($14.0 million). The GOH contribution will be provided through the budget of SNEM, (under which the GOH finances all vehicles, equipment, and supplies for SNEM's activities); and through the GOH's gradual assumption of full funding responsibility for SNEM over the life of the project.

5. Project Development

AID/Washington guidance concerning the PRP and development of the PP is attached (Annex I). That guidance and USAID's response to it is summarized below.

On November 17, 1975, the DAEC reviewed USAID's Strengthening Health Services I PP amendment for a $2.5 million two-year "bridge" grant to support malaria control and strengthen GOH health services. At the same time, the DAEC reviewed a PRP for a $7.0 million loan and $470,000 grant package to implement a malaria control plan of action and extension of health services commencing in FY 1977. This review was followed by:

(A) State 275799 - 11/21/75 - "Strengthening Health Services PP and PRP"

1) PP approval was made contingent on a clear understanding with SNEM that AID grant funds for operating expenses would terminate in FY 1977. USAID was also to indicate to the GOH AID's willingness to fund a broad loan and grant health sector project in FY 77, with malaria control as a part of that project.

... The recent change to all-grant funding for the Haiti program reversed plans to move SNEM operations into a larger, loan-funded health sector project. However, the present project provides for complet GOH assumption of SNEM's operating costs and integration of malaria control activities within DSPP.

2) The Project Agreement for the bridge grant was to contain a malaria control plan of operations and evaluation benchmarks for the malaria program.

... The SNEM five-year Plan of Operations (for 1978-82) is described in Section II-A Of this PP (Technical Analysis). Progress benchmarks will be incorporated in SNEM's annual Plan of Action (based on the 5-year plan) which describes activities to be carried out in the coming year, and with what resources. SNEM is currently drawing up the Plan of Action for 1978. It is expected that this will be submitted to AID in satisfaction of the Condition Precedent for an implementation plan for the first year of the project. Subsequent annual plans will be submitted to AID to up-date the project implementation plan.

(B) State 298278 - 12/18/75 - "Strengthening Health Services PP & PRP"

1) It was recommended that USAID expand the FY 77 project to include studies of constraints to be removed prior to SNEM integration into the DSPP and certain broader health problems:

(a) Professional migration and its implications for paramedical training.

... Under this project a full sector manpower survey will be carried out by DSPP with WHS assistance. Some tentative initial findings by WHS are described in this paper.

(b) Identification of health services not presently offered or proposed by the GOH, PVO's, or private sector.

... An inventory of PVO Services and facilities is planned for the Fall, 1977.

(c) Identification of ways to strengthen AID, PVO, and private health and nutrition inputs, as well as new opportunities in this field.

... See item (d) below.

(d) Evaluation of services provided by private and PVO sources, and consideration of incorporating these services into the DSPP where justified due to inadequate quality of services or financial support.

... The ability of DSPP (BHP/E) to identify needed health and nutrition inputs (whether supplied by AID, PVO, or other) and evaluate the amount and quality of services provided by non-DSPP sources will be developed as part of the overall strengthening of DSPP's planning and evaluation capacity with WHS assistance. The question of whether to absorb the service responsibilities of any particular non-DSPP offeror must await the outcome of DSPP's planning process for the model RHDS.

(e) Projection of GOH and external resources available to the health sector; and identification of critical resource requirements.

... The DSPP and WHS team have as an immediate priority the completion of an initial estimate of the gap between GOH health sector requirements and resources to serve as a departure point for planning purposes. This estimate will of course be refined as the planning process produces a model RHDS. Although emphasis will be on making RHDS services as low-cost as possible, a substantial gap is expected between the recurring cost of extending basic health services to the majority of the rural population and GOH resources to meet that cost. See Section I-D, Issues.

(f) Expanded research into the basic causes of disease in Haiti.

... Such research will be undertaken by the School of Medicine's Department of Community Medicine; and is already underway in the Petit-Goave rural health test project.

A revised grant PP and loan/grant PRP were reviewed by AID/Washington on January 16, 1977. This was followed by:

(C) State 019555 - 1/27/76 - "Strengthening Health Services"

USAID was asked to revise PRP estimates for technical assistance and training in order to cover the studies listed in State 298278, as well as present a time-phased SNEM workplan, and objectives and benchmarks for evaluating the SNEM bridge grant.

... The PRP revision had already been completed when this cable was received. AID/Washington changed its instructions accordingly in the cable which followed:

(D) State 038022 - 2/10/76 - "Strengthening of Health Services".

AID/Washington approved the bridge grant PP, but required that the Project Agreement contain a time-phased SNEM workplan (as requested in State 275799) including a schedule for major events and their relationship to projected outputs (e.g. strengthening SNEM's epidemiological capability, achieving adequate coverage of malaria areas, integration of SNEM into the DSPP). This plan was to have PAHO's concurrence and provide AID the means to determine whether events critical to termination of bridge financing were occuring as planed.

... SNEM's implementation plan is described under the discussion of State 275799.

The DAEC reviewed USAID's PRP for an FY 1978 Integrated Rural Health Delivery System (RHDS) loan and grant project on October 21, 1976. The results are set forth here, since USAID feels the FY 78 project should be discussed and certain decisions taken during review of this PP (Section I-D, Issues):

(E) State 299233 - 12/9/76 - "RHDS PRP - DAEC Review"

This cable approved intensive review, but requested an Interim Report prior to December 31, 1977, based on the FY 78 project's close relationship to Strengthening Health Services II. The Interim Report was to contain;

(1) An outline (based on analysis to be performed in FY 77) of the model RHDS to be replicated in the FY 78 project.

... The FY 77 analysis was to have been performed by DSPP with WHS assistance. However, the team's arrival was delayed almost two years beyond original expectations. Since the WHS Chief of Party did not arrive until late January, 1977, and the rest of the WHS team cannot be on-board until the Summer-Fall, 1977 period, the sort of outline

desired by AID/Washington cannot be provided within the December 31, 1977, time frame without attempting an undesirable (in fact, impossible) compression of the schedule for organizing DSPP's planning effort.

(2) An analysis of the feasibility of reducing malaria sufficiently to allow integration of the malaria control program into the RHDS.

... SNEM's 5-year Plan of Operations calls for reducing malaria incidence to 500 cases/million by 1982. This is assumed to be the level of incidence at which merger into the RHDS would be technically feasible. SNEM's ability to reach this reduced level of incidence will be determined by many factors, e.g. ability to overcome vector resistance in some areas. This, in turn, depends upon the results of experimentation. Thus, it would be premature to attempt to guess what level of incidence will prevail at the end of 5 years. PAHO support for SNEM's research and training activities is critical to achieving the hoped-for reduction.

(3) An analysis of the feasibility of developing the necessary DSPP institutional capacity to implement the RHDS on the schedule proposed.

... DSPP's ability to, and schedule for institutional strengthening (both in planning and administration) is described in greater detail later in this Project Paper. However, the question of timing for project development is a valid one.

(4) An explanation of how FAA Section 611-a (required engineering and technical analyses) would be carried out if it was determined that the RHDS should include components such as potable water supply and rural sanitation.

... USAID believes that activities such as potable water and rural sanitation were ruled out of the FY 78 RHDS project design by an AID/W decision that such activities were already covered under other AID projects (notably SDA), or by other donors such as the World Bank.

(5) An assessement of recurring cost of the RHDS to the GOH including the effect of this and other loan-funded projects on Haiti's debt burden, and a policy discussion of possible sources for continued support of the RHDS (e.g. service fees, reallocation within the GOH budget).

See Section I-D, Issues, as well as the discussion of State 298278 above. The conversion of the Haiti economic assistance program to all grant, would appear to render moot the question of AID project impact on the GOH debt burden.

(6) An estimate of USAID's direct-hire and contract needs to develop and monitor increased investments in the sector.

... See Section IV, Mission Monitoring. Contract needs for long-term technical assistance are supplied through the WHS team through January, 1979,. Although developments by that time may indicate the need for a different mix of contract support, USAID is assuming essentially a straight-line for long-term technical assistance to the end of the project. Most short-term technical assistance will be provided (as the specific need is identified in the DSPP planning process) under the long-term contract.

D. Issues

1. Period of Obligation and Disbursement

The project is to extend over a 5-year period. The Foreign Assistance Act (Section 110-b) permits capital grant projects a disbursement period of no more than 36 months without further justification to Congress. (Such a justification was made for Haiti's recent Highway Maintenance II project). Obligation in FY 77 of $7,100 million and a planned obligation in FY 78 of $425,000 will provide 5 year support to SNEM to control malaria and 2 years support to the DSP/P to strengthen central planning and administration.

2) Development of Follow - On Project & Related Documentation

When AID/Washington reviewed USAID's PRP for an FY 1978 integrated rural health delivery system (RHDS) project in October, 1976, signature of a contract for long-term technical assistance to the DSPP was already delayed beyond original expectations by almost 2 years. The Westinghouse Health Systems (WHS) Chief of Party did not arrive in Port-au-Prince until late January, 1977, followed by a few team members in March who returned to the U.S. at the end of April.

The creation of the DSPP's central planning unit, the Bureau of Health Planning and Evaluation (BHP/E), was also delayed until late February of this year, to coincide with the arrival of the WHS technical advisors.

3) Recurring Costs and Future Financial Commitments

It is the policy of the GOH to provide free health services to the mass of rural and urban poor. However, taking into consideration the government's limited resources to meet such a commitment, the DSPP plans to give high priority to the study of means by which both community and the family can contribute to the support of the health services they are to receive. The experience in payment for services

at Des-Chapelles and La Gonave was reviewed at the District Health Officers recent semi-annual meeting, and is being further studied by the DSPP. As the design of the model for rural health services is developed this problem will be further addressed.

Nevertheless, AID must face the facts that, a) if substantive improvement is to be made in the health status of the rural poor in Haiti, a long term commitment will be necessary on the part of the donor community both in technical assistance and budget support; and b) such a commitment seems clearly called for in the mandate resulting from former Secretary Kissinger's last UNCTAD address. Although it is highly undesireable to try to "second-guess" the planners at this early stage, if one took (as a rough order of magnitude) a goal of providing 70% of rural residents, or 2.8 million people, with $1.50 per capita in health services annually, the recurring cost to the GOH (in today's prices) would be about $3.2 million; a sum for which no funding is available, except from external donors. Obviously, it is unlikely that recipients of these services could do much to defray this expense. Therefore, USAID recommends the Agency address the limits it may wish to place on the commitment to Haiti's health sector, as well as future expectations of the GOH and other donors, for the guidance of the DSPP in designing its integrated rural health delivery system.

E. Project Committee:

USAID/PHO, Dr. Charles Weldon
USAID/PHO, Ms. Linda Morse
USAID/CAP, Ms. Ann McDonald
USAID/CAP, Mr. Frank Bettucci
USAID/PRM, Mr. John Craig
USAID/CONT, Mr. A. Hulliung
USAID/ENGR, Mr. R. Douglass
GC/LA, Mr. Tom Geiger

DSPP, Dr. Willy Verrier, Sec. of State for Public Health & Populati
DSPP, Dr. Gaston Deslouches, Director General
DSPP, Dr. Evariste Midy, Director, Bureau of Planning

Westinghouse Health Systems, Dr. Donald Freedman, Chief of Party
" " " Nicholas Fusco
" " " Sharon Russell
" " " Carlos Gomez

SNEM, Dr. Charles Dambreville, co-director
" Mr. Jean Richardot, contract advisor
" Dr. Vladimir Rathauser, head of PAHO team in Haiti
" Dr. David Bonnet, TDY

Other advisory services/inputs provided by:

Dr. Gene Boostrum, TDY
Dr. Frank Beckles, TDY

II. PROJECT BACKGROUND AND DESCRIPTION

A BACKGROUND

1. SECTOR PROBLEMS AND CONSTRAINTS.

Poor health status in Haiti is evidenced by the high rates of mortality (Table II-A) and morbidity. Communicable diseases compounded by malnutrition and under-nutrition are the principal factors influencing these rates.

TABLE II-A

SUMMARY STATISTICAL DATA: Haiti*

Total Population	4,668,162
Rural Population	3,589,022 (77% of total)
Urban Population	1,079,140 (23% of total)
Population-Density/Arable Land	395 persons/km^2
Crude Death Rate	14.5/000
Crude Birth Rate	36.8/000
Infant Mortality Rate (0-1 yr)	136.4/000
Mortality Rate** (1-4 yr)	45/000
Maternal Mortality Rate***	13.7/000
Average life expectancy at Birth	52.2 yr.

Nutrition

Malnutrition constitutes perhaps the major health problem in Haiti. Between 20-25% of Haitian children under five years of age suffer from second and third degree malnutrition (Grades II and III according to the Gomez classification of weight for age). In some parts of Haiti, the prevalence of severe protein/calorie malnutrition has been estimated to be as high as 10-15% of children under five years of age. In addition, more than 60% of the child population is judged to be underweight (Grade I malnutrition on the Gomez scale). Malnutrition is the primary or secondary cause of most infant deaths and approximately 60% of all reported deaths are contributed by children under five years of age. The synergistic relationship between nutritional deficiency and communicable disease also accounts for the high morbidity rates in the under-five population.

.....

* From Haitian Institute of Statistics, 1976

** From Haiti Health Sector Assessment, 1975

*** From Division of Family Hygiène, DSPP, 1976

Best estimates of overall food availability in Haiti (based on food consumption data) suggest a daily per capita deficit in the range of 400-800 calories. Hospital cases of adult kwashiorkor, and isolated clinical cases identified in nutrition centers suggest the possibility of a protein deficiency problem in the adult population. Vitamin A deficiency, goiter (iodine deficiency), aribofalvinosis (riboflavin-Vitamin B^{12}, and/or folic acid) are also serious problems in specific regions and population sub-groups. While no regional data or specific nutritional status by age group data currently exist, three population sub-groups (in addition to children under five) may be identified as high-risk groups: a) pregnant women, b) lactating women, and c) recently arrived rural poor in urban areas.

Communicable Diseases

Malaria

While malaria is no longer a major cause of death, morbidity rates continue to be high. Malaria control activities have been undertaken semi-continuously in Haiti since 1958 (for full chronology, see Health Sector Assessment, April 1975). Since that time, the number of positive cases and the slide positivity rate have shown considerable variation (.2% in 1968 to 8.2% in 1972) relating to periods of hurricane and flooding.

Preliminary 1976 data (9 months) indicate an improvement in both number of positive cases and slide positivity rate from 1975.

TABLE II-8

MALARIA INCIDENCE*

	Jan-June 1975	July-Sept 1975	Jan-June 1976	July-Sept.1976
No. of Cases	15,020	3,304	8,127	2,933
Slide Positivity	8,33%	4.3%	3.75%	4.05%
Slides Examined	180,123	75,699	216,238	72,251

It remains unclear, however, what may specifically account for the decrease, and whether such a decline will be maintained over time.

.....

* From SNEM's Five Year (1978 - 1982) Plan of Operations issued 2/77.

Tuberculosis

Tuberculosis is an important cause of mortality and morbidity in persons of all ages. GOH and World Health Organization estimates range from 1.8 to 3% of the population with tuberculosis. Recent figures indicate that 20% of the population under 15 have positive tuberculosis reactions. Overall TB mortality runs at about 82/100,000.

Tetanus

Tetanus neonatorum may still be considered an important cause of infant mortality in Haiti. Data from the Schweitzer Hospital indicate that in the period from 1956-1960, 14% of live births died from tetanus. These data are 20 years old and date from a time when the national infant mortality rate was much higher (from all causes) than at present.

Gastro-Enteritis/Infant Diarrheas/Intestinal Parasitism and Typhoid

This category of water and food related illnesses, again based on reported cases (hospital records), constitutes a major cause of mortality and morbidity in the under-five population, and accounts for much of the morbidity in the population at large. According to the 1975 GOH "Plan de Santé" enteric diseases account for 3.5% of reported deaths in hospitals with 86% of these deaths among children under five. Deaths from typhoid fever account for 1% of all hospital deaths. The estimated incidence of this category of illness is 175/000,000 with children under five accounting for 74% of this figure. Enteric diseases account for approximately 15% of all hospital admissions. The incidence of intestinal parasites is estimated to be 222/000,000. It is noted in the "Plan de Santé" that these figures are derived from hospital reports, and therefore represent a gross underestimation of actual incidence and prevalence of these diseases throughout the country.

Respiratory Illness

Influenza and bronchopneumonia contribute extensively to the ill health of the population. No reliable data exist but hospital records in governmental institutions show a 45-50% death rate for those admitted with pneumonia. This reflects perhaps a reluctance to seek care until advanced stages of the disease.

The diseases enumerated above are currently considered to be the most serious health problems in Haiti based on either observation or case records. In Haiti where the majority of the population does not have access to modern health services, and existing case reporting is sporadic and unreliable, the existing epidemiological information is not sufficient to make sound technical decisions as to the priority of individual disease entities. It is assumed, however, that with the virtual absence of health services in the rural areas, rates of morbidity and mortality for most diseases would be considerably higher than the respective urban rates. A baseline health survey will be designed under the Strengthening Health Services II Project by the DSPP to provide an initial data base from which epidemiological priorities may be established.

CONSTRAINTS TO THE DEVELOPMENT OF THE HEALTH SECTOR

In general, constraints to development in the health sector may be grouped into four categories: 1) local availability of essential inputs, including budgetary inputs and personnel; 2) adequacy of family income; 3) sociocultural factors; and 4) nutrition-infection interaction.* In Haiti, the overriding constraints to the development of the health sector are the lack of available and appropriate resources including capital and human resources and the severity of the nutrition problem in the rural areas. (Constraints No.1 and No.4 above).

Availability of Essential Inputs:

Budgetary

Approximately 14% of Haiti's national budgetary resources are currently allocated to the Health-Population-Nutrition sector. However, with an operational allocation of little more than 25 cents per capita to cover medical supplies, drugs, transportation and other components of a functioning health delivery system, the real worth of the investment is questionable, at least as far as the rural areas are concerned. There are few ministry vehicles, no means of regular communication between Health posts, and no unified supply system. With technical assistance from WHS, a further analysis of the GOH operating and development budgets for health will be undertaken. In addition, the current format will be modified so that the budget may be used as a tool for planning and administration.

*"Equity and Income Effects of Nutrition and Health Care" by Olan T. Oftedal and F. James Levinson, August 1974.

The present facility-based public and private health care delivery system in Haiti is estimated to cover between 30 and 40 percent of the urban population (Supplementary Health Sector Assessment, September, 1976). Approximately 300 health facilities currently exist in Haiti of which 40% are operated by Private Voluntary Organizations.

Health Personnel

As has been noted in previous descriptions of the health sector in Haiti, no current, precise information concerning each type of health worker is available. Information concerning the total national stock of health personnel in governmental, private Haitian, and PVO subsectors will be provided in surveys undertaken as part of the planning exercise under the Strengthening Health Services II project. Estimates for professional personnel are as follows: Physicians (MD's)-total 428 (207 fully qualified; 221 residents); Dentists (DD's)-total 57 (33 fully qualified; 24 residents; Professional nurses total - 484 (273 diplomates; 211 in training). Most professional health workers are concentrated in the Port-au-Prince area and serve about 13% of the population. Non-professional or para-professional categories of personnel include: auxiliary nutritionists - 240. These represent highly tentative estimates from a preliminary survey by WHS (See Annex II - "Preliminary Manpower Estimates" by WHS). Estimates are not yet available for agents sanitaires, traditional midwives trained for improved performance of usual functions, or community level health workers trained in bi-or multi-lateral assistance programs, etc.

It is inappropriate to use these figures at this time to measure demand for health practitioners in Haiti in terms of standard ratios to population or even demand as estimated by staffing patterns of existing health facilities. A detailed manpower analysis including an inventory of personnel will be conducted in the course of DSSPP's planning activities, and aimed particularly at identifying manpower needs for an expanded rural health delivery system. While the output (quantity trained) of existing health training institutions appears adequate for the present system. The relevance of the training of all levels of health workers is very much open to question, and will be examined as part of DSPP's planning process. The clinical skills of health workers may be adequate for the existing curative focus of the health system.

However, the present lack of a preventive, public health, community-based focus among health personnel constitutes a constraint to the development of a rural health delivery system. DSPP recognition of the need for reorientation of training programs is evident as exemplified by the Community Medicine Department within the School of Medicine. Related to the issue of appropriate training is the problem of the lack of planning and administrative capability in the Ministry of Health system. The lack of training of Ministry personnel, the lack of a data base, and an inadequate salary structure within the Ministry make effective program planning, implementation, and evaluation virtually impossible.

Malnutrition and Infection

The policy implication of the so-called "synergistic relationship" between malnutrition and infection is that the benefits of medical services will be diminished to an unknown extent where malnutrition and poor sanitation are widespread. The constraints to improved nutritional status are numerous and reflect the multi-casual nature of the malnutrition problem. In Haiti, sheer poverty limits the amount of disposable income available to spend on food. Food availability itself is chronically uncertain with shortages becoming more and more common for climatic and other reasons. Ignorance of basic nutrition knowledge prevents best utilization of existing resources. Finally, health and personal hygiène practices coupled with the virtual absence in the rural areas of potable water and sanitary facilities, perpetuate the malnutrition-infection cycle. The constraints to nutrition and health improvement are multiple, inter-related, and point to the need to address the nutrition-health problems in Haiti on a multi-sectoral front.

Income and Socio-Cultural Factors

Extremely low per capita income and socio-cultural factors are also constraints to the utilization of health services, and therefore, become design issues for development of the proposed rural health delivery system. The issue of payment for service is discussed in part I D. Issues, of this paper of this document and Socio-cultural factors related to utilization are addressed in the Social Analysis (Section III-A of this PP).

2. GOH & OTHER DONOR ACTIVITIES

All foreign assistance is coordinated by the DSPP office of Contrôle de l'Assistance Extérieure. It is anticipated that a fully staffed and operational Bureau of Planning will also play a role in the coordination function.

The Inter-American Development Bank (IDB) is currently the largest external donor to Haiti's health sector. A $6.3 million dollar loan was signed with the GOH in 1975, for the construction and renovation of facilities in two health districts, Cap-Haitien and Les Cayes. The regionalization plan of the GOH is being implemented by the DSPP initially in these two areas, with technical assistance from the Pan-American Health Organization (PAHO). PAHO is assisting in establishing the complete administrative structure for health services in the two regions as well as serving as IDB's implementing agency for facilities construction.

PAHO is involved in latrine construction and improving water supply systems in both rural and urban areas. In manpower development, efforts are being made to improve the curriculum of the School of Medicine, (upgrading the examination system, and refurbishing physical facilities). Teaching in nursing schools, sanitary engineer education, and training of auxiliary nurses are also being improved.

PAHO also provides the major technical input to the SNEM malaria control program. SNEM is a vertical program also funded by AID. It commenced operations in 1961 to eradicate malaria from Haiti through the use of intra-domicilary spraying and appeared to have achieved its goal in 1968 when the slide posivity rate dropped to .2%. However, the rate went no lower, and the extensive network of SNEM workers was utilized to introduce anti-malarial chemotherapy nation wide. This did not eliminate malaria and the slide positivity rate increased, due to financial and natural factors (hurricanes and floods). Malaria morbidity rates remain high.

AID is the largest bilateral contributor in health development. Malaria control is the oldest program with which there has been involvement. AID has invested roughly $20 million dollars in the program over 14 years.

The Haitian-American Community Help Organization (HACHO) has among its projects operation of nutrition centers, Maternal/ Child Health (MCH) services, and water systems projects. AID funding for HACHO to date has totaled $2.5 million, although it is not possible to determine exactly what proportion of these funds was targeted for health services. HACHO has assisted some communities in installing potable water and sanitation facilities. The World Bank is conducting feasibility studies to refurbish water systems in 10 "urban" areas. No nation-wide program for development of potable water or sanitary facilities yet exists. Private Voluntary Organizations (PVO) are an important source of material resources and technical assistance in the form of medical care, public health education and community development. This is especially true in the rural areas where it is extremely difficult to attract professional medical personnel. Estimates by the GOH in 1975 show that 33% of all hospitals; 65% of health center hospitals, and 40% of dispensaries in the country are operated by PVOs. Of total medical establishments in the country, PVOs operate almost 40%. Organizations with religious affiliations account for the majority of these, although CARE, Ford Foundation, Direct Relief Foundation, Focus, Inc., and the International Eye Foundation all provide important curative and preventive services.

The major effort in nutrition to date has been through the GOH Bureau of Nutrition which has concentrated on eradication of kwashiorkor and marasmus in the under-five population, and education of their mothers through participation in the rehabilitation of their own children. The mothercraft center approach to have been successful in reducing the level of malnutrition in the siblings of recuperated children. Through operation of these centers, the Bureau of Nutrition has gained experience in data collection, management, field supervision, and training; and has accrued a small but technically competent staff and a cadre of trained field workers. Distribution of Vitamin A tablets in nutrition centers and health clinics (an AFOB project funded by AID) is another activity in which the Bureau is involved.

Under the supervision of the two agronomists on the Bureau Staff, a pilot project is being carried out in nutrition education of fathers to affect agricultural production. However, the impact of these activities on the nutritional problems in the country has been (and is likely to remain) extremely limited relative to the magnitude and diversity of the problems.

In addition to the activities of the Bureau of Nutrition, isolated nutrition projects and programs are being undertaken in Haiti. The private voluntary agencies Care, Catholic Relief Service, and Church World Service (Service Chrêtien d'Haiti) are the sole distributors of PL 480 Title II foodstuffs in schools, food-for-work projects, and MCH centers. Projections for 1978 indicate that approximately 50,000 beneficiaries or 7% of the total population will receive Title II foodstuffs with more than 50% being distributed in school-feeding programs. CARE is just completing a three-year project which provided nutrition education to 240 primary school teachers in 82 schools coupled with school feeding. The establishment of 65 "home economics" centers, to be coordinated with a World Bank project for the construction of 65 new rural schools, is currently being planned by CARE. CWS/SCH supervises approximately five under-five clinics which serve a community of approximately 90,000 people residing in the area. Integrated rural health/nutrition delivery projects are underway in the Petit-Goâve area under the supervision of the DSSP's Division of Family Hygiène. PAHO recently completed a 9-month advanced training course for auxiliary nutrition supervisors whose function will be to supervise nutrition activities at the district level.

USAID/H is planning to introduce a FY 79 project intended to expand the scope of nutrition activities in Haiti, foster intersectoral coordination and cooperation at the ministerial and operational levels, and strengthen the administrative and technical capability of the Bureau of Nutrition. IDB activity in nutrition is also expected to expand in 1979.

Clearly, population and family planning are central considerations in dealing with Haiti's health problems. AID's analysis of the population situation and GOH response to it is contained in the DAP revision submitted in June, 1977. It is expected that family planning services will be part of the repertoire of services offered by the basic health worker (agent sanitaire) under a nation-wide rural health delivery system.

GOH POLICY

The fact that approximately 14% of national budgetary resources has been allocated to the population, health, and nutrition sector indicates a significant commitment by the GOH. However, in absolute terms, this amounts to only approximately U.S. $1.20 per capita per year. Since the majority of the sector budget covers salary rather than operating costs, the effective per capita allocation in the urban areas is only about $0.25 per year. In the rural areas (i.e. for the majority of the population), it would be far less.

Until recently, publicly supported health services in Haiti were limited to relatively high cost, clinically oriented, curative medicine primarily accessible by the urban population. In 1971, the Ministry of Health (DSPP) initiated an attempt to extend this same type of service to the rural areas through a program of regionalization (i.e. decentralization) which was to rely on a network of dispensaries, health centers and regional hospitals. This approach, while adopted in principle, was not at that time developed.

In the past two years, the DSSP has shown increasing interest in the possibility of providing rural health services through a rural delivery system and basic community level health worker. In fact, such a system would be based on "regionalizing services" but the content and cost of the services delivered would be modified from the original GOH concept to more effectively meet health needs in the rural areas. The GOH has formally requested AID assistance in both planning and implementing of an integrated rural health delivery system (Annex I). The strategy outlined below describes AID's response to that request.

AID STRATEGY

AID's objective is to provide basic preventive and curative services to the rural poor through the use of an integrated Rural Health Delivery System (RHDS). The strategy to realize this objective incorporates 3 elements. Work will continue at the central level with the DSPP, strengthening its planning and administrative capability.

In addition, resources will be provided to design the rural health delivery system which ultimately will be expanded to provide health coverage to 70% of the rural population.

This strategy will be carried out under three consecutive AID projects. Strengthening Health Services I (521-11-510-070) provides funds for the administration of SNEM's malaria control program and for the improvement of the health planning and administrative capability of the DSPP. This project funds a Westinghouse Health Systems (WHS) technical services contract to 1) improve the DSPP's personnel system; 2) establish DSPP communications, financial, and logistical links with rural health posts; and 3) create a more reliable and effective information and data collection system in the DSPP.

The FY 1977 project, Strengthening Health Services II (521-0086) provides funding for a) the continued operations of the SNEM malaria control program, while the incidence of malaria is reduced sufficiently to incorporate the control program into the RHDS, and while the phaseover to complete GOH financing for this activity is accomplished; and b) support of activities determined in the DSPP - WHS planning exercise to be necessary for the strengthening of the DSPP and design of the RHDS. These activities fall into three categories: 1) administrative strengthening at the central level, including manpower development and training, technical equipment to support an information system, operational costs of the Bureau of Planning; 2) the design of a functioning logistics system; and 3) the design of a model rural health delivery system.

In FY 1978 a third project, Rural Health Delivery System (521-0091), will provide the necessary assistance to implement the model rural health delivery system on a national scale.

B. DETAILED PROJECT DESCRIPTION

1. GOAL & PURPOSE.

The goal of this project is to improve the quality of life for the rural people of Haiti by reducing health sector constraints to development. This is also the goal of the current Strengthening Health Services I and proposed FY 1978 RHDS projects, since all three projects are seen as being on a time-phased continuum leading to extension of GOH health services to the majority of Haiti's rural residents by 1982.

In Haiti, a high rate of infant and child mortality appears to be a factor which may encourage (give social approval to) a high birth rate. Multiple births, in turn, cause females to produce infants too weak to resist the onslaught of malnutrition and poor environmental conditions leading to illness. As seen in the preceding analysis of health sector problems and constraints, the likelihood of an individual suffering from recurring, if not, simultaneous incapacitating illnesses is extremely high throughout life. Incapacitating illness must, in turn, reduce the potential production of the individual including his ability to produce sustenance and a healthy environment for himself and his dependents. Therefore, although no official ratios or formulae can be offered, it is assumed that chronic and endemic poor health among a majority of Haiti's population is a key constraint to national development. Further, it is assumed that actual availability of health services at the local level has, until now, constituted the major constraint to improving rural health; and that, therefore, the effectiveness of such services will not be outweighed by outside factors which effect health status (e.g. malnutrition or poor sanitation).

Achievement of the project goal will be measured by decreased ratios of morbidity and mortality in the rural areas served. The exact degree of reduction targeted will depend to a large extent on the planning process to be undertaken by the central Health Ministry (DSPP) under this project. This process should incorporate collection and analysis of sufficient data on rural Haiti's health needs to design a rural health delivery system aimed at attacking the apparent health priorities through the greatest number of rural inhabitants technically and financially feasible. With a rural health delivery model in mind, the DSPP should be able to postulate the ranges of reduced morbidity and mortality expected by 1982 and beyond.

The purpose of this project is to establish within the DSPP the ability to support the planning administrative and operational tasks for expanding preventive and curative health services in Haiti; and concurrently, to reduce the incidence of malaria to allow integration of the malaria control program into the rural health delivery system. The first assumption is that, in order to extend health services to the rural areas, the central DSPP must be strengthened in the areas of planning, information systems, and general administration as an essential first step. (This strengthening will be accomplished in the context of planning the actual rural health delivery system to be replicated nation-wide through the proposed FY 1978 project). Secondly, it is assumed that the incidence of malaria must be reduced considerably, since the resources required to control the present relatively high incidence of malaria would not be compatible with a low-cost rural health delivery system. It is only when malaria

reaches a "containment" level (estimated to be about 500 cases per million inhabitants per year) that malaria control activities can be handled as part of a package of health services offered at the local level to rural residents. Finally, since current high incidence makes it advisable to continue support (albeit decreasing) for a separate malaria control program, it is assumed that PAHO will continue technical advisory support which will help improve SNEM's capabilities to reduce and control malaria.

2. PROJECT COMPONENTS DESCRIPTION

This project has two related but distinct aspects. First, it provides steadily decreasing support to the malaria control program of SNEM for calendar years 1978-1982. Second, assistance will be provided at the central level of the DSPP over the period CY 1978-1979 to enable the DSPP, (a) to improve its administrative and planning capability; (b) to finalize a design for a rural health delivery service model to be extended nation-wide. A project planned for FY 1978 will assist the GOH in replicating this model on a national scale.

The FY 1977 project provides up to $7.5 million in U.S. grant funding for both project components with approximately $6.0 million to be utilized by SNEM, and $1.5 million by the DSPP. This will allow GOH decision-makers to plan and implement a health strategy over the next two years which will benefit the maximum number of poor and deprived rural residents, for the minimum amount of money consonant with technical feasibility. This will be done through identification of essential services at each level of the health hierarchy (clinics, dispensaries, hospitals, etc.), and analysis of the most cost effective means of delivering those services. The system is expected to rely heavily on local health workers (the agent sanitaire) to provide simple preventive, curative, and referral services directly to the population.

The major activities to be supported under this project are:

SNEM

-- The yearly operational costs of SNEM (on a decreasing basis). By the end of the project, the GOH will have sole financial responsibility for the SNEM program;

-- The services of a senior management and administrative advisor;

-- Expansion and improvement of sector control capabilities,

emphasizing source reduction and water management, (e.g. drainage, fill, and cover operations).

PAHO will provide technical assistance to SNEM, and will finance four person-years of participant training for one entomologist and one epidemiologist at the Master's Degree level.

DSPP

-- Long and short-term technical assistance to improve the administrative and planning capability of the DSPP, including the carrying out of necessary organizational and management reforms. Such technical assistance is to be provided by contract with Westinghouse Health Systems (WHS) through January 1979, (financed under project 521-11-510-070), and by a follow-on contract financed under this project for two additional years;

-- Budget support for personnel and other operating costs of the DSPP's Bureau of Planning, Bureau of Administration, and Statistical Service;

-- Technical assistance for the development of the supply system; training of supply personnel; and provision of certain operational costs;

-- provision of funding to continue the Petit-Goave health project as a field laboratory for the DSPP, including funds for personnel, operating costs, and training;

-- Field training for students in the Department of Community Medicine of the School of Medicine;

-- A technology exchange program between the Department of Community Medicine and a U.S. public health educational institution to be identified;

-- Finally, funds will be provided under the project for technical assistance in periodic evaluation of progress.

3. PLAN FOR APPLICATION OF PROJECTS INPUTS

The major inputs to the project are technical assistance, training, and budget support including operating and personnel costs.

Technical assistance to the DSPP will be supplied primarily through the Westinghouse Health Systems (WHS), contract. This contract was funded in FY 75, began in January of 1977 and runs for 2 years. A technical assistance contract will be continued for an additional 2 years beginning in January, 1979 (under the Strengthening Health Services II project). Under the WHS contract, technical assistance will be provided for the development of the transport and supply systems starting in Year One of the FY 77 project, and will continue throughout the life of the project. WHS will act in an advisory capacity and assist the DSPP in deciding the other types and levels of technical assistance needed under this project and the follow-on RHDS project.

PAHO, as technical advisor for the IDB health project, is also furnishing technical assistance to the DSPP on administrative matters involved in "regionalization". The exact division of effort and responsibility between WHS and PAHO is now being discussed with the DSPP. As a consequence, technical assistance is included to augment the WHS contract for Year One. Precise subsequent levels will be determined as a result of the decisions made on PAHO's potential inputs to the FY 77 project within the DSPP.

4. ROLE OF OTHER ORGANIZATIONS

The Pan American Health Organization (PAHO) plays important direct and indirect roles in this project. First, PAHO is responsible for providing all technical guidance to SNEM. An important assumption underlying this project is that PAHO's support to SNEM will continue, and that PAHO will finance 4 person-years of advanced (M.S. - level) training for two members of the SNEM staff in order to help improve SNEM's capabilities to analyze the causes of malaria and apply appropriate methodology to reduce it.

PAHO's work with the central DSPP is also of significance to this project. PAHO is providing the technical assistance which will enable the DSPP to carry out the "regionalization" (administrative decentralization) called for in the 1975 National Health Plan. To date, the regionalization process has begun in both a northern (Cap Haitien) and southern (Cayes) health district. Administrative responsibility is being transferred to these two districts. The next step will be to bring all health services in these districts

under the purview of the respective district chiefs; and to install a system under which planning for health needs commences at the lowest field levels and moves up the administrative chain to the district chief who will obtain those needs from the central DSPP. In reality, this "bottom-up" type of planning has yet to be installed.

The Cap Haitien and Cayes districts were selected to lead off the regionalization, in part, because their existing human and infrastructure resources are at a higher level than the other districts, making implementation and testing easier. What is accomplished in these districts will undoubtedly take considerably longer in the remaining health districts. However, in the long-run, it would appear more desirable for the rural health delivery system to be administered by, and most responsive to the needs of, the health districts, rather than the central Ministry. It is also self-evident that the quality of district-level administration will greatly affect the quality of the RHDS (i.e. ability to deliver services) in any given region. Therefore, the efforts of the Westinghouse Health Systems (WHS) contract team under this project will be closely coordinated with PAHO's assistance to the DSPP's regionalization program. The working out of that coordination has a high priority on WHS' agenda of tasks to be performed in the initial stages of the project.

The IDB-financed project to construct over 60 new health facilities will not have a direct bearing on this project, but will create infrastructure useful for the rural health delivery system. However, AID's analysis of the health sector does not indicate that construction of physical facilities is of prime importance in meeting the most urgent health needs of the rural areas. AID is looking to the World Bank - PAHO effort to strengthen the institutional capabilities of the rural water service in order to begin bringing improved water supplies to rural areas. Once the rural water authority has been sufficiently strengthened, it may be possible to incorporate some of its services in the established RHDS.

The DSPP will have as a major objective under this project the inventorying of goods and services supplied to the health sector by external organizations, and determining how these shall be coordinated and incorporated into the RHDS. Thus, commodities such as drugs and vehicles contributed by a variety of external organizations should ultimately be received and utilized in accord with the sector needs as identified by DSPP. Likewise, health services now provided by PVO's should conform to DSPP standards, and eventually supplement government health services in the rural areas.

5. GOH COMMITMENT

The National Health Plan of July, 1975, required the DSPP to bring about a fundamental reorganization aimed at gradual extension of health services to rural Haitians (French text contained at Annex C). Soon thereafter, a law for regionalization of health services was enacted on October 23rd, 1975. It's main objectives are:

(1) To charge the DSPP with setting up the structure and standards for regional public health operations to achieve rapid health improvement throughout the country through a system adapted to the particular demographic, agricultural, economic, and organizational structures of each region;

(2) To define and institutionalize clear lines of authority within the DSPP for planning, evaluation and execution of health programs

(3) To change the DSPP with responsibility for:

a. Formulation, execution, and evaluation of GOH public health programs and national health plans in accordance with Haiti's broader economic and social development objectives;

b. Coordination of the National Health Plan with programs of other GOH Ministries and activities of non-Government agencies working in the health sector;

c. Formulation and enforcement of all rules, regulations, and procedures to be followed by public health entities;

d. Identification and negotiation for new sources of financing to strengthen the DSPP budget; and

e. Administration of health manpower programs

As a result of this legislative authority, DSPP has taken steps to re-group the eleven previous health districts into six; and is in the process (with PAHO technical assistance) of issuing rules and regulations defining the DSPP's organizational structure and operating procedures. The new procedures are being worked out for the regional levels in two test "regionalized" areas (Cap-Haitian and Cayes).

In October, 1976, the GOH (CONADEP) issued the 5-year (1976-1981) Development Plan, Volume II - Sectoral Plans. The section dealing with health set as GOH 5-year objectives, (a) to raise national life expectancy levels to 50 years of age; and (b) assure total health services coverage for all the population. The basic strategy to attain these objectives would be to extend and strengthen the health facilities network within the framework of regionalization of health services. The regionalization concept was described as administratively and operationally "pyramidal". Each region is to be composed of health districts, and will have a regional hospital, district-level hospitals, dispensaries, and local Health Centers (both with and without beds). The administrative structure is to be organized at 3 levels: central, regional, and local.

Six basic health programs were to be carried out in the period of the 5-year Plan:

(1) Regionalization of Health Services

- To install the necessary administrative and operational structures in accordance with the Government's priority on the North and the South;

- To prepare technical personnel (both medical and para-medical);

- To construct and equip medical facilities in the North and South regions.

(2) Maternal-Child Protection & Family Planning

- To lower the maternal, infant, and early childhood mortality rate.

- To integrate maternal/child health services and family planning.

(3) Campaign Against Endemic Diseases

- To progressively reduce the incidence of malaria.
- To extend vaccination programs to the rural areas.

(4) Campaign Against Malnutrition

- To diminish the malnutrition mortality rate among children 5 years of age or under.

(5) Strengthening of Health Services

- To improve technical and administrative capabilities within the health sector.

(6) Medicines & Supplies

- To furnish the best medicines and medical supplies to the people.

TABLE II-C (below) is adapted from CONADEP's 5-year projections for the health sector:

TABLE II-C HEALTH SECTOR INVESTMENTS OVER 5 YEARS ($U.S.000) 1/

	1976 - 1981			1976-1977		1977/78		1978/79		1979/80		1980/81	
	Total	GOH	Donor	GOH	Donor	GOH	Donor	GOH	Donor	GOH	Donor	GOH	Donor
a) Regionalization of Health Services 2/	10,740	1,190	9,550	304	2,165	258	2,214	229	152	200	1,705	200	1,152
b) MCH & Family Planning 3/	8,300	250	8,050	50	2,070	50	2,070	50	2,090	50	910	50	910
c) Endemic Disease Campaign (SNEM) 4/	12,019	5,600	6,419	600	1,372	800	1,486	1,100	1,401	1,400	1,100	1,700	960
d) Malnutrition Campaign 5/	1,698	310	1,388	30	300	70	272	70	272	70	272	70	272
e) Strengthening the Health Sector 6/	6,300	-	6,300	-	1,500	-	700	-	200	-	1,075	-	1,025
f) Medicine & Supplies 7/	10,028	643	9,385	-	-	148	2,540	165	2,115	165	2,115	165	2,615
(Sub-Total without SNEM) 8/		(2,393)		(384)		(526)		(514)		(485)		(485)	
Development Total	49,085	7,993	41,092	984	7,407	1,326	9,282	1,614	9,930	1,885	7,177	2,185	7,294
Total Development & Operating 9/	80,594	39,501	41,092	6,984	7,407	7,686	9,282	7,995	9,930	8,268	7,177	8,568	7,294

1/ From five year National Development Plan - Vol.II (Health Sector), by CONADEP (10/76)

2/ Assumed to incl. IDB project for health facilities construction

3/ Approx. $800,000 additional in salaries incl, in DSPP operating budget

4/ More recent estimates show total SNEM cost decreasing to $2.2million in 1982

5/ Incl. DSPP, Bureau of Nutrition, & DARNDR activities. Does not incl. proposed AID FY 79 project.

6/ Assumed to represent AID's FY 77 Strengthening Health Services II project.

7/ Assumed to represent AID's FY 78 RHDS project, and portion of the FY 77 project.

8/ Represents GOH contributions from National (Fiscal) Budget Resources, since SNEM is not funded from this source.

9/ GOH fiscal budget contributions to development proj. plus contributions from other sources SNEM; plus donor contributions; plus DSPP's annual operating budget starting from a $6.0million base in 1976 & increased by 6% per year for inflation

Table II-D provides a further breakdown of GOH and donor contribution to the sector, showing the degree of increase or decrease in contributions contemplated over the 5-year (1976-1981) period:

TABLE II-D

COMPARATIVE HEALTH SECTOR CONTRIBUTIONS 1976-1981

($U.S.000) 1/

	1976/77 Base		Net Change:1976-1981		Percent Change	
	GOH	DONOR	GOH	DONOR	GOH	DONOR
a) Regionalization of Health Services	304	2,165	- 104	- 1,013	- 34%	- 47%
b) MCH/FAM.Planning	50	2,070	None	- 1,160	None	- 56%
c) Endemic Disease Campaign (SNEM)	600	1,372	- 1,100	- 412	+ 183%	- 30%
d) Malnutrition Campaign	30	300	+ 40	- 28	+ 133%	- 9%
e) Strengthening the Health Sector	-	1,500	None	- 475	None	- 32%
f) Medicine & Supplies 2/	148	2,540	+ 17	+ 75	+ 11%	+ 3%
Development Totals	984		+ 1,201		+ 122%	
Development plus Operations Totals	6,984	7,407	+ 1,584	- 113	+ 23%	- 1.5%

1/ Derived from CONADEP's 10/76 National Development Plan (Health Sector Investments over five years).
2/ GOH & Donor contributions do not actually begin until 1977/78. Net change calculated over 4 years. GOH & Donor totals not counted in 1976/77 base.

The preceding Tables cannot be considered a reliable array of data, since the sources and reliability of figures appearing in CONADEP's Five-Year Health Sector Plan were extremely limited. Although CONADEP's five-year plan is really nothing more than an amalgamation of external donor programs which are now being executed or planned plus what amounts to a "straight-lining" of the GOH contribution. USAID can only speculate as to the reasoning that went into the final figures. Use of these figures here is strictly for broad illustrative purposes. The reader is cautioned against attempting more detailed analysis or extrapolation with them.

As a broad indicator of ranking among sub-projects, the CONADEP plan reveals that GOH statements of priority are unevenly supported with both public and donor funds. For example, malnutrition is identified as perhaps the major contributing factor to the ill health of the Haitian population. However, in terms of financial support, the malnutrition campaign remains at the lower end of the scale of both GOH and donor contributions. (Although AID's proposed FY 79 nutrition project will improve the relative standing of the nutrition category, it will still probably not be funded commensurate with its apparent priority. MCH-Family Planning is also low in the rankings by financial support. However, CONADEP's figures apparently exclude some $800,000 per year devoted to operational support of the Division of Family Hygiene. Inclusion of this amount would place MCH-Family Planning in approximately the second order of priority for GOH funding (after SNEM). Clearly, a major task of the DSPP with WHS assistance, will be to develop a rational basis for identification of priorities in the health sector, and to produce a national plan which reflects (and justifies) these priorities so available funds may be programmed accordingly.

Finally, it should be noted that, in spite of the apparent need for better internal definition of priorities, the GOH is demonstrating a clear priority on the health sector as a whole. Not only does health account for some 14% of the national budget, the GOH contribution to development programs (defined by CONADEP as programs involving external donor assistance) is projected to increase by at least 122% between 1976-1981 The combined contribution to so-called development programs & DSPP operations is expected to increase by a net 23% over the same period.

Finally, Table II-E ranks by funding level the six major development programs identified by CONADEP within the health sector:

RANK ORDER BY FUNDING LEVEL - DEVELOPMENT PROJECTS TABLE II-E 1/

	GOH			DONOR		
	1976/77	1980/81	5-Year Total	1976/77	1980/81	5-Year Total
a) Regionalization of Health Services.	2	2	2	1	2	1
b) MCH & Family Planning 2/	3	5	5	2	5	3
c) Endemic Disease (SNEM)	1	1	1	4	4	4
d) Malnutrition Campaign 3/	4	4	4	5	6	6
e) Strengthening the Health Sector 4/	-	-	-	3	3	5
f) Medicine & Supplies 5/	-	3	3	-	1	2

1/ Taken from [illegible] Health Sector Investments [illegible] National Development Plan.
2/ Does not reflect $800,000 in annual salaries traditionally incl. in DSPP's operating budget.
3/ Does not reflect proposed AID FY 79 Nutrition project.
4/ All GOH contribution the FY77 AID project is for SNEM
5/ Assumed to be proposed FY 78 RHDS project.

6. END OF PROJECT STATUS

At the end of the project malaria will have been reduced to such levels that control measures can be carried out with reduced budgetary inputs, and the GOH will be able to assume financial responsibility for this activity. At the same time the DSPP's administrative and supervisory capacity will have been strengthened to the point where SNEM can be absorbed and integrated into the DSPP, and function as a part of the RHDS. The quantifiable indicators of arriving at this status will be reduction in slide positivity rates, reduction in vector density and an annual incidence of malaria cases of 500 per million people or less.

A strengthened DSPP will be adequately staffed and trained to carry out its planning and administrative functions. The indicators will be the issuance of a national health plan and the planning of a model RHDS which will be replicated during the third phase (i.e., the FY 1978 follow-on project) to provide affordable preventive and curative services to the population with an attendant reduction in morbidity and mortality.

III. Project Analysis

A. Technical Analysis

1. Technical Description of Project

(A) SNEM: The Operational Plan for the next five years (1978-1982) proposes that the following activities be carried out by SNEM in order to reduce the incidence of malaria to approximately 500,000,000:

(1) House Spraying Program

It is proposed to spray the interior of the houses of 341,000 people or approximately one-tenth of the population at risk of infection from malaria. These houses are located in 1276 localities in various areas of SNEM's field zones. This activity will be closely monitored to determine the effectiveness of DDT spraying in relation to reducing the incidence of malaria. Spraying effectiveness depends upon the continued susceptibility of the vector to the insecticide. Tests of susceptibility, interior house capture of mosquito, use of exit traps, etc. should be carried out and the results carefully analyzed. A pilot project using an alternative insecticide (Malathion) will be considered for purposes of establishing a comparative analysis.

The use of DDT in the Haiti malaria control program is predicated on its proven effectiveness and safety in eliminating malaria from other Caribbean islands. The effect on the environment is minimal as the insecticide is applied only to the interior walls and eaves of houses, and only twice a year in selected areas of hyper and meso endemic regions. The alternative to DDT is the more toxic, biodegradeable organophosphate Malathion. This insecticide is less persistant and must be applied 3 or 4 times per year. Special care and safety precautions as recommended by WHO/PAHO are followed.

(2) Drug Distribution

It is proposed to distribute anti-malaria drugs in areas of high transmission, and where the vector has been shown to be resistant to DDT. Projecting on the basis of previous years'experience, anti-malarial drugs will be given to approximately 582,000 people. The drugs will be distributed by more than 6,500 voluntary collaborators to people who have fevers, and are presumed to have malaria due to blood slide inspection. The elimination of malaria by radical treatment

with known safe and effective drugs has a proven beneficial effect on the population, and no adverse effect on the external environment.

(3) Source Reduction

Malaria transmission by the vector Anopheles Albimanns is directly correlated with the densities of this vector mosquito. Action that will permanently reduce the production of mosquitoes will have a pronounced effect upon the incidence of malaria. Larviciding and adulticiding is transitory in nature and must be repeated at frequent intervals. Source reduction by filling, drainage or water management is high in capital investment, but the permanent or semi-permanent nature of this approach essentially amortizes the expense over several years. Therefore in a malaria control program this is the method of choice. SNEM proposes to establish a new operational section under the supervision of an engineer to carry out the augmented source reduction activity.

(4) Vector Control

Due to apparent resistance of the malaria vector to DDT in several sectors of the country, a comprehensive program has been planned in these sectors including:

a. Spatial spraying with DDT
b. Fumigation with biodegradeable Malathion using the SwingFog apparatus.
c. Source reduction by filling, drainage or water management.
d. Placement of larvivorous fish
e. Larviciding with Temophos (Abate) and / or Gasoil.

Since conquering vector resistance is seen as a key to achieving SNEM's goals for reduced malaria incidence, SNEM plans to conduct studies to:

a. Evaluate the efficacy of house spraying,
b. Evaluate the efficacy of larviciding,
c. Determine actual vector densities in selected localities,
d. Detremine vector susceptibility to various insecticides,
e. Correlate mosquito densities with meteorological data, and
f. The Entomology Division will evaluate effectiveness by regular measurements of larval and adult mosquito densities in the in the vicinity of SNEM-sponsored filling, drainage and/or water management programs.

(5) Training

The Plan of Operations contains provision for training malariologists, engineers and entomologists. This training both academic training and short term, and will be supported by PAHO. The training proposals will be

carefully reviewed as they are submitted to insure they fit the needs of the program. Training is not anticipated for administrative personnel. However, AID (being responsible for administrative advice to SNEM) proposes to extend the contract of the administrative advisor to SNEM.

(6) Health Education

There is one health educator in each of the three zones. Their primary responsibility has been the instruction of more than 6700 voluntary collaborators recruited to work in the malaria control program.

SNEM's Plan of Operations proposes to strengthen health education activity. A section will be created at headquarters under a senior health educator who will be responsible for in-service training of SNEM personnel, use of mass media, personal contacts, and posters to capture and maintain the interest of the public with understanding and active support for the programs of SNEM.

SNEM has a reasonably good track record over the last 14 years of AID's involvement with the organization. It's effectiveness (when properly funded & supported) was clearly demonstrated in its having reduced the national slide positivity rate to .2% in 1968. Although it is not clear what precisely caused the return to higher rates of malaria incidence, it was probably a combination of reduced funding and severe natural disasters (hurricanes & flooding). Concerted action over the last two years or so, combined with the strong technical support and advice of resident PAHO experts, have produced what appears to be a declining trend in slide positivity. The five year plan has been reviewed by PAHO and AID technicians who have concluded that SNEM has better than reasonable prospects of reaching its goals for malaria reduction within the 5 year time period, asuming continued technical support from PAHO, some additional technical training for SNEM staff, and continued AID technical support in the area of administration.

(B) DSPP:

Under this project, the DSPP will receive technical assistance aimed at establishing a strong central capacity to plan and administer the national health program, and extend health services to the majority of the rural population. Westinghouse Health Systems (WHS) was selected under Strengthening Health I to provide technical services to the DSPP (approximately 24 p.m. of a Health Planner/Team leader; 6 p.m. of a statistician; and 6 p.m. of specialized short-term services to be identified). The WHS Scope of Work calls for the contractor to assist the DSPP in its plans to:

I. Ongoing activities under present Westinghouse contract.

a) assisting with the creation and staffing of the Bureau of Health Planning and Evaluation (BHP/E)

b) assisting BHP/E with a study of the administrative and organizational system of the MOH.

c) determining manpower requirements in the BHP/E, initially, and as they change from time to time.

d) analysing all statistical data for reliability and adequacy, methodology the entire operation of the Statistics Unit.

e) analysis of MOH budget including considerations of program budgeting methodology.

f) assist with MOH program description, analysis and with project planning for budgetary purposes.

This undertaking includes the following:

a) aiding each MOH program director with the preparation of material such as program description and justification, staffing, budget needs, substantiating data, future directions and goals and analysis of individual projects.

b) analysing all of the above material in conjunction with the Chief of the BHP/E and with the CONADEP Health Sector representative.

c) preparing the finalized material for CONADEP.

d) analysis and formulation of a plan for improving and executing a sound system for supply and distribution of drugs and other medical supplies.

h) conduct a detailed inventory of all types of MOH health facilities.

i) conduct an analysis of the transportation system and logistics.

j) conduct an analysis of the system of communications within the MOH, country-wide.

II. Other activities that will be carried out under the existing Westinghouse contract.

a. assisting the BHP/E in establishing norms, scope of work, appropriate modes of operation, clarification of relationships, desired inputs and putputs.

b. consultation in the areas of reorganization of the MOH of the MOH and steps toward implementation of administrative reforms (central and regional).

c. preparation of a plan for on-the-job training of health planning officials at both central and regional levels.

d. conduct an analysis of existing and planned staffing patterns in MOH including the utilization of the several types of auxiliary health workers, such as agent communautaire.

e. conduct select manpower task analyses as models for use in staff training.

f. commence the process of implementation of recommendations for restructuring the information and health data system of the MOH.

This includes:

— administrative reorganization of the Section of statistics

— improvement in quality and quantity of health statistics

— better utilization of data and improved distribution

— training of central office and field statistical staff

— purchase, installation and training in use of hardware and equipment for expediting data analysis, reliability and availabiltiy.

g. design and develop the framework for a national health plan.

h. specify the components of the plan for a Rural Health Delivery System.

i. design a financing system based upon program budgeting.

The contractor's work schedule will be reviewed with AID and the DSPP at 6-month intervals, and revised as necessary by mutual agreement. However, the contractor is expected to help DSPP produce the following documents:

1. implementation and work plans for the Bureau of Health Planning (BHP/E);

2. training requirements for personnel of the BHP/E;

3. a report on results of the baseline survey;

4. a national health plan for Haiti;

5. plan for gradual integration of the SNEM program into DSPP;

6. component reports of the development of the administrative system improvement plan as follows:

   i. accounting
   ii. manpower and task analysis
   iii. drug inventory and supply systems
   iv. analysis of physical facilities
   v. transportation systems

7. a specific plan for improvement of the administrative systems of the DSPP, including for gradual integration of the SNEM.

A second technical assistance contract is contemplated for financing under this project, commencing after January, 1979. This contract will be to assist the DSPP in final implementation of administrativ improvements identified land presumably initiated under the preceding contract, as well as extension of health services delivery to the rural areas.

III. Activities to be carried out under a new contract strengthening Health Services - II Project.

a. assist BHP/E in its effort to function effectively, efficiently and at a professional level of capability.

b. assist BHP/E in preparation and clarification of its expanded manpower needs, with preparation of job description and guidelines for candidate selection.

c. assist BHP/E to accomplish its tasks of program analysis, determining program and cost-effectiveness, program coordination, impact upon existing and new program directions, utilization of data in health planning and of coordination of the several sources of health data and information.

d. assist in the development and implementation of on-the-job training seminars in health planning at central and regional levels.

e. assistance in realizing the plan for integration of SNEM staff, budget, function and administration within the MOH.

f. finalize a national health plan that embraces or envelope the concepts elaborated in Strengthening Health Services I, such as decentralization and regionalization, health planning, program budgeting, expanded and integrated rural health services, and reorganization.

g. advising and assisting on specific unanticipated problems as they occur.

h. strengthening the RHDS by such assistance preparing task definition analyses, developing tools for assessment and evaluation of the system, supporting components of the RHDS Plan, etc.

i. consultation steps toward strengthening and modernizing the MOH personnel system.

j. assist in the achievement of the restructured statistics and information system, its appropriate use and reliability, and its integration with the BHP/E responsibilities.

k. assist in the realization of an effective Division of Administration.

l. assistance in integrating regional office budgeting with the central office budget preparation and execution responsibilities.

The WSH contract is funded through CY 1978 by the ongoing Phase I project. It (or other contractor) will be funded for an additional two years for approximately $300,000 by this project, SHSII.

It cannot be strongly enough emphasized that the Haitian Government requires maximum flexibility to design and test a health delivery system appropriate for, and compatible with, the realities and priority needs of the rural people. For this reason, USAID has declined to specify the elements of such a system in advance of the GOH planning process to be financed under this project. However, at present, it appears that the DSPP is inclined toward a program which represents a synthesis of activities being carried out under certain existing health projects in rural areas. The two obvious candidates for adaptation are already successful projects at Petit Goave and Croix-des-Bouquets.

The Petit-Goave (or Integrated Health Project) was started in 1975 with German, Harvard School of Public Health, and GOH funding . Sponsorship and supervision is in the DSPP's Division of Family Higiene. Technical assistance is provided by two public health professionals from Harvard's School of Public Health. Three populations of appproximately 10,000 rural residents each were identified as the targets of this project. Extensive demographic, epidemiologic and socio-economic data have been obtained on these populations. The data are used to study the effects of varying types and levels of health inputs on morbidity, mortality, and fertility. The health inputs provided are limited to those which can be delivered directly by low-level basic health workers who are easily trained for this task and require minimal budgetary support. It is anticipated that funding will be picked up under the FY 77 Strengthening Health Services II project, and Petit Goave will serve both as a field laboratory for the DSPP, as well as a training ground for medical students, interns, and residents at the Department of Community Medicine of the medical school.

Croix-des-Bouquets is located in the rural portion of the Cul-de-Sac about 1/2 hour north of Port-au-Prince. It was developed as a training center for personnel to staff the Division of Family Hygiene's MCH-Family Planning Program. The area covered also includes Fond-Parisien and Thomazeau two adjacent rural communities. The area is representative of most aspects of the rural environment in Haiti. The central facility at the village of Croix-des-Bouquets was constructed with AID funding, and combines training and service capability for both class-room teaching and practical application. The complementary features of Petit-Goave and Croix-des-Bouquets for practical research and development of human resources will give the DSPP a valuable institutional capability as it develops its rural health delivery service model. Since the combination of these two projects already provides the necessary framework and experience both for training health personnel and for testing alternative inputs, it would appear unproductive and uneconomical to plan for additional "pilot" projects outside this framework.

2. Social Soundness Analysis

Socio-cultural Feasibility

The painful experiences in life for which one seeks healing services fill a broad spectrum with the physical at one pole and the metaphysical at the opposite with a subtle blending in between.

The Haitian peasant family, which will be the target group of this rural health delivery system has an entirely different conception of good and ill health, than do members of the developed, modern societies. In Haiti, the afflicted makes his or her own diagnosis and chooses the healer considered most appropriate and skilled in treating such an illness

(if he or she has the means to pay for such services).

In the local, Haitian tradition there are usually four types of healers who are potentially available. First there are practitioners of what we view as modern medicine, available at government facilities and from benevolent organizations working in the country. Unfortunately, such services are scarce and serve only a small proportion of the population.

Next there is the "charlatan" who is untrained, but uses modern drugs and injections purchased on the public uncontrolled market. The charlatan sells his services at a considerable profit, usually with little benefit and very often with considerable danger to the patient.

A third type of practitioner is the " doctor feuille"(herbalist)who may provide both harmless and noxious but in general ineffective "remedies".

Finally at the methaphysical end of the health spectrum are the voodoo practitioners, the "hougan" and "bocor". Certainly, in the area ofpsychic and psychosomatic illness these practitioners are broadly effective and are unlikely to be displaced in the near future

Health care is an active concern of the peasant. He or she is motivated to seek it and to pay for it. According to a 1976 World Bank economic survey a significant portion of per capita expenditures for basic consumer goods and services (12%) is allotted to purchase of medical services. " On the other hand, good (i.e. modern, well-trained) care is usually inaccessible and that which is accessible is largely ineffective. In any event the healer is viewed with respect by the community because of the service provided. This attitude of Haitians toward healers is epitomized by the long-time (and still continuing) peasant veneration of the late President, Francois Duvalier. His political base was in the countryside in the peasantry, and resulted from his role as director of the program which eradicated yaws in Haiti.

With the demand for health care and the multiplicity of healers a competition for resources of the "client", currently exists. This competition for resources has implications for the utilization of newly accessible modern health services in the projected RHDS. To the extent that the vodoo healer deals successfully with illness of metaphysical origins, he or she will not be in competition with the newly trained healer worker. In the nebulous middle area of the healer spectrum, there may be some competition among practitioners. There is very little known about the number, distribution, fees,

and skills of this group of healers in Haiti. A sociological study is currently being undertaken under the Petit Goave integrated project to ascertain what health care is provided by these individuals, to whom, for what fees and with what success. This type of analysis will be utilized by the planners of the RHDS in order to ascertain potential contributions of these individuals to the RHDS.

Other factors related to potential for success in providing health care are:

a. the geographic dispersion of the population;

b. the lack of rural socio-political cohesion and organization

c. a literacy rate of less than 10%

These obstacles together with the question of the role of the additional healer(s) constitute major design issues for the RHDS planners especially in the areas of:

a. facilities - location, size

b. staffing - what types of individuals with what types of training are the most effective providers of care.

c. supervision - what types of individuals provide the most effective supervision for a community health worker.

d. health education of the consumer - What types of education programs with what messages may be communicated to a largely illeterate consumer.

e. service - mix - what services to be provided and utilized based on perception of illness.

These questions will be addressed in the first year of project implementation by the Bureau of Planning, and the Westinghouse Health Systems team.

Role of Women

The role of women in the Strengthening Health Services Project is twofold. Women are both providers and recipients of services. Although the actual staffing and assignments of responsibilities under the rural health delivery system must be decided in the course of DSPP's planning process, it is anticipated that women are likely to be employed for administrative, supervisory and delivery of health services functions,

from the central and district levels out to the periphery.

In the last year, the first woman district health officer was appointed. The country is currently divided into eleven health districts. The district health officer post is prestigious and coveted. Although this is a small start, the DSPP has indicated that as additional district health officer positions are vacated, there will be equal consideration that they be filled by women as well as men.

The rural dispensary will serve as a nucleus and base for the peripheral health worker. Here women are likely to predominate as supervisors and coordinators of the health activities being carried by basic level health workers because these positions will probably require levels of training attained by nursing school graduates. The basic health worker carrying out tasks at the community level will be chosen from both female and male members of the community in which they will work. In other words, it is probable that women will make up a significant part of the total staff providing rural health services. Certainly, there is no indication that women will not receive equal consideration with men for available posts. It should also be mentioned that the on-going programs in MCH - family planning and in nutrition which will be integrated into this project are almost completely staffed by women.

As recipients of health services and subsequent improvement in physical well-being, women should benefit particularly from a rural health delivery system. Improved personal health should enable women to play a more active and dynamic role in the family and the community. Family planning services will allow her to limit the size of her family. Her desire to do so should result from improved health services which will give reasonable assurance of the survival and improved health of the children she does bear. Freed from unwanted pregnancy, she can make a greater contribution in improving the socio-economic well-being of the family unit.

3. Replicability

Replicability of the model of the RHDS will be assured by its being designed and developed within the normal administrative and operational structure of the DSPP. No new institutional or organizational means will be used in either planning or implementation. The Bureau of Planning and Evaluation (BHP/E) will develop the preliminary design by analysis of on-going projects and in-country experience. A synthesis of this experience will be made in consultation with the technical heads of the service divisions of the DSPP.Training will be carried out in an established institution (expected to be Croix-des-Bouquets). Implementation will be within the administrative structure of a health district, with the district health officer having final responsibility for supervision

and administration. Technical and logistic support will be provided by the DSPP at the same level as that envisioned for the nation-wide replication phase (commencing in FY 78). In other words, the design and implementation of the model will be a learning exercise carried out within the normal constraints and capability of the DSPP, thus preparing the Ministry for the nation-wide replication phase.

4. Environmental Considerations:

Of the activities financed under this project, only those carried out by SNEM should have any impact on the environment. The preceding technical analysis indicates that such impact is expected to be related to the use of pesticides for malaria control. AID/W has previously determined. that pesticide use for malaria control warrants a negative environmental determination, as reflected in the environmental determination already approved by the Assistant Administrator (December 7, 1976) for the FY 78 proposed follow-on RHDS project. USAID believes the FY 77 project will not have a significant effect on the human environment, and therefore neither an environmental assessment nor an environmental impact statement are required. A Negative Declaration is recommended (see Annex III for the Initial Environmental Examination).

5. Rationale For Project Length

The length of the project of 5 years is primarily based on the malaria control program, rather than the activities at the central level of the DSPP. This time frame was chosen by consultation between the AID technical advisors from TA/H with the in-country PAHO technical advisors and SNEM. There was agreement by all three parties that, with a goal of reduction in malaria incidence to not more than 500 cases/million population/year, 5 year would be a reasonable time frame. However, it is also believed that this is compatible with the activities to improve the planning and administrative capability of the DSP/P, establish the infrastructure and logistic base and plan and replicate a RHDS. It is estimated that the administrative reforms which are already in progress will be sufficiently advanced by 1979 so that the DSPP will be able to implement the trial phase of the RHDS and gain wide coverage in the country.

6. Summary

Haiti is the poorest country in the Western Hemisphere, and one of the poorest countries in the world. Morbidity and mortality are appallingly high. Social services, particulary in the health sector, are largely non-existent or inaccessible to the majority of the poor. The Department of Public Health and Population (DSPP) is under-staffed, poorly organized, inadequately financed, and has ineffective planning and administrative capability. Basic infrastructure necessary to support projects and field activities (such as transport and supply systems) are virtually non-existent. If any amelioration of this situation is to occur, we must start with the basics of institution building and make the DSPP a viable and effective agency for provision of health services. To do this, technical assistance and budget support must be provided to develop DSPP's administrative and planning capability, and establish the infrastructure and logistic elements essential as a base on which to build an eventual rural health delivery system.

The technical assistance needed will be provided in large part by contract with Westinghouse Health Systems (WHS). The Westinghouse consultants and technicians will assist the DSPP in developing its institutional capability at the same time the DSPP is carrying out a planning exercise for the development of the rural health delivery services system. The planning exercise will serve as a training mechanism and framework for reorganization and improvement of the central institution.

A priority has been placed on integrating SNEM into the DSPP. There are two pre-requisites which must be met before this becomes feasible. First, malaria must be brought under control, and secondly (and most importantly) the DSPP must have the administrative capability of absorbing and administering the malaria control program. Until such capability is developed in the DSPP, integration cannot be considered viable. This project is designed to assure that, by the end-of- project, malaria will be under control (500 cases/million people per year), and the DSPP will have the necessary capability to effect the SNEM integration.

Assistance to SNEM under this project will focus on strengthening that organization's administrative capabilities for most efficient utilization of resources. PAHO will provide essential technical support and training aimed at strengthening SNEM's technical capability to achieve its malaria control goals.

Under this project, the DSPP will also develop a model for the rural health services delivery sytem, which can be tested and replicated under future AID projects.

The technical assistance will be provided by WHS. It is anticipated that this model will result from a synthesis and refinement of various activities presently being carried out in the country which have been proven effective, (such as the Integrated Health Program in Petit Goave, certain aspects of PAHO activities in the Cap-Haitian and Cayes regions, and the Division of Family Hygiene program based at Croix-des-Bouquets). Much useful information has been developed in these various programs with respect to epidemiologic data; norms for basic health workers; training of basic health workers; mobilization of community leadership support and resources; and reporting and supervisory techniques. Maximum utilization of this existing body of knowledge and experience constitutes a more effective use of AID & GOH resources than would starting anew to develop it under discrete pilot projects.
Probably one of the major constraints to health development in Haiti is the inappropriate type of medical professional which is presently trained by the school of Medicine. He is a clinician prepared for private practice in the tradition of the developed countries with no training or orientation in public health and preventive Medicine. He does not know his country's health problems and is completely incapable of coping with them. Yet he exerts a paramount influence on allocation of resources and decision making at the policy level. To help obviate this constraint, the project will provide assistance to the Department of Community Medicine in the School of Medicine so that students, interns and residents can be given training and orientation more relevant to the problems of Haiti.

B. Financial Plan

1. Summary Financial Tables

The following four tables show the financial components of the project.

Table A - Summary Cost Estimate and Financial Plan--AID will finance foreign exchange and local currency costs which comprises 54% of the total project costs. The GOH will contribute approximately 40% and PAHO 6%.

Table B - Annual Project Expenditures - This table portrays the source and application of funds in a time phased presentation of project expenditures.

Table C - Output/Input Costs - This financial plan presents the major output activities as related to input activities and corresponds to output activities present in Logical Framework.

Table D - Comparative AID Financing - This is an illustrated comparison of the three phased project broken down by project increments.

2. Narrative Discussion of Financial Tables

a. GOH Financial Viability

Financing of the DSPP comes from both the general and development budgets. The latter is comprised of special accounts that are managed separately by the GOH and intended to insure the availability of necessary local counterpart resources for development of DSPP projects financed by international agencies.

b. Financial Assistance - Other Donors

PAHO has agreed to contribute $852,000 over the life of the project for technical assistance (1 malariologist, 1 sanitary engineer, 3 malaria technicians) in addition to short and long term participant training (1 entomologist, 1 epidemiologist).

c. Financial Requirements

1. Project Costs

The total cost of this five-year grant project is estimated at $13.977 million of which $7.525 million will be financed by AID, $5.6 million by the Government of Haiti, and $.852 million by PAHO.

This project is Phase II of a three phase project which began in 1975 (Project No. 070) with AID financing of $346,000 to DSPP for technical assistance (Westinghouse contract) and administrative improvement. In FY 1977, AID provided assistance of about $1.2 million of which $950,000 was budgeted to SNEM and $250,000 to DSPP.

Of the $7.5 million AID financing for this project $6.0 million is budgeted to SNEM and $1.5 million to DSPP. The third phase of the project (scheduled to begin in CY 1979) provides AID financing of $5.7 million and $3.4 million GOH contribution for RHDS. (See Table III-D). Foreign exchange costs are budgeted for $3.892 million and local currency costs will be $7.468 million.

2. Financial Components

A total of $399,000 has been budgeted for technical assistance. Out of this total $300,000 will be budgeted for replacement of the Westinghouse Health Systems contract; $60,000 will be provided to finance a contract for the SNEM administrative advisor; $20,000 will be required for technical assistance for the SNEM/DSPP integration plan. The remainder will be for miscellaneous short-term, technical assistance requirements. The technical exchange program will be $160,000 during the first two years. AID will finance a total of $4.882 for personnel and salary costs ($270,000 DSPP and $4,552,000 SNEM).

Local training costs are $148,000 over a two-year period for upgrading DSPP's technical and administrative capability. About $259,000 will be used to provide training at Petit Goave and Croix-des-Bouquets.

SUMMARY COST ESTIMATE AND FINANCIAL PLAN

AID
($000)

SOURCE	FX	LC	TOTAL
DSPP*			
AID			
Technical Assistance	399		399
Subtotal	399		399
1. Bureau of Planning			
Personnel		159	159
Equip. & Materials	8		8
Training		17	17
Operating Costs		11	11
Subtotal	8	187	195
2. Bureau of Admin.			
Personnel		23	23
Equip. & Materials	5		5
Training		23	23
Operating Costs		11	11
Subtotal	5	57	62
3. Bureau of Statistics			
Personnel		49	49
Equip. & Materials	16		16
Training		108	108
Operating Costs		79	79
Subtotal	16	236	252
4. Design RHDS			
Personnel		39	39
Equipment	7		7
Croix-des-Bouquets		109	109
Petit Goave		150	150
Subtotal	7	298	305

* There is no GOH contribution to the DSPP portion of this project.

SOURCE	FX	LC	TOTAL
5. Department of Community Medicine			
Technical Exchange	160		160
Subtotal	160		160
TOTAL	595	778	1,373
Contingency & Inflation	66	86	152
TOTAL - DSPP (AID)	661	864	1,525
SNEM			
AID*			
Personnel		4,552	4,552
Allowances		633	633
Per Diem		317	317
Lubricants & POL	332		332
Other		166	166
Subtotal - AID	332	5,668	6,000
GOH*			
Personnel		945	945
Rent & Utilities		162	162
Technical Assistance (OPATMA)		299	299
Commodities			
1) Drugs & Medicines	780		780
2) Equipment & Materials		598	598
3) Pesticides & Larvicides	1,[illegible]		1,2[illegible]
4) Vehicles & Spares	290		[illegible]
Other		1,314	1,314
Subtotal - GOH	2,282	3,318	5,600
PAHO*			
Advisory team commodities training	852		852
TOTAL-SNEM/AID/GOH/PAHO	3,466	8,986	12,452
TOTAL DSPD (AID)	661	864	1,525
TOTAL	4,127	9,850	13,977

Percentage Contributions		AID	GOH	PAHO
	DSPD	100.0	-	-
	SNEM	48.2	45.0	6.8
	Total	53.8	40.1	6.1

* Contingency and Inflation already figured in.

ANNUAL PROJECT EXPENDITURES
(000)

INPUTS (DSPP - AID)	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTALS
Technical Assistance	132	267				399
Personnel	105	165				270
Training	68	80				148
Equipment & Materials	25	11				36
Technical Exchange	80	80				160
Croix des Bouquets	55	54				109
Petit Goave		150				150
Operating Expenses	65	36				101
Subtotal	530	843				1,373
Contingency & Inflation	59	93				152
TOTAL DSPP (AID)	589	936				1,525
AID (SNEM*)						
Salaries	1,109	1,130	1,106	657	551	4,553
Allowances	144	144	128	113	104	633
Per Diem	89	92	51	40	45	317
Lubricants & POL	55	60	66	72	79	332
Other	110	55	---	---	---	165
Subtotal (AID)	1,507	1,481	1,351	882	779	6,000
GOH						
Rent & Utilities	27	29	32	35	38	161
Technical Assistance	61	62	60	60	56	299
Commodities						
a) Drugs & Medicines	200	220	150	110	100	780
b) Equipment & Materials	149	145	235	2	1	532
c) Office Furniture	14	14	16	13	10	67
d) Pesticides, Larvicides	245	274	254	222	216	1,211
e) Vehicles, Spares	62	59	55	57	58	291
Salaries	---	---	---	413	532	945
Other	162	217	318	308	309	1,314
Subtotal	920	1,020	1,120	1,220	1,320	5,600
Total SNEM (AID/GOH)	2,427	2,501	2,471	2,102	2,099	11,600
Total SNEM/DSPP (AID/GOH)	3,016	3,437	2,471	2,102	2,099	13,125
Total PAHO	186	154	160	171	181	852
Total AID/GOH/PAHO	3,202	3,591	2,631	2,273	2,280	13,977

* Contingency & Inflation previously added in.

PROJECT OUTPUTS/INPUTS COSTS

TABLE III C

INPUTS DSPP	(a)	(b)	(c)	(d)	TOTAL
AID					
Technical Assistance	399				399
Personnel	231	39			270
Training	148	259		160	567
Equipment & Materials	29	7			36
Operating Expenses	101				101
Subtotal (AID)	908	305		160	1,373
Contingency & Inflation	100	34		18	152
TOTAL DSPP (AID)	1,008	339		178	1,525
SNEM*					
AID					
Personnel	4,552				4,552
Allowances	633				633
Per Diem		317			317
Lubricants & POL			332		332
Other		166			166
Subtotal (AID)	5,185	483	332		6,000
GOH					
Personnel		945			945
Rent & Utilities	162				162
Technical Assistance		298			298
Commodities					
Drugs & Medicines		780			780
Equipment & Materials			598		598
Pesticides & Larvicides			1,212		1,212
Vehicles & Spares				291	291
Other			1,314		1,314
Subtotal (GOH)	162	2,023	3,124	291	5,600
Total SNEM (AID/GOH)	5,347	2,506	3,456	291	11,600
Total DSPP/SNEM(AID/GOH)	6,355	2,845	3,456	469	13,125
PAHO		852			852
Total AID/GOH/PAHO	6,355	3,697	3,456	469	13,977

*Contingency & Inflation already added in.

(a) Strengthening planning and administrative capability.
(b) Design RHDS
(c) Supply & logistics systems
(d) Department of Community Medicine

Table III-D

COMPARATIVE AID ASSISTANCE

	75	76	77	78	79	80	81	82
Phase I	5.558 million							
AID	4,023 million							
GOH	1,535 million							
Phase II			14.0 million (Strength Health Services II)					
AID			7.5 million DSPP(1.5)SNEI(6.0)					
GOH			5.6 million SNEI					
PAHO			852 thousand SNEI					
Phase III						9.1 million (DSPP)		
AID						5.7 million		
GOH						3.4 million		

C. Economic Analysis

1. Cost /Effectiveness of Project Activities

The reduction in malaria morbidity relieves the suffering and loss of energy in an already impoverished people. It has been estimated that a single febrile attack of malaria in an adult consumes 5,000 calories. (H. Pollack - " Disease as a Factor in World Food Production - 1968). This is equivalent to two days of hard labor. The average adult calorie intake in Haiti has been estimated at 1,850 calories perday (community averages were 1,100 to 2,300 calories per day) with a daily protein consumption of 45 grams. The recommended daily caloric intake for adults is 2,200 to 3,200 calories and 75 grams of protein. (Syncrisis- " A Health Study- Haiti " 1972). However, at least two episodes of febrile illness are average for people in developing countries.

It is not difficult to see from the above the terrible toll that malaria must take in a population that starts out seriously undernourished, and considered by world standards to be in a marginal condition of starvation. Reduced incidence of malaria, therefore, should free reserves of human energy for agricultural production and other contributions to the family, the community, and the economy. This is particularly important in a country such as Haiti where food production is marginal and people are living at a subsistence level. Intestinal parasites can cause a loss to an individual of almost 10% of total caloric intake. In other words, these two morbid states can cause a loss of 83,000 calories per year per person; or the equivalent of 23 kilograms of cereal grains per year. If we say there are approximately 4,000,000 Haitians with essentially no access to health services to prevent or remedy chronic parasitic illness, this equals 92,000 metric tons of grain. Further if these grains sell for $150 per metric ton, the loss amounts to almost $14,000,000 each year; or more than twice the annual national budget for health. Certainly any substantive reduction in this wasteful process could be a great social and humanitarian benefit to the country.

These figures are of course only tentative attempts to convey some idea of the nature of the productive cost to Haiti and to its individual citizens of a generally low state of health in the majority of the population. Actual causal relationships between given levels of good or ill health and a nation's measurable production levels have yet to be established. Therefore, it is necessary to assume a connection (Logical Framework, Part IV-B).

However, a basic function of GOH health planners should ultimately be to identify the cost effectiveness of attacking the various facets of Haiti's health problem and the means selected to do so. This must be considered fundamental to the planning process for the best allocation of scarce resources (and improved direction of external donor contributions to the sector). In fact, without first creating such a capability, the cost-effectiveness of selecting other inputs to the sector (i.e. alternative project proposals) is considered questionable, (hence, AID's strategy to first strengthen the DSPP's planning capability in the framework of designing a model RHDS). The Ministry's capacity to evaluate the cost-effectiveness of alternative inputs to a national rural health delivery system will be developed under this project with WHS technical assistance.

2. Rationale for Non-Reimbursable Funding

As will be seen from Tables II - C, D, & E (see Part II), the GOH lacks the necessary resources to expand health services to the rural population on any scale which would have a measurable impact on national health. The fiscal budget already earmarks some 14% of the total for the health sector. This is an extraordinarily high percentage which, realistically, cannot be expected to increase. USAID projects an approximate 6% annual increase in the DSPP's fiscal allocation which should just about cover inflation. As the BHP/E's planning capability evolves and certain key analyses (e.g. study of actual manpower needs and availability) are carried out under this project, it may be possible to effect some shifts within the current programming of DSPP but the inevitable conclusion must be that substantial external donor contributions to the sector must continue indefinitely (See Part I-D, Issues) in order to establish and maintain rural health services to minimum acceptable levels.

In addition, it was recently decided that in order to implement the decisions of the UNCTAD IV meeting, those countries on the U.N.'s list of the Least Developed would receive totally concessional U.S. assistance for an indefinite period. Therefore, AID's economic assistance program in Haiti was converted from a mix of loan/grant projects to all-grant. This project, originally intended for loan/grant financing, falls among those converted to all-grant funding. In the case of health, this is a far more rational choice, since it is not possible to establish direct economic returns to assistance, (as can be done in agriculture for example). Non-reimbursable funding will also lessen the strain on Haiti's debt burden (a matter of increasing concern for all developing countries).

IV. IMPLEMENTATION ARRANGEMENTS

A. INSTITUTIONAL ANALYSIS

1. Overview of Organizational Issues

At this point rather than describe at length, or further document the organizational deficiencies of the DSPP, emphasis will be given to delineating some of the prevailing conditions which operate as constraints or factors to be weighed in choosing solutions to the evident problems.

Briefly, the DSPP appears to be impeded in effective execution of its regular functions by the absence of personnel in certain key administrative positions; limited task-related training in particular skill areas at the operational levels; occasionally, the presence of an underqualified incumbent in a given position; the absence of clearly prescribed -- or, alternatively, envisioned -- objectives and specified tasks to give work units and their directors a clear mandate as to their bureaucratic roles and functions; and a pervasive lack of the physical resources (paper, ink, file cabinets, transportation, modes of rapid tele-communication) which are the fundamental requisites of orderly and effective administration and management.

The problems have been identified, both by Haitian officials and advisors, with varying degrees of boldness and specificity. As a context for consideration of solution options, certain key points concerning the DSPP should be clarified.

First, no one knows, precisely, the number of personnel employed by the DSPP. The Moniteur specifies by title and salary budgeted job slots for about 4860 people. Yet, several DSPP officials, independently of one another, have placed the actual number of personnel well in excess of 8,000 people. Salaries of DSPP personnel are notoriously low, to which fact low performance motivation is attributable. Preliminary examination of absence reports suggested absenteeism ranging from 6% to 35% (average 19%) of staff on a given day. Yet, despite the low salaries, the DSPP has continued to grow at the rate of 4.7% between 1975 and 1976; and at 6.4% annually during the present year. This growth is the result not only of hires in excess of terminations, but of relatively low labor turnover -- between 2.2% and 3.8%, depending upon the base figure used. Salaries presently account for somewhere between 60% and 80% of the operating budget.

These conditions, when considered as background to the problems enumerated earlier, have at least two sets of implications for manpower development policy and programming:

(a) The DSPP can afford new hiring. In these instances, filling key positions may require overseas training to develop specialized skills. Often, however, qualified people can be found " on the market" -- but they cannot be hired at the price being offered. In the latter case, salary supplementation and active recruitment are indicated. Care-should be taken, however, to ensure that supplements do not result in salaries totally out of line with those of other workers at proximate levels of responsibility.

(b) The inability of the DSPP to absorb more than a few key new employees, togehter with the need to develop skills at the operational levels, indicate the appropriateness of recyclage (in-service and on-the-job training) or work-release for brief periods of local institutional training of existing workers. Low levels of educational attainment among certain cadres of employee (e.g. statistical clerks and garage mechanics) should not be construed as impediments to potentially good job performance. Training simply must be task-specific and must build from existing cognitive skills.

Current Activities in Organizational and Manpower Development

Two principal sets of activities are currently ongoing in the sphere of manpower and organizational development at the level of the central DSPP. Under AID sponsorship, Westinghouse Health Systems is working with the Bureau of Health Planning to make the BHP/E an effective unit which can identify and propose remedies for administrative and organizational dysfunctions, particularly as they pose impediments to the planning process PAHO, in its technical and executive capacity in relation to the IDB loan to the DSPP, has responsibility for the detailed articulation of work-unit objectives, task descriptions, and procedures manuals for the DSPP operating divisions. Specif mechanisms for collaboration between these t., efforts are, at this writi . being established by DSPP officials.

Specific Manpower Development Requirements

In its review of organizational and manpower development issued, Westinghouse has identified a number of requirements appropriate for AID support. It should be noted that, with the exception of some training and salary supplementation specifically associated with development of a Rural Health Delivery System project, manpower development needs indentified in this paper are confined to those which are already clearly apparent at the central operating level. This is largely because, without precise definition of the region(s) in which program activities will be undertaken, and without a detailed inventory of personnel engaged in direct health services, definitive training requirements at the regional levels for direct service personnel cannot be specified at this time. A block of

funds may be earmarked for allocations once the required background information is available.

Coordination of Manpower Development Activities

The volume and complexity of the manpower actions recommended here and expected to result from further analysis will necessitate an improved coordinating capability within the Central DSPP. Eventually, a unit of Manpower and Organizational Development may be envisioned to handle these functions. For the present, it has been recommended that the section of Medical and Paramedical Training (one of the special services sections attached to the office of the Secretary of State) expand its functions to include coordination of Administrative and Indirect-services personnel training.

Summary of Manpower Development Inputs

A summary of tentative educational and training requirements identified the WHS team with cost calculations and summary costs is included in the annexes to this pages. WHS has recommended that overseas training be sought in french language institutions in Canada, Africa, or France when possible.

The detailed rationale for WHS's tentative estimates of manpower development needs in Accounting and Budg eting, Statistics,Transportation, Supply and Logistics and Maintenance are in the Annexes to this paper. THe initial manpower analysis carried out by WHS in April 1977 gave particular attention to 1) the BHP/E and 2) Central Administrative Division leadership and the personnel section of that Division:

The Bureau of Health Planning and Evaluation

During the course of WHS April consultancy, a proposed set of objectives and activities for the BHP/E was developed and the skills necessary to implement these activities were identified. A matrix was developed to permit the BHP/E and its consultant team to review the skills available on the presentBHP staff, (of whom there are now four, including the WHS resident consultant) and to determine skills which have yet to be obtained. On the basis of initial observation, it appears that persons with skills at the technical/analytic level, in the areas of health economics, budget analysis, performance evaluation, health planning and policy analysis will prove desirable additions to staff. These proposals are under review by the BHP/E, but initial reaction has been favorable. Assuming, however, that some overseas training will be necessary for the types of analytic skills required , provisions have been made in the manpower development requirements summary.

Central Administrative Division and Personnel Section

There is, at present, no incumbent in the position of Director of the Administrative Division. The reason appears largely to be that qualified candidates will not agree to work for the base salary available. Salary supplementation has been recognized as a clear need under this project. Continued supplementation must be anticipated and, given the other planned investments in organizational development, a supplement to allow hiring of an executive assistant would be a prudent expenditure.

The Personnel Section, (consisting of a chief of section, a secretary and a typist) will require development of clear cut objectives, activities and procedures, and institution of a personnel management information system as well as some staffing alterations. Salary supplementation to permit hiring of an administrative level person experienced in personnel administration to supervise the tabulation of data are advised, as is salary supplementation to transfer 2 clerks to maintain tabulations of personnel data.

In addition to the specific technical assistance covered by the WHS contract, the following list represents a number of non-specific items recommended by the WHS team for future short-term assistance to the DSPP to improve administration. Specific use of this ,a, depends on the potential duplicate support provided under the PAHO assistance for the IDB loan:

a) 4 person-months (over two years) for analysis of the financial situation in the DSPP with regard to personnel, salary, and compensation, leading to proposals for streamlining the personnel system and balancing salaries and compensation with the private sector.

b) 4 person-months (over two years) for analysis and proposals relating to restructuring and making more efficient the internal accounting and auditing system in the DSPP.

c) 2 person-months (year 2) for assistance in organizing and approach to the priv[illegible]untary sector (through the Bureau of Foreign Assistance) . [illegible]der to bring these activities into fuller coordination with the D[illegible].

d) 6 person-months (year 1-3) for general administration and organization analyses and proposals related to these implementation of planning proposals and regionalization.

Two recent laws (1971 and 1975) have been enacted concerning the Public Health [illegible] system. Both laws involve aspects of health planning. Yet there is a great deal of ambiguity even among DSPP. administrators about the potential conflicts and overlaps in the two laws. Technical assistance

could be sought from a lawyer, either one familiar with foreign legislation and legal systems or a local Haitian lawyer.

e) 3 person-months (year 2) compare and analyze the two existing laws (1971 and 1975) for inconsistencies and duplications, and prepare a proposal for new legislation.

2. Bureau of Planning and Evaluation BHP/E

In its preliminary review of the BHP/E (April, 1977) the WHS team:

a) Read the laws of 1971 and 1975 concerning the DSPP, noting responsibilities and structural relationships which are, by law, specifically outside the BHP/E. These were excluded from WHS proposed list of objectives and activities for the BHP/E.

From the legal objectives and responsibilities of the BHP/E, together with DSPP's schematic of the organization of the BHP/E (drafted in January 1977), a review of the current Health Plan, and the knowledge of Haiti's health planning needs gained during the course of their April visit WHs developed objectives and activities for the fully operational BHP/E.

b) WHS carried out a " content analysis" of the skills and functions required to fulfill the objectives and activities.proposed. These presented in a matrix (see below) with skills and functions on one axis and existing BHP/E staff on the other axis.

c) An organization chart was developed (see below) showing the relationship of the BHP to other units of the DSPP, based on both membership of the various counsels and advisory groups, as specified in DSPP's schematic, and some relationships implied in proposed objectives and activities.

d) I lly WHS out d some action steps which are of immediate importance to the b E in building its planning and evaluation capability.

Objectives and Tasks Proposed for the Fully Functioning BHP/E

Overall Objective. To prepare and revise periodically a national health plan which will point out health problems, priorities, and the best use of available resources.

Sub-objective 1: Identify principle health problems and, through analysis, identify options for their solution.

Activities 1.1: Maintain an ongoing analysis of information and data from the health information system. Information to be analyzed for policy implications should include health status indices, a physical

resources inventory which indicates both quality and quantity of available resources, and cost data.

Activity 1.2: Provide to the Secretary of State of DSPP detailed policy analyses (e.g. cost-benefit analyses, future spending implications, resource constraints) for proposed health policy actions. Analyses should include impact of policy actions on the DSPP budget and on health status of the population.

Activity 1.3 : Initiate and conduct evaluations of multi-regional and national health policies and of special health programs, when necessary.

Activity 1.4 Prepare a Statement of Health Strategy which will include criteria for establishing priorities for the National Health Plan.

Activity 1.5 : Make specific recommendations to other DSPP divisions and sections concerning the need for alterations in the operational system in support of health planning activities.

Sub- Objective 2: Integrate the needs of all elements of the health system and determine priorities to be applied in the National Health Plan.

Activity 2.1 Establish guidelines for evaluation of Regional health programs according to National Health Plan information needs.

Activity 2.2: Receive and coordinate evaluations of health programs and the functioning of health services carried out by the regional health administrations.

Activity 2.3: Establish guidelines and the format for the regional health plans and provide technical assistance to the regions for regional plan development.

Activity 2.4 Receive and coordinate health plans from the regional health administrations.

Sub-Objective 3: Specify the best use of available resources to realize the objectives and priorities of the National Health Strategy.

Activity 3.1: Exercise an active role (Including preparation of a draft budget) in the formation of the Development Budget and in the specification of guidelines for disbursement of the operating budget of the DSPP.

Activity 3.2: Based on measures of deficit and surplus determined through analysis of the physical resources inventory and evaluations of their adequacy, determine the potential for shifting the allocation of existing physical resources within the system to meet health strategy needs.

Activity 3.3 : Plan the allocation of DSPP budget growth to meet Health Strategy objectives.

Activity 3.4 : In collaboration with the Section of Foreign Assistance Control, specify in detail health system input requirements which could be met through coordinated donor assistance.

Activity 3.5: In collaboration with the Department of Training, determine manpower development needs and policies to meet them.

Sub-objective 4: Develop and maintain a functioning Bureau of Health Planning and Evaluation capable of carrying out the above mentioned activities and meeting the specified objectives.

Activity 4.1: Develop an initial workplan for the BHP/E and continue on an annual basis.

Activity 4.2: Review BHP/E activities and tasks to ensure they are consistant with objectives. Present and review BHP activities and health planning progress to the Secretary of State of the DSPP.

Activity 4.3 : Develop and apply criteria for evaluation of the BHP/E. Such criteria could include: cooperative response of DSPP sections to BHP/E information needs; attainment of milestones specified in workplan; quantifiable measures of extent to which BHP/E proposed Health Plan Budget is adopted; and degree of acceptance of BHP/E other outputs.

Ac[illegible] 4.4: Develop linkages with external agencies [illegible] enhance the a[illegible]ytic capability of the BHP/E (e.g. social analysis,Ethnology, economic analysis).

It is the initial impression of the Westinghouse Team that the BHP/E will wish to develop its staff by the addition of persons whose principal activities are in the realm of technical analyses (as distinct from policy presentation and regular daily interaction with other DSPP sections and officials). WHS also suggested that persons with strong capability in health economics and national budget analysis, as well as health planning techniques be sought. Finally, it may be advisable to designate one staff

MATRIX OF BHP/E PERSONNEL NEEDS
COMPARED TO AVAILABLE STAFF

BHP/E PERSONNEL

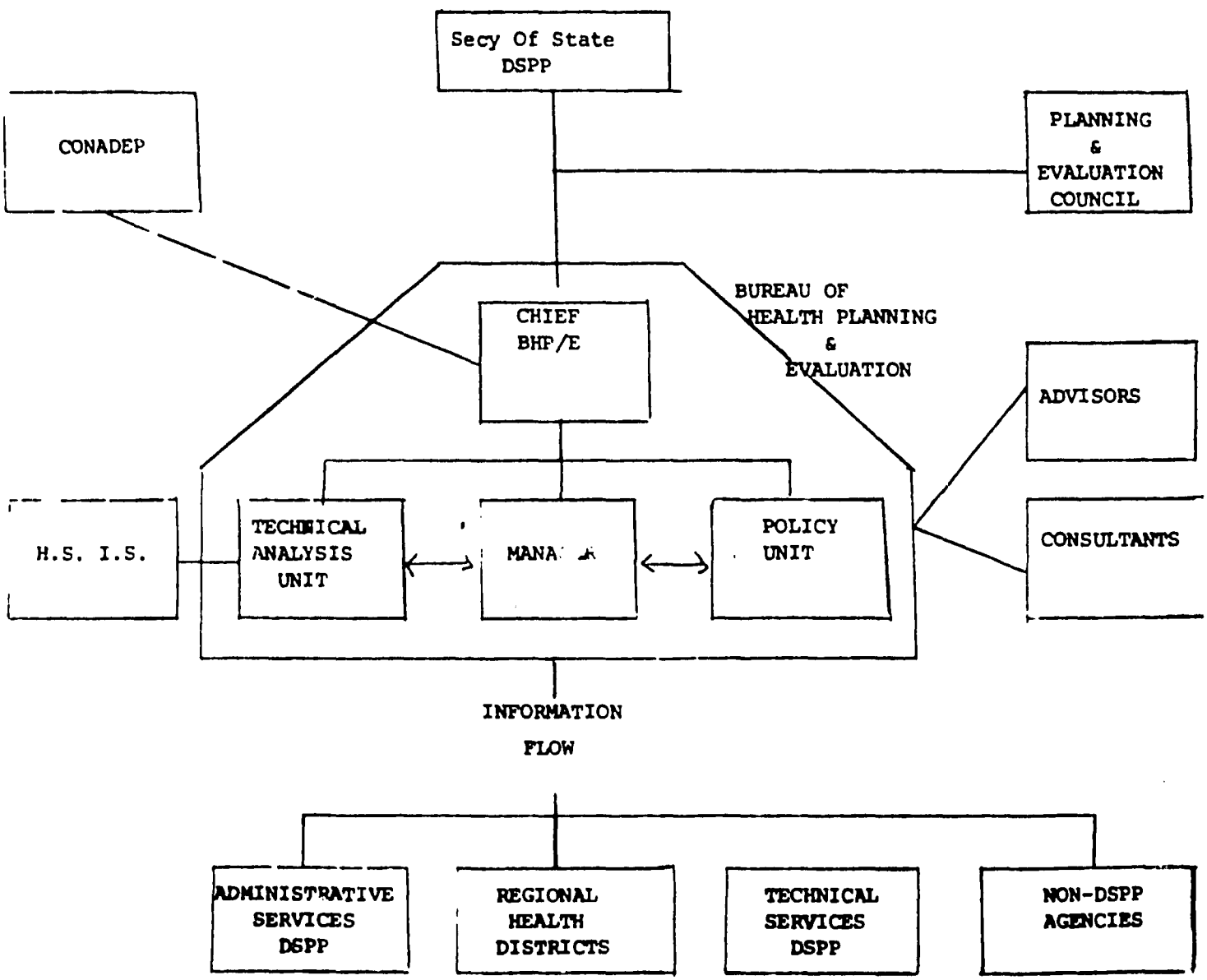
P= POLICY LEVEL CAPABILITY - O

T= TECHNICAL ANALYSIS CAPABILITY - *

	TECHNICAL SKILLS	ADMINISTRATION	BUDGET ANALYSIS	COST-BENEFIT ANALYSIS	DAILY MANAGEMENT, BHP/E	DATA ANALYSIS	DEMOGRAPHY	EPIDEMIOLOGY	EVALUATION, BHP/E	HEALTH ECONOMICS	HEALTH MANPOWER PLNG	HEALTH PLANNING	INTER-AGENCY COLLAB'N	ORGANIZATIONAL ANALYSIS	POLICY ANALYSIS	PROGRAM EVALUATION	SOCIAL ANALYSIS	STATISTICS (BIO & SOCIAL)	SURVEY RESEARCH	SYSTEMS ANALYSIS	T.A. IN PLANNING	TECHNICAL WRITING
CHIEF OF THE BUREAU	P																					
	T																					
	P																					
	T																					
SPECIAL ADVISOR	P																					
(FROM S.O.S/DSPP)	T																					
	P																					
	T																					
PUBLIC HEALTH NURSE	P																					
	T																					
	P																					
	T																					
CONSULTANT (IV)	P																					
	T																					
	P																					
	T																					
	P																					
	T																					
SUPPORT PERSONS SECRETARY, BILINGUAL TYPIST																						

Suggested Organization Chart

For DSPP



member from among the Policy Level group with principal responsibility for day-to-day management of technical/analytical operations.

Once the organization and staffing recommendations of the WHS are adopted, the BHP/E will develop a workplan which specifies milestones to be achieved, tasks to accomplish them, and allocation of responsibility among BHP/E staff members to carry out tasks.

BHP/E will also begin design of a baseline data system. In collaboration with Westinghouse Health Systems' consultants. BHP/E will determine the adequacy of existing data sources to meet baseline data requirements; specify additional needed data; review survey instruments being used in North and South regions; design a baseline data collection process and instruments; and execute a baseline survey.

3. Information Systems

With the reorganization of August 1971, the DSPP established two administrative branches for the development of a Health Statistic Information System: one for Technical Services and other for Special Services. The Technical Services comprised two sections: one for Statistics and the other for Planning and Evaluation. Special Services included the sections of medical and para-medical education; control of foreign assistance; special national programs; and population. According to its organization chart, both administrative branches, Technical Services and Special Services, lie on the line of authority between the Minister and the Director General. The Statistical Section is by law the central GOH agency for the collection and distribution of all data related to health services and their administration.

The population Section is responsible for the collection and distribution of all data related to mortality, morbidity, fecundity, technical human resources development, migration, nutrition and the projection of socio-economic development as related to population settlements. Other tasks are the design of population surveys. These functions must be carried out with the collaboration of the Haitian Institute of Statistics taking into account the overall economic conditions of natural resources, production, consumption and revenues.

However, as of April 1977, only the Statistical Section was in operation, and had taken over some functions of the Population Section, such as the collection and distribution of data related to mortality, morbidity, births. The collection of malnutrition data was not added until January 1977.

The Statistical Section should be much more than an administrative unit of the DSPP. Its mandate involves a leadership role in the collection and distribution of all health statistics. Hence, it has a formal coordinating power with other agencies (government and non-government) producing health statistics. This mechanism, however, has not been utilized effectively for the strengthening of Haiti's health statistics information system due to:

1) Lack of administrative rules and regulations to implement the mandates of the DSPP's organic law;

2) Lack of effort to coordinate with other organizations;

3) Absence of a consistent and adequate conceptualization of the proper functions of a health statistics information system. (There is a persistent belief that health statistics are only hospital statistics).

4) Lack of guidelines, manuals or directives that would permit regular collection of data concurring GOH and non-government activities in nutrition, family planning, family health services,sanitation etc.

As a result, the leadership capacity of the Statistical Section program is slight and coordination with other agencies producing health statistics has been minimal.

Under the new regionalization law, the DSPP recognizes that high priority must be given to strengthening information gathering and handling capability. Adequate data are essential to provide the baseline for current and future national health plans.

Since 1971, Haiti's health service delivery system has been organized by law into eleven health districts covering the entire country, (Bella[illegible], Cap-Haitien, Cayes, Gonaives, Hinche, Jac[illegible], Jeremie, Petit [illegible], Port-au-Prince, Port-de-Paix and Saint Ma[illegible] Data has been c[illegible]g to the Statistical Section directly from the [illegible]ief Administrator of each health district who is in charge of the supervision of all health establishments (hospital, health-Center-Hospital, Health Center, Dispensaries, Asiles) in the district.

With the regionalization law of October 1975, the eleven health districts have been regrouped (into six health health regions with officially decentralized services as follows:

1) Nord (Cap-Haitien: Quanaminthe, Limbé)

2) Nord-Ouest (Gonaives: Port-de-Paix)

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3) Centre (Hinche, Pelladère, Saint-Marc)

4) Métropolitaine (Port-au-Prince: Pétion-ville, Carrefour)

5) Ouest (Jacmel: Croix-des-Bouquets, Petit-Goâve)

6) Sud (Cayes: Jérémie, Miragoane)

In this new health service geographical network, it should be noted that the territorial boundaries defined for each of the six health regions are completely different from both:

1) The political administrative territorial division conventionnally followed by the Institut Haitian de Statistiques to report demographic, social and economic data.

2) The territorial boundaries defined by the DSPP's law of 1973 for each of the former eleven health districts.

This means that improved data to be produced by the information system will be difficult to compare with that produced in previous years by the old network, and/or with that published by the Institut Haitian de Statistique. One of the tasks confronting the DSPP will be to develop means of " translating rapidly and correctly between sets of new and old data.

Another problem requiring early resolution is the high rate of delinquency in monthly reporting. Tardiness in monthly reports is standard throughout the year for the various health establishments. National reports are running a year or more late while awaiting data from the field. Causes incl e: lack of supervision in the field: lack of transportation: lack o paper and ink in the central and field offices: lack of trained personnel at the Central Office and in the field: lack of interest due to low salaries: etc. t is a vicious cycle of poor management due to limited resources.

The DSPP is aware that the lack of reporting and inconsistent reporting from the field is a heavy handicap for health development planning, for the formulation of new health projects, and for the management of health program operations. Recently, at a Seminar on Policies and Strategies for the Regionalization of Health Services, held in Cap-Haitien, March 1977, (which the eleven Chief Administrators of the Health Regions and Districts attended)

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the Director General emphasized the obligation of Chief Administrators of health establishments (government and non-government) to report promptly on a monthly basis in order to build up an adequate baseline data system to guide management decisions for health program activities. The National Health Plan (July 1975) calls for a complete modernization of the present health statistics information system. This is a necessary step for health development programming. The need for reform of the health statistics information system is acute. Without an effective health statistics system much of the national effort could be misdirected

Infrastructure data

Inventory assessments of the infrastructure available are compiled by the DSPP's Statistical Section on a limited basis. The most common data collected are related to the number of health establishments, hospital beds and personnel. Data on stocks and costs of drugs and supplies, although available in the Procurement and Supplies Section, are not processed as part of Haiti's health statistics information system. Operating expenditures and data on capital investment are also excluded. Similarly personnel (new appointments, payroll) data maintained by the Personnel Section are not being utilized to update inventories of health manpower working in the field in various program activities.

Processing of Data

For processing data, the DSPP's Statistical Section employs seventeen clerks. The basic procedures for processing data are: evaluation of data collected, editing and coding, and tabulation. All operations are manual.

Manual sorting is not applied to obtain cross classification of data with two or more variables (i.e. number of births by age of the mother and parity). Unfortunately, only tabulations of one variable are made. This implies a significant waste of data [illegible] to extrapolate from existing data. Installation of a simple mechanical tabulation system should improve the organization of data, as well as produce results much faster. Under the presently short system, the tabulations of health service data are far behind schedule. The latest DSPP Annual Report on hospital statistics is for 1974. The one for 1975 is cut in stencils, but has not been published, due to lack of paper and ink. One important aspect that has been neglected in the preparation of DSPP's

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[illegible]

[illegible]

[illegible]

[illegible]

A great [illegible] health statistics [illegible] to utilize the [illegible]

1) [illegible]
2) [illegible]
3) [illegible]

[illegible] tional [illegible] of the [illegible] health [illegible] Section [illegible]

[illegible] management [illegible] health [illegible] Section [illegible] combinatorial [illegible] of this [illegible]

[illegible]

[illegible]

Tangible evidence of well-balanced planning

Health program as an integral part of economic development and social progress planning.

The assistance of A.I.D. personnel or other short-term consultants will be requested for each evaluation. For the final evaluation, the services of a team under an IQC or other short-term contract arrangement will be requested.

LOGICAL FRAMEWORK

Life of Project
From FY 1977 to 1986
Total U.S. Funding $2.525 million
Date Prepared: [illegible]

Project Title & Number: 521-0086 Strengthening Health Services II

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes. To remove the health sector constraints to socio-economic development in rural Haiti.	Measures of Goal Achievement: Increase in per capita income. Decrease in unemployment and underemployment. Reduction in rural-urban migration. Decrease in morbidity and mortality rates. Increase in number of contraceptive acceptors. Decrease in birth rate.	Household surveys. Market surveys. Demographic surveys. Vital statistics records. Clinical records.	Assumptions for achieving goal targets: Poor health and high birthrates among the rural population constitute a major constraint to economic development. Nonhealth system factors do not outweigh the effect of health system improvements and prevent better health. Medical services of sufficient magnitude are available. Rural population uses these services.
Project Purpose: To establish within the Department of Public Health and Population (DSPP) the planning and administrative structure to expand health services in rural Haiti; concurrently, to reduce the incidence of malaria sufficiently to integrate the malaria control organization (SNEM) into the DSPP.	Conditions that will indicate purpose has been achieved: End of project status. DSPP Key personnel assigned and staff trained in the requisite skills in an operationally effective (1) Bureau of Health planning and Evaluation responsible for preparing and revising periodically a health plan encompassing problems, priorities, and best use of available resources; (2) Central Administrative and Personnel Section; (3) Statistical Section functioning as central agency for collecting and distributing national data on health services and administration. RHDS Department of Community Medicine established within the School of Medicine. Malaria Control Incidence of malaria reduced to 500 cases per 1 million population. DSPP and SNEM prepared for integration.	DSPP personnel and training records. Bureau of Health Planning and Evaluation reports. A.I.D. contractor reports. Curriculum of Department of Community Medicine. Entomological studies. Prevalence Surveys.	Assumptions for achieving purpose: A.I.D. and other donors continue to provide technical assistance and support for health program. SNEM completes operations in accordance with its five-year plan.

Project Outputs:	Magnitude of Outputs:		Assumptions for achieving outputs
Health Manpower			
Inventory of health personnel: governmental, private, PVO.	Surveys and analyses completed during this planning phase of developing an integrated rural health service.		
Manpower analysis Bureau of Health Planning & Evaluation.			
Manpower analysis RHDS.			
Manpower Development			
Training for personnel of Bureau of Health Planning & Evaluation, Central Administrative Division Statistical Section.	Selection of personnel and identification of specific skills are a part of the planning phase for developing an integrated rural health delivery service.	DSPP personnel records.	Qualified candidates are available for training.
Field training for students of Department of Community Medicine.			Participant trainees are appropriately employed within the DSPP and RHDS.
Inservice Training DSPP personnel.	In process.		
	Increase from 29 vehicles in 1977 to 122 vehicles in 1982. Garage expansion scheduled for completion in 1978.		
		DSPP organizational records.	
Institutional Development			
Technology exchange program between Department of Community Medicine and U.S. public health educational institution.			Department of Community Medicine develops as planned.
Malaria Control			
DDT spraying program			Commodities arrive as scheduled.

	1978	1979	1980	1981	1982
			(In thousands)		
No. of houses to be sprayed	224	224	220	160	100
No. of people to be protected	341	341	300	240	150
Antimalarial drug distribution					
No. of people to receive drugs	582	582	347.5	247.5	195
Source Reduction					
Water control, larviciding	In approximately 36 localities annually.				

Project Inputs	Implementation Target (Type and Quantity)		Assumptions for providing inputs
See III B, Financial Plan.			

ANNEXES

A. Legal Exhibits

B. Technical

C. Institutional

D. Financial Estimates

- LIST OF CONTENTS -

Annex A - Legal Exhibits

Exhibit 1. Letter of Application

" 2. Draft Project Authorization and Request for Allotment of Funds (PAF)

" 3. Mission Director's Certification

" 4. Statutory Checklist

" 5. AID/W Guidance

Annex A Exhibit J

DEPARTMENT OF STATE
DIVISION OF LANGUAGE SERVICES

(TRANSLATION)

L.N. 62686
EJA/BP
French

Mr. Scott L. Behoteguy
Director of USAID in Haiti
Port-au-Prince, Haiti

Dear Mr. Behoteguy:

On the basis of the discussions held between our top personnel and various outside consultants, as well as on the analysis made of the health plan, we have the honor to request financial assistance from AID in order to carry out, beginning in 1977, a five-year project for the development of the health sector.

This project will constitute the second stage of a three-stage program initiated by the Government of the Republic of Haiti in 1975, having as its final objective the regionalization of the administration of health services and the placing of accessible medical and health services at the effective disposal of the majority of the rural population.

In that regard, AID and the Pan American Health Organization continue to contribute funds for executing the first stage, the objective of which is to improve, on the one hand, the ability of the National Major Endemic Diseases Service (SNEM) to reduce the incidents of malaria and, on the other hand, to strengthen the central administrative and planning capabilities of the Department of Public Health and Population and regionalize the administrative structure.

On the basis of an analysis of the progress made to date and bearing in mind the Haitian Government's objective to achieve by 1982 an equitable distribution of health services, we are of the opinion that the second stage of the project should finance:

1. A progressively decreasing amount for the SNEM in order to reduce the yearly rate of malaria to 500 cases or less per million inhabitants as a preliminary condition for integrating this institution into the regular services of the Department of Public Health and Population.

2. The strengthening ofthe central administrative capabilities of the Department of Public Health and Population (including logistics and supply) in order to establish and maintain a rural health care distribution system in the rural zones, as well as to integrate the SNEM into this Department.

3. The strengthening of the capabilities of the Central Planning Office of the Department of Public Health and Population in order to prepare or revise the National Health Plan, as well as to prepare and utilize on a test basis a model of a rural health care distribution system with a view to extending it throughout the country at the time of the execution, beginning in 1979, of the third and final stage of the program.

In order for the Government of the Republic of Haiti to achieve those objectives, it will require not only short- and long-term technical assistance and personnel training, but also materials, supplies, and equipment (including certain medications and vehicles), as well as the construction and maintenance of health centers, and funds to cover certain expenditures for operations and personnel.

In view of the fact that the second stage of the project will to a great extent be dedicated by the Department of Public Health and Population to planning activities, it falls to this Department to determine the levels of the individual draft budgets and to specify them in the proposed agreement that will be signed with AID. The budgetary levels will then be revised during the preparation and test use of the health care distribution model in the rural zones.

It will then be incumbent upon the Government of the Republic of Haiti to submit in the appropriate form detailed execution plans, supply plans, plans regarding operational needs, and a formal evaluation plan to be submitted for approval by AID prior to any request for a release of funds by AID in those various categories.

It is understood that the Government of the Republic of Haiti, in order to assure the success of the project, will provide formal proof of the establishment of an Administration Division within the Department of Public Health and Population, will give top priority to the extension of health services to the rural population, and will coordinate the efforts of AID and the Pan American Health Organization within the aforementioned Department.

In spite of the high priority given by the Government of the Republic of Haiti to the health of its population (as demonstrated by the allocation of 14% of the national budget to the health sector), the limited prospects for increased public funds make it impossible for the Government to finance the total cost of this project or the cost of extending effective health care to the majority of the rural population.

Although the Government proposes to assume the operational costs of the National Major Endemic Diseases Service in conjunction with this

project, a total of approximately 5.6 million dollars (US $5,600,000.00), and although the Pan American Health Organization contributes approximately US $850,000.00 in technical support to the National Major Endemic Diseases Service, it must be noted that the total cost of the second phase of the project is estimated at 16.9 million dollars (US $16,900,000.00).

Therefore, AID assistance in the amount of 10.5 million dollars (US $10,500,000.00) is needed at present on a non-refundable basis, in accordance with the recent decisions of the Government of the United States of America to treat Haiti as a special development case.

We are convinced that you will view this request favorably and

[complimentary close]

[Signature]

Dr. Willy Verrier
Secretary of State for
Public Health and Population

[Signature]

Emmanuel Bros
Secretary of State for
Finance and Economic Affairs

cc: Director General
Dr. E. Midy (Planning Section)
Dr. V. R. Joseph (Foreign Assistant Control Section)
Dr. Charles Weldon (AID)
Mrs. Ann McDonald (AID)

17 JUIN 1977

Mr. [illegible] . [illegible]
Directeur de l'USAID EN HAITI
[illegible]-au-Prince Haiti

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Cher Monsieur le Directeur,

En nous basant sur les discussions qui ont été engagées entre nos hautes personnalités respectives et diverses consultants externes ainsi que sur l'analyse du plan de santé, nous avons l'honneur de solliciter l'assistance financière de la AID pour l'exécution, à partir de 1977, d'un projet de développement du secteur santé s'échelonnant sur cinq ans.

Ce projet constituera la seconde phase d'un programme qui en comporte trois et dont le Gouvernement de la République a commencé en 1975 la mise en place, avec pour objectif final la régionalisation de l'administration des services de santé et la mise à la disposition effective de la majorité de la population des zones rurales, des services médico-sanitaires adéquats.

A cet égard, l'AID et l'Organisation Panaméricaine de la Santé apportent encore la contribution de leurs ressources à l'exécution de la première phase qui a pour but, d'une part, d'améliorer la capacité du SERVICE NATIONAL DES MALADIES PARASITAIRES à réduire l'incidence de la malaria, d'autre part, de renforcer les capacités d'administration centrale et de planification du Département de la Santé Publique et de la Population, et d'en régionaliser la structure administrative.

Sur la base de l'analyse des progrès réalisés jusqu'ici et étant donné l'objectif du Gouvernement Haïtien d'arriver en 1982 à une distribution équitable des services de santé, nous pensons que la seconde phase du projet devrait financer:

1) une aide progressivement décroissante au SNMP dans le but de réduire l'incidence annuelle de la malaria à 500 cas en moins par million d'habitants, comme condition préalable à l'intégration de cette Institution dans le cadre régulier des services du Département de la Santé Publique et de la Population.

2) le renforcement des capacités de l'administration centrale du Département de la Santé Publique et de la Population (y compris la logistique et l'ap-

[illegible] un système de distribution de soins de santé dans les zones rurales, assurant de l'intégration du [illegible] département.

[illegible] de l'unification du [illegible] de la santé publique et de la Représentation [illegible] de l'élaboration du [illegible] 1979, ainsi que la préparation et de l'[illegible] à titre d'essai d'un réseau de postes de distribution de soins de santé [illegible] rurale, dans la perspective de son extension à tout le pays lors de l'évaluation, à partir de 1979, de la [illegible] et durée [illegible] du programme.

La réalisation [illegible] objectifs nécessitera [illegible] Gouvernement de la RS [illegible] non seulement une assistance technique à court et à long terme et l'[illegible] renouvellement du personnel, [illegible] du matériel, des fournitures et de l'équipement (y compris certains véhicules et une vedette), ainsi que la construction et l'entretien d'établissements de santé, et des fonds pour couvrir certaines dépenses d'opérations et le personnel.

Au fait que la seconde phase du projet [illegible] mesure [illegible] par le Département de la Santé Publique [illegible] aux exigences de la planification, il reste à en donner à confirmer [illegible] les projets [illegible] individuels et à les spécifier dans le projet [illegible] général qui sera signé avec l'AID. Les niveaux budgétaires [illegible] revisés au cours de la [illegible] et de l'utilisation à bien [illegible] le distribution de soins [illegible] les zones rurales.

[illegible], il [illegible] du Gouvernement [illegible] d'Unité de [illegible] plans d'activités d'assistance, [illegible] approvisionnement, des [illegible] aux besoins de formations [illegible] d'évaluation à soumettre à l'approbation de l'AID préalablement [illegible] le versement par [illegible] le cadre de ces divers [illegible] appropriée.

[illegible] que le Gouvernement [illegible], pour assurer le [illegible] projet, fournira la preuve [illegible] d'une Division d'Administration dans le cadre du Département [illegible] et de la Population, [illegible] une haute priorité à l'[illegible] de santé à la population [illegible] et examinera les [illegible] l'organisation [illegible] de santé dans le cadre du [illegible].

[illegible] de la haute priorité accordée, [illegible] Gouvernement de la République à la santé de sa population (cette [illegible] d'affectation de 14% du [illegible] au secteur Santé), les [illegible] l'augmentation des [illegible] rendent impossible pour le Gouvernement [illegible] le financement du coût total du projet ou du coût de l'extension du soins de santé effectifs à la majorité [illegible] population rurale.

Si le Gouvernement se propose d'assumer les coûts opérationnels [illegible] dans le cadre de ce projet pour une dépense totale d'environ CIN[illegible] [illegible] 00/100 ([illegible]) et si on s'attend à [illegible] l'Organisation Panamericaine de la Santé contribue pour environ [illegible] 00 de 00/100 ([illegible]) en appoint [illegible], il est à remarquer cependant que le coût total de la

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[illegible] ; dans ce projet est évalué à [illegible] MILLE DOLLARS [illegible] ($ [illegible].000.000.00).

En conséquence, l'assistance de l'AID est présentement requise pour le montant complémentaire de DIX MILLIONS [illegible] DOLLARS 00/100 ($ 10.[illegible].000.00), et ce, sur une base non-remboursable, en conformité des décisions du Gouvernement des Etats-Unis d'Amérique du Nord de traiter Haïti comme un cas spécial de développement.

Nous demeurons persuadés que vous accorderez favorablement la présente requête et, dans l'attente de votre réponse, vous comptons, cher Monsieur le Directeur, avec nos remerciements anticipés, l'assurance renouvelée de notre très distinguée considération.

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Le Ministre d'Etat de l'Economie Publique et de la Planification

Leonel [illegible]
Secrétaire d'Etat des Finances et des Affaires Économiques

Cc: Directeur Général
Mr. [illegible] Didy (Section Financement)
Dr. V. [illegible] Joseph (Section Contrôle [illegible] Ultérieure)
Mr. [illegible] Weldon (TD)
Mme [illegible] Gomaid (AID)

[illegible]

Annex A Exhibit 2

DEPARTMENT OF STATE

AGENCY FOR INTERNATIONAL DEVELOPMENT

WASHINGTON, D.C. 20523

ASSISTANT
ADMINISTRATOR

PROJECT AUTHORIZATION AND REQUEST FOR ALLOTMENT OF FUNDS

PART II

Name of Country:	Haiti
Name of Project:	Strengthening Health Services II
Number of Project:	521-0086

Pursuant to Part I, Chapter 1, Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize a Grant to the Republic of Haiti (the "Grantee") of not to exceed Seven Million One Hundred Thousand United States Dollars ($7,100,000) (the "Authorized Amount") to help in financing certain foreign exchange and local currency costs of goods and services required for a project which will improve the capability of the Department of Public Health and Population ("DSPP") to plan and administer a rural health delivery system, design a rural health delivery system for Haiti and fund a decreasing share of the operating costs of the malaria control program administered by the National Society for Endemic Disease ("SNEM") ("Project"). $7.1 million of the A.I.D. financing herein authorized and approved for the project will be obligated when the Project Agreement is executed.

I approve the total level of A.I.D. appropriated funding planned for the Project of not to exceed Seven Million Five Hundred Twenty-Five Thousand United States Dollars ($7,525,000) of Grant funding, including the funding authorized above, during the period FY 1977 through FY 78. I approve further increments during that period of Grant funding up to $425,000, subject to the availability of funds in accordance with A.I.D. allotment procedures.

I hereby authorize the initiation of negotiation and execution of the Project Agreement by the officer to whom such authority has been delegated in accordance with A.I.D. regulations and Delegations of Authority, subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate:

A. Source and Origin of Goods and Services

Except for Ocean Shipping, goods and services financed by A.I.D. under the Project shall have their source and origin in Haiti or countries included in A.I.D. Geographic Code 941 except as A.I.D. may otherwise agree in writing. Ocean Shipping financed under the Grant shall be procured in any eligible source country except Haiti.

B. First Disbursement

Unless A.I.D. otherwise agrees, prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee will furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(1) An opinion of counsel acceptable to A.I.D. that the Project Agreement has been duly authorized and/or ratified by, and executed on behalf of, the Grantee, and that it constitutes a Valid and legally binding obligation of the Grantee in accordance with all of its terms; and

(2) Evidence that the Grantee has duly and lawfully established a department for administration within DSPP.

C. Additional Disbursement.

Unless A.I.D. otherwise agrees, prior to disbursement under the Grant, or to issuance by A.I.D. of documentation pursuant to which disbursement will be made, for any purpose other than to finance the technical advisor to SNEM, the Grantee will furnish to A.I.D. in form and substance satisfactory to A.I.D. an implementation plan containing a time phased work schedule for SNEM's activities during the first year of the Project and a similar schedule for DSPP, which schedules describe the activities to be carried out, the goals and targets to be achieved, and the offices or individuals responsible for each activity.

D. Disbursement for Operating and Personnel Expenses

Unless A.I.D. otherwise agrees, prior to disbursement under the Grant, or to issuance by A.I.D. of documentation pursuant to which disbursement will be made, to finance operating or personnel expenses of SNEM or DSPP, the Grantee will furnish to A.I.D. in form and substance satisfactory to A.I.D. a plan including:

(1) An itemization of the specific operating and personnel expenses for SNEM and DSPP during the first year of the Project for which Grant funds will be used; and

(2) A staffing plan for SNEM and DSPP showing the organizational and position necessary for the Project, the schedule for establishing and filling these positions, the salaries for these positions, and the source of funds for paying the salaries.

E. Disbursement for Training

Unless A.I.D. otherwise agrees, prior to disbursement under the Grant, or to issuance by A.I.D. of documentation pursuant to which disbursement will be made, to finance training, the Grantee will furnish A.I.D. in form and substance satisfactory to A.I.D. a training plan for the Project including:

(1) Proposed long and short term training;

(2) The schedule and estimated costs of the proposed training;

(3) The criteria used in selecting participants; and

(4) Measures to be taken for insuring that trainees continue to work in the positions for which they receive training.

F. Disbursement for SNEM after December 31, 1979

Unless A.I.D. otherwise agrees, prior to disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made,

after December 31, 1979, to finance any SNEM activity, the Grantee will furnish to A.I.D. in form and substance satisfactory to A.I.D. a plan for the integration or merger of SNEM and the DSPP.

G. Grantee's Covenants

Grantee shall covenant that:

(1) During this Project and thereafter, the Grantee will continue to give the extension of health services to rural areas high priority as a national goal and will coordinate the activities of A.I.D. and the Pan American Health Organization ("PAHO") relating to DSPP's extension of health services to rural areas to insure that A.I.D.'s and PAHO's efforts complement and reinforce each other without wasteful duplication or inconsistency.

(2) Unless A.I.D. otherwise agrees, the Grantee will furnish A.I.D. in form and substance satisfactory to A.I.D. annually during the Project a revised, updated version of the training plan submitted by Grantee under Section F and of the implementation plans submitted by Grantee under Section D.

(3) The technical advisor to SNEM for the Project referred to in Section C will be a medical entomologist capable of monitoring the effectiveness of the pesticide spraying.

Clearance:

GC/LA,JLKessler_____ Date____
LA/DR,CWeinberg_____ Date____
LA/DR,PBittner_____ Date____
LA/CAR,WRhoads_____ Date____

_____
Assistant Administrator
Bureau for Latin America

_____
Date

GC/LA,TLGeiger:lb:8/25/77
TLG/AW

ANNEX A

EXHIBIT 3

CERTIFICATION PURSUANT TO

Section 611 (e) of the

FOREIGN ASSISTANCE ACT

As Amended

I, Parke D. Massey, acting principal officer of the Agency for International Development in Haiti, do herewith certify that in my judgment, Haiti has both the financial capability and human resources to maintain and utilize effectively goods and services procured under the grant capital assistance project entitled Strengthening Health Services II.

This Judgment is based upon the record of implementation of AID financed projects in Haiti, including projects in the Public Health Sector and the results of the consulations undertaken during intensive review of this project.

Parke D. Massey

Acting Director,

USAID/Haiti

Date June 10, 1977

6C(1) - COUNTRY CHECKLIST

Listed below are, first, statutory criteria applicable generally to FAA funds, and then criteria applicable to individual fund sources: Development Assistance and Security Supporting Assistance funds.

GENERAL CRITERIA FOR COUNTRY	
FAA Sec. 116. Can it be demonstrated that contemplated assistance will directly benefit the needy? If not, has the Department of State determined that this government has engaged in consistent pattern of gross violations of internationally recognized human rights?	All AID projects in Haiti are aimed at the rural poor majority who comprise 95% of the population and whose average per capita income is less than $100 per year. The Department of State has not determined that this government has engaged in consistent pattern of gross violations of internationally recognized human rights.
2. FAA Sec. 481. Has it been determined that the government of recipient country has failed to take adequate steps to prevent narcotics drugs and other controlled substances (as defined by the Comprehensive Drug Abuse Prevention and Control Act of 1970) produced or processed, in whole or in part, in such country, or transported through such country, from being sold illegally within the jurisdiction of such country to U.S. Government personnel or their dependents, or from entering the U.S. unlawfully?	Haiti's law regulating the use & control of narcotic drugs was signed in December 8,1975. It provides stiff penalities for use & distribution of illegal drugs & Haiti cooperates with the U.S. controlling drug traffic.
3. FAA Sec. 620(a). Does recipient country furnish assistance to Cuba or fail to take appropriate steps to prevent ships or aircraft under its flag from carrying cargoes to or from Cuba?	No
4. FAA Sec. 620(b). If assistance is to a government, has the Secretary of State determined that it is not controlled by the international Communist movement?	Yes
5. FAA Sec. 620(c). If assistance is to government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) debt is not denied or contested by such government?	There is no evidence that Haiti is so indebted.
6. FAA Sec. 620(e)(1). If assistance is to a government, has it (including government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities?	There is no evidence that Haiti has taken such actions.

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7. F/A Act Sec. 620(f); App. Sec. 102. Is recipient country a Communist country? Will assistance be provided to the Democratic Republic of Vietnam (North Vietnam), South Vietnam, Cambodia or Laos?	No
8. FAA Sec. 620(j). Is recipient country in any way involved in (a) subversion of, or military or aggression against, the United States or any country receiving U.S. assistance, or (b) the planning of such subversion or aggression?	No
9. FAA Sec. 620(l). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction, by mob action, of U.S. property?	There are no incidences of such action in recent years.
10. FAA Sec. 620(i). If the country has failed to institute the investment guaranty program for the specific risks of expropriation, inconvertibility or confiscation, has the AID Administrator within the past year considered denying assistance to such government for this reason?	An investment guaranty agreement with Haiti is in effect.
11. FAA Sec. 620(o); Fisherman's Protective Act Sec. 4. If country has seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters,	Haiti has taken no such action.
a. has any deduction required by Fisherman's Protective Act been made?	Not applicable.
b. has complete denial of assistance been considered by AID Administrator?	Not applicable.
12. FAA Sec. 620(q); App. Sec. 504. (a) Is the government of the recipient country in default on interest or principal of any AID loan to the country? (b) Is country in default exceeding one year on interest or principal on U.S. loan under program for which App. Act appropriates funds, unless debt was earlier disputed, or appropriate steps taken to cure default?	a) Since rescheduling debts in 1970, Haiti has been current. b) No
13. FAA Sec. 620(s). What percentage of country budget is for military expenditures, how much of foreign exchange resources spent on military equipment? How much spent for the purchase of sophisticated weapons systems? (Consideration of these points is to be coordinated with the Bureau for Program and Policy Coordination, Regional Coordinators and Military Assistance Staff (PPC/RC).)	10. 8.7% of the $106 million budget in FY76-77 is budgeted for the armed forces. No equipment breakdown is provided, but most of this sum is for administration. No sophisticated weapons are procured. We are not aware of PL480 sales or development assistance funds having been used to cover military expenses.

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14. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have they been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

No

15. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the AID Administrator in determining the current AID Operational Year Budget?

The U.N. treasurer informed the U.S delegation to the U.N. on August 29,1975 that Haiti had made payments which removed the possibility that the country might lose its vote in the General Assembly because of arrears in its contributions. Haiti is continuing its voting rights and is being granted continued U.N. assistance.

16. FAA Sec. 620A. Has the country granted sanctuary from prosecution to any individual or group which has committed an act of international terrorism?

No.

17. FAA Sec. 666. Does the country object, on basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. there to carry out economic development program under FAA?

No

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18. FAA Sec. 669. Has the country delivered or received nuclear reprocessing or enrichment equipment, materials or technology, without specified arrangements on safeguards, etc.?

No.

19. FAA Sec. 931. Has the country denied its citizens the right or opportunity to emigrate?

No

B. FUNDING CRITERIA FOR COUNTRY

Development Assistance Country Criteria

a. FAA Sec. 102(c), (d). Have criteria been established, and taken into account, to assess commitment and progress of country in effectively involving the poor in development, on such indexes as: (1) small-farm labor intensive agriculture, (2) reduced infant mortality, (3) population growth, (4) equality of income distribution, and (5) unemployment.

B.1.a. With the assistance of AID & other donor the GOH is developing programs with measurable objectives in the fields of agriculture, health nutrition & population. Most of these programs are rural based.

b. FAA Sec. 281(a)(3), (7) & (8); Sec. 281(b)(3), (7). Describe extent to which country is:

(1) Making appropriate efforts to increase food production and improve means for food storage and distribution.

(2) Creating a favorable climate for foreign and domestic private enterprise and investment.

b. (1) The GOH allocated 34% of its 1977 annual development budget to agriculture and assigned a high priority to agriculture development. Within its limited resources and with external assistance the GOH is increasingly providing extension and credit services to farmers and is undertaking resources to improve production and marketing.

(2) The GOH has taken a number of steps to create a favorable investment climate, passing legislation to provide incentive for foreign and domestic investment, establishing a special office to facilitate investment, and encouraging and cooperating with private enterprise. With US assistance a study is being undertaken for expanding capital markets and domestic investment and enterprise through a proposed Development Finance Cooperation project.

(3) [illegible] the people's role in the developmental process.

(4) (a) Allocating available budgetary resources to development.

(b) Diverting such resources for unnecessary military expenditure and intervention in affairs of other free and independent nations.

(5) Making economic, social, and political reforms such as tax collection improvements and changes in land tenure arrangements, and making progress toward respect for the rule of law, freedom of expression and of the press, and recognizing the importance of individual freedom, initiative, and private enterprise.

(6) Otherwise responding to the vital economic, political, and social concerns of its people, and demonstrating a clear determination to take effective self-help measures.

c. FAA Sec. 201(b), 211(a). Is the country among the 20 countries in which development assistance loans may be made in this fiscal year, or among the 40 in which development assistance grants (other than for self-help projects) may be made?

d. FAA Sec. 116. Will country be furnished, in same fiscal year, either security supporting assistance, or Middle East peace funds? If so, is assistance for population programs, humanitarian aid through international organizations, or regional programs?

2. Security Supporting Assistance Country Criteria

a. FAA Sec. 502B. Has the country engaged in a consistent pattern of gross violations of internationally recognized human rights? Is program in accordance with policy of this Section?

b. FAA Sec. 531. Is the Assistance to be furnished to a friendly country, organization, or body eligible to receive assistance?

c. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

3) An objective of this project is involvement of local personnel in actual delivery of health services (agents sanitaires).

4) The GOH's development budget for 1976-77 is $43.8 million. This is 8.6% larger than the amount allocated for 1975-76.

4.b) The budget for the department of Interior & National Defense is the largest of the operating ministries. However, included in the total are police, fire protection and other non-military costs. There has been no intervention in affairs of other nations.

5) The GOH has established its intent to undertake reforms in public administration and fiscal management and has requested assistance from AID through an Administrative Improvement Project. Haiti is receiving or has requested assistance from external sources in these and in the social areas. Haiti has a much more open society now than it had several years ago, as evidenced by the recent return of many citizens to the country.

6.c) Development assistance loans and grants were made until approximately mid-FY77, when it was determined that all future projects would be grant financed in accordance with decisions taken at UNCTAD IV concerning the least developed countries

d) No

2 (a-c) Not applicable.

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6C(2) - PROJECT CHECKLIST

Listed below are, first, statutory criteria applicable generally to projects with FAA funds, and then project criteria applicable to individual fund sources: Development Assistance (with a subcategory for criteria applicable only to loans): and Security Supporting Assistance funds.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? IDENTIFY. HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

GENERAL CRITERIA FOR PROJECT.

1. App. unnumbered; FAA Sec. 653(b)

   (a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project; (b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than $1 million over that figure plus 10%)?

   a) Project was included in FY 1977 Congressional Presentation as a $7.0 million loan, $100,000 grant.

   b) Assistance is within (Operational Year Budget) country allocation reported to Congress.

2. FAA Sec. 611(a)(1). Prior to obligation in excess of $100,000, will there be (a) engineering, financial, and other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

   a) Yes

   b) The cost estimate of the project is considered sound.

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

   No legislative actions are required to permit accomplishment of the program.

4. FAA Sec. 611(b); App. Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per Memorandum of the President dated Sept. 5, 1973 (replaces Memorandum of May 15, 1962; see Fed. Register, Vol 38, No. 174, Part III, Sept. 10, 1973)?

   Not applicable.

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed $1 million, has Mission Director certified the country's capability effectively to maintain and utilize the project?

   Not applicable.

A.

6. FAA Sec. 209, 619. Is project susceptible of execution as part of regional or multilateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. If assistance is for newly independent country, is it furnished through multilateral organizations or plans to the maximum extent appropriate?

No regional organization is prepared to undertake improvement of the Health Ministry's internal planning and administrative process. Multi-lateral donors are already financing related undertakings in Haiti's health sector, and are not interested in financing this Project. However, this Project will be coordinated with, and built on their work.

7. FAA Sec. 601(a); (and Sec. 201(f) for development loans). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

8. FAA Sec. 601(b). Information and conclusion on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

Project will utilize U.S. technical advisors on both long and short term contract. All grant-financed procurement must be from U.S. source and origin.

9. FAA Sec. 612(b); Sec. 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized to meet the cost of contractual and other services.

The GOH local currency contribution is $3.2 million specified under terms of the grant for specific features of the project.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency and, if so, what arrangements have been made for its release?

No

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(c); Sec. 111; Sec. 281a. Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production, spreading investment out from cities to small towns and rural areas; and (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions?

Not applicable.

B1

b. FAA Sec. 103, 103A, 104, 105, 106, 107. Is assistance being made available: [Include only applicable paragraph -- e.g., a, b, etc. -- which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.]

(1) [103] for agriculture, rural development or nutrition; if so, extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, is full account taken of needs of small farmers;

Not applicable.

(2) [104] for population planning or health; if so, extent to which activity extends low-cost, integrated delivery systems to provide health and family planning services, especially to rural areas and poor;

The project will produce a design for a model rural health delivery system which will provide both health and family planning services.

(3) [105] for education, public administration, or human resources development; if so, extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, or strengthens management capability of institutions enabling the poor to participate in development;

Not applicable.

(4) [106] for technical assistance, energy, research, reconstruction, and selected development problems; if so, extent activity is:

Not applicable.

(a) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

(b) to help alleviate energy problem;

(c) research into, and evaluation of, economic development processes and techniques;

(d) reconstruction after natural or manmade disaster;

(e) for special development problem, and to enable proper utilization of earlier U.S. infrastructure, etc., assistance;

(f) for programs of urban development, especially small labor-intensive enterprises, marketing systems, and financial or other institutions to help urban poor participate in economic and social development.

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(5) [107] by grants for coordinated private effort to develop and disseminate intermediate technologies appropriate for developing countries.	Not applicable.
c. FAA Sec. 110(a); Sec. 208(e). Is the recipient country willing to contribute funds to the project, and in what manner has or will it provide assurances that it will provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or has the latter cost-sharing requirement been waived for a "relatively least-developed" country)?	Haiti will contribute $5.6 million to this project from the planned operating budget of SNEM. This will be closer to 40% of the total project cost.
d. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing?	Justification remains to be approved for a 5-year project life. Such justification shows that other financing is not available.
e. FAA Sec. 207; Sec. 113. Extent to which assistance reflects appropriate emphasis on; (1) encouraging development of democratic, economic, political, and social institutions; (2) self-help in meeting the country's food needs; (3) improving availability of trained worker-power in the country; (4) programs designed to meet the country's health needs; (5) other important areas of economic, political, and social development, including industry; free labor unions, cooperatives, and Voluntary Agencies; transportation and communication; planning and public administration; urban development, and modernization of existing laws; or (6) integrating women into the recipient country's national economy.	U.S. assistance in Haiti and elsewhere places emphasis on encouraging economic, social and political institutions required for a viable democratic society. One purpose of the project is to develop and strengthen administrative and technical institutions in the GOH. Another purpose will be to produce the basis for improving trained health manpower in the country. Particular attention will be given to using women as "agents of change" and deliverers of health and family planning services.
f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.	One important goal of this program is to increase the flow of resources to rural areas concerned for increased economic and social benefits. This program is looking to appropriate governmental agencies to provide trained personnel and essential services.

B1

g. FAA Sec. 201(b)(2)-(4) and -(8); Sec. 201(e); Sec. 211(a)(1)-(3) and -(8). Does the activity give reasonable promise of contributing to the development: of economic resources, or to the increase of productive capacities and self-sustaining economic growth; or of educational or other institutions directed toward social progress? Is it related to and consistent with other development activities, and will it contribute to realizable long-range objectives? And does project paper provide information and conclusion on an activity's economic and technical soundness?

Project Paper contains economic and social analysis. While there is no accepted formula which demonstrates a direct production (or economic) response to improved health care, such a relationship is generally assumed. Both economic (cost/benefit) and social analytical capability will be built into the Health Ministry's staff in designing a model rural health delivery system under this project.

h. FAA Sec. 201(b)(6); Sec. 211(a)(5), (6). Information and conclusion on possible effects of the assistance on U.S. economy, with special reference to areas of substantial labor surplus, and extent to which U.S. commodities and assistance are furnished in a manner consistent with improving or safeguarding the U.S. balance-of-payments position.

No adverse effects on U.S. balance of payments positions is expected.

2. Development Assistance Project Criteria (Loans only)

Not applicable.

a. FAA Sec. 201(b)(1). Information and conclusion on availability of financing from other free-world sources, including private sources within U.S.

b. FAA Sec. 201(b)(2); 201(d). Information and conclusion on (1) capacity of the country to repay the loan, including reasonableness of repayment prospects, and (2) reasonableness and legality (under laws of country and U.S.) of lending and relending terms of the loan.

c. FAA Sec. 201(e). If loan is not made pursuant to a multilateral plan, and the amount of the loan exceeds $100,000, has country submitted to AID an application for such funds together with assurances to indicate that funds will be used in an economically and technically sound manner?

d. FAA Sec. 201(f). Does project paper describe how project will promote the country's economic development taking into account the country's human and material resources requirements and relationship between ultimate objectives of the project and overall economic development?

e. FAA Sec. 202(a). Total amount of money under loan which is going directly to private enterprise, is going to intermediate credit institutions or other borrowers for use by private enterprise, is being used to finance imports from private sources, or is otherwise being used to finance procurements from private sources?

f. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete in the U.S. with U.S. enterprise, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan?

3. Project Criteria Solely for Security Supporting Assistance

Not applicable.

FAA Sec. 531. How will this assistance support promote economic or political stability?

4. Additional Criteria for Alliance for Progress

[Note: Alliance for Progress projects should add the following two items to a project checklist.]

a. FAA Sec. 251(b)(1), -(8). Does assistance take into account principles of the Act of Bogota and the Charter of Punta del Este; and to what extent will the activity contribute to the economic or political integration of Latin America?

The positive steps taken by the GOH in increasing its annual development budget for economic and social benefits for the Haitian population through increased emphasis on public health, nutrition and assisting small farmer development and poor rural population is encouraging.

b. FAA Sec. 251(b)(8); 251(h). For loans, has there been taken into account the effort made by recipient nation to repatriate capital invested in other countries by their own citizens? Is loan consistent with the findings and recommendations of the Inter-American Committee for the Alliance for Progress (now "CEPCIES," the Permanent Executive Committee of the OAS) in its annual review of national development activities?

Not applicable.

AE

are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

8. International Air Transport, Fair Competitive Practices Act, 1974

If air transportation of persons or property is financed on grant basis, will provision be made that U.S.-flag carriers will be utilized to the extent such service is available? — Yes

B. Construction

1. FAA Sec. 601(d). If a capital (e.g., construction) project, are engineering and professional services of U.S. firms and their affiliates to be used to the maximum extent consistent with the national interest? — Not applicable.

2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? — Yes

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed $100 million? — Not applicable.

C. Other Restrictions

1. FAA Sec. 201(d). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter? — Not applicable.

2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? — Not applicable.

3. FAA Sec. 620(h). Do arrangements preclude promoting or assisting the foreign aid projects or activities of Communist-Bloc countries, contrary to the best interests of the U.S.? — Yes

4. FAA Sec. 636(i). Is financing not permitted to be used, without waiver, for purchase, long-term lease, or exchange of motor vehicle manufactured outside the U.S. or guaranty of such transaction? — Not applicable.

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6C(3) - STANDARD ITEM CHECKLIST

Listed below are statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by exclusion (as where certain uses of funds are permitted, but other uses not).

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. Procurement

1. FAA Sec. 604(a). Are there arrangements to permit U.S. small business to participate equitably in the furnishing of goods and services financed?	Yes
2. FAA Sec. 604(a). Will all commodity procurement financed be from the U.S. except as otherwise determined by the President or under delegation from him?	Yes
3. FAA Sec. 604(d). If the cooperating country discriminates against U.S. marine insurance companies, will agreement require that marine insurance be placed in the U.S. on commodities financed?	Yes
4. FAA Sec. 604(e). If there procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the delivered price of such commodity is less than parity?	Not applicable.
5. FAA Sec. 604(g). Government excess personal property be utilized wherever practicable in lieu of the procurement of new items?	Yes
6. FAA Sec. 901b. In compliance with requirement that at least 50 per centum of the gross tonnage of commodities (computed separately for dry cargo carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent that such vessels are available at fair and reasonable rates.	Yes
7. FAA Sec. 601(d). If technical assistance is financed, will such assistance be furnished to the fullest extent practicable as goods and services from private enterprise on a contract basis? If the facilities of other Federal agencies will be utilized,	Yes

5. Will arrangements preclude use of financing:

a. FAA Sec. 114. to pay for performance of abortions or to motivate or coerce persons to practice abortions?	Yes
b. FAA Sec. 620(g). to compensate owners for expropriated nationalized property?	Yes
c. FAA Sec. 660. to finance police training or other law enforcement assistance, except for narcotics programs?	Yes
d. FAA Sec. 662. for CIA activities?	Yes
e. App. Sec. 103. to pay pensions, etc., for military personnel?	Yes
f. App. Sec. 106. to pay U.N. assessments?	Yes
g. App. Sec. 107. to carry out provisions of FAA Sections 209(d) and 251(h)? (transfer to multilateral organization for lending).	Yes
h. App. Sec. 501. to be used for publicity or propaganda purposes within U.S. not authorized by Congress?	Yes

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E.O. 11652: N/A

TAGS:

SUBJECT: STRENGTHENING HEALTH SERVICES PP AND PRP

1. THE DAEC REVIEWED SUBJECT PROPOSALS ON NOVEMBER 17. SINCE THERE IS A SUBSTANTIAL AMOUNT OF WORK TO BE ACCOMPLISHED PRIOR TO DEC. 31, 1975, WE ARE PROVIDING EARLY GUIDANCE CONCERNING GOH COMMITMENTS AS WELL AS A BRIEF OVERVIEW OF DAEC RECOMMENDATIONS. MORE EXTENSIVE COMMENTS WILL FOLLOW BY SEPTEL WITHIN TWO WEEKS.

2. THE DAEC CONCLUDED THAT PRIOR TO AID/W APPROVAL OF THE PP FOR THE BRIDGE GRANT, A FIRM UNDERSTANDING SHOULD BE REACHED WITH THE GOH THAT AID GRANT FUNDS FOR SNEM OPERATING EXPENSES WOULD TERMINATE IN FY 77. THE USAID

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SHOULD EXPLAIN TO THE GOH THAT AID IS PREPARED TO SEEK FY 77 LOAN FUNDS IF THE GOH IS PREPARED TO APPLY FOR AID FINANCING FOR MALARIA CONTROL ON A LOAN BASIS.

WHILE THIS UNDERSTANDING MUST INVOLVE DISCUSSIONS WITH THE MOPH/P, IT SHOULD ALSO INVOLVE THE MINISTRY OF FINANCE, AND ANY OTHER LEVEL IN THE GOH WHICH IS NECESSARY TO ASSURE A FIRM GOH COMMITMENT. IN THE DISCUSSIONS, USAID SHOULD INDICATE AID'S WILLINGNESS TO CONSIDER INCREASED

FUNDING (DEPENDING UPON AVAILABILITY OF FUNDS) FOR A BROAD LOAN/GRANT HEALTH SECTOR PROGRAM BEGINNING IN FY 1977 AS PART OF THE MALARIA CONTROL EFFORT. THIS IS FURTHER ELABORATED IN PARAS. 4 AND 7 BELOW.

THE DAEC CONCLUDED THAT IN ADDITION TO THE NEED FOR A GOH UNDERSTANDING, AND ON THE BASIS OF DISCUSSIONS, AID'S INTENTION TO PHASE OUT OF GRANT FINANCING OF OPERATING EXPENSES FOR MALARIA CONTROL SHOULD ALSO BE SET FORTH IN THE NEW PROAG. (AID/W REPS WOULD DESIRE TO PARTICIPATE IN DRAFTING PROAG EITHER IN WASHINGTON OR IN HAITI). IF TIME OR OTHER CONSTRAINTS PRECLUDE INCORPORATION OF THIS GOH UNDERSTANDING IN THE PROAG, AN ACCEPTABLE ALTERNATIVE WOULD BE A SEPARATE GOH LETTER OF UNDERSTANDING SIGNED BY MINISTRY OF FINANCE PRIOR TO SIGNING OF PROAG.

3. THE PROAG SHOULD ALSO INCLUDE A TIME PHASED WORK PLAN, SETTING FORTH THE OBJECTIVES OF THE BRIDGE GRANT PROGRAM, THE EXPECTED COMPLETION DATES FOR THE MALARIA AND MOPH/P STUDIES AND THE MALARIA CONTROL PLAN OF OPERATIONS, AND EVALUATION BENCHMARKS. BECAUSE THE PP REPRESENTS A BRIDGE GRANT AIMED AT ESTABLISHING A BASIS FOR SUBSEQUENT LOAN FINANCING, THE DAEC FELT THAT SUCH DETAIL WAS NECESSARY IN ORDER TO INSURE ORDERLY PROGRESS TOWARD OBJECTIVES DURING THE COURSE OF THE PROJECT.

4. THE DAEC ALSO CONSIDERED THAT ADDITIONAL FY 76 AND TQ FUNDS (TOTALLING DOLS 195,000) COULD BE ADDED TO BRIDGE GRANT FOR TRAINING AND TECHNICAL ASSISTANCE UP TO THE LEVEL OF THE CONGRESSIONAL PRESENTATION, I.E.,

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DOLS 1,244,000 IN FY 1976 AND DOLS 310,000 IN THE TQ, TO MAXIMIZE THE EFFECTIVENESS OF THE MOPH PLANNING TEAM, AND TO EXPLORE RELATED HEALTH CONSTRAINTS AND THE FEASIBILITY OF BROADER INTEGRATED APPROACHES TO HEALTH PROGRAMS AND PROBLEMS. TECHNICAL ASSISTANCE IN DESIGN OF PILOT PROJECTS AND LIMITED SUPPORT FOR INTEGRATED DELIVERY SYSTEM BASED ON UTILIZATION OF MEDICAL AUXILIARIES SHOULD BE CONSIDERED, AS WELL AS RURAL POTABLE WATER, ETC.

5. CONSIDERING THE GUIDELINES PROVIDED IN AIRGRAM - "TO AMEMBASSY/PAP 17 OCTOBER 29, 1975 - REVIEW OF ONGOING GRANT PROJECT PORTFOLIO;" CONTINUATION OF THE BASKET TYPE PROJECT PRESENTED IN THE PP SHOULD NOW BE JUSTIFIED BY THE MISSION IN LIGHT OF APPARENT PURPOSE TO EXPAND HEALTH ACTIVITIES IN HAITI AND TO PROVIDE A BRIDGE TO TOTAL GOH RESPONSIBILITY FOR THE MALARIA PROGRAM, I.E., LOAN FINANCING. PLEASE PROVIDE THIS JUSTIFICATION BY SEPTEL ASAP.

6. SPECIFIC WORK PLAN DEVELOPED FOR PROAG SHOULD BE INCLUDED IN REVISED PP ALONG WITH UPDATED LOG FRAME IN ACCORDANCE WITH REVISION.

7. TO SUPPORT THE COMPREHENSIVE NATURE OF THE PROPOSED LOAN PRP, CONCOMITANT GRANT FINANCING DURING LIFE OF LOAN COULD BE INCREASED OVER THAT PROPOSED. SUGGEST AT LEAST DOLS 3.5 MILLION DURING FIVE YEARS BE CONSIDERED.
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E.O. 11652: N/A

TAGS:

SUBJECT: STRENGTHENING HEALTH SERVICES PP AND PRP

REF: STATE 275795

1. REFTEL STATED THE DAEC CONCLUSION THAT A FIRM UNDERSTANDING SHOULD BE REACHED WITH THE GOH THAT AID GRANT FUNDS FOR SNEM OPERATING EXPENSES WOULD TERMINATE IN FY 1977. THIS FOLLOW-UP CABLE PROVIDES DETAILED COMMENTS REGARDING PARAGRAPHS 4 AND 7 OF REFTEL.

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2. THE DAEC RECOMMENDED THAT THE MISSION EXPAND THE TECHNICAL ASSISTANCE REQUIREMENTS TO INCLUDE STUDIES OF BROADER HEALTH PROBLEMS CONFRONTING THE GOH, SUCH AS THE NEED FOR DELIVERY SYSTEMS BASED ON MEDICAL AUXILIARIES, RURAL POTABLE WATER, ETC., AS INDICATED IN REFTEL PARA 4. PP WORK PLAN FOCUSES ON IDENTIFYING CONSTRAINTS TO BE RESOLVED PRIOR TO INTEGRATION OF SMCM INTO THE MOPH, AND STUDIES AIMED AT IMPROVEMENT OF MOPH OPERATIONAL AND PLANNING CAPABILITY. THE DAEC SUGGESTS THAT FOCUS BE BROADENED TO INCLUDE:

-A. ANALYSIS OF THE EXPECTED LEVELS OF MIGRATION OF PROFESSIONALLY TRAINED PERSONNEL AND RESULTING IMPLICATIONS FOR TRAINING REQUIREMENTS FOR PARA-MEDICAL PERSONNEL;

-B. IDENTIFICATION OF HEALTH SERVICES NOT PRESENTLY OFFERED OR PROPOSED WITHIN THE GOH AGENCIES, LOCAL NON-GOVERNMENT ORGANIZATIONS (NGOS) AND PVOS;

-C. IDENTIFICATION OF WAYS TO STRENGTHEN AID, PVO AND NGO HEALTH AND NUTRITION INPUTS AND NEW OPPORTUNITIES FOR ASSISTANCE IN THOSE SAME FIELDS;

-D. EVALUATION OF THE QUALITY OF SERVICES PROVIDED BY NGO/PVOS AND CONSIDERATION OF INCORPORATING THESE SERVICES INTO MOPH IN CASES OF INADEQUATE OR LIMITED CAPACITY OR WHERE FINANCIAL SUPPORT HAS TERMINATED;

-E. PROJECTION OF GOH AND EXTERNAL RESOURCES AVAILABLE TO THE HEALTH SECTOR AND IDENTIFICATION OF CRITICAL RESOURCE REQUIREMENTS; AND

-F. EXPANDED RESEARCH INTO THE BASIC CAUSES OF DISEASE IN HAITI.

3. RE PARA 7 REFTEL, THE TECHNICAL ASSISTANCE AND PARTICIPANT TRAINING REQUIREMENTS IDENTIFIED IN THE PRP SHOULD BE RE-EXAMINED IN LIGHT OF THE STUDIES SUGGESTED IN PARA 2 ABOVE. THE DAEC RECOGNIZES THAT THE DOLS 7.0 MILLION LOAN MIGHT BE INADEQUATE TO SUPPORT AIDS INTEREST IN A BROADER HEALTH SECTOR PROGRAM. THEREFORE,

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INCREASED GRANT FINANCING UP TO DOLS 3.5 MILLION OVER FIVE YEARS SHOULD BE CONSIDERED. THE GRANT COMPONENT CAN BE USED TO SUPPORT COSTS ASSOCIATED WITH HUMAN RESOURCE DEVELOPMENT, FEASIBILITY STUDIES AND PILOT PROJECTS. KISSINGER.

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E.O. 11652: N/A

TAGS:

SUBJECT: STRENGTHENING HEALTH SERVICES PP AND PRP

REF: (A) STATE 275799 - NOV. 21, 1975
(B) STATE 298278 - DEC. 18, 1975

1. AID/W REVIEWED RESUBMISSIONS OF SUBJECT PP AND PRP ON JANUARY 16. WE FOUND THAT NEW DOCUMENTS DID NOT ENTIRELY ANSWER THE ISSUES RAISED IN THE DAEC REVIEW AND THE GUIDANCE PROVIDED IN REFTELS. WITH REGARD TO THE TIME-PHASED WORK PLAN, WE WOULD LIKE THE MISSION TO ADDRESS PARAGRAPHS THREE AND SIX OF REF (A). WITH REGARD TO ADDITIONAL FUNDS FOR TECHNICAL ASSISTANCE, WE WOULD LIKE THE MISSION TO INCORPORATE THE CONSIDERATIONS AND SUGGESTIONS DISCUSSED IN PARAGRAPH TWO, REF (B) INTO THE TEXT OF THE PP AND PRP IN ORDER TO EXPLAIN THE COSTS ASSOCIATED WITH AITIONAL TECHNICAL ASSISTANCE STUDIES, HUMAN RESOURCE DEVELOPMENT AND PILOT PROJECTS.

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2. REF (A), PARAGRAPH SEVEN, INDICATED THAT ADDITIONAL GRANT FINANCING OF AT LEAST DOLS 3.5 MILLION OVER FIVE YEARS SHOULD BE CONSIDERED TO SUPPORT THE PROPOSED LOAN. AID/W APOLOGIZES FOR THE CONFUSION, BUT DUE TO EXISTING BUDGET COMMITMENTS FOR FY 77, ONLY DOLS 100,000 OF GRANT FUNDS IS AVAILABLE FOR FY 77 FOR PROJECT 086.
FYI - AID/W HAS BUDGETED A TOTAL OF DOLS 3.5 MILLION IN GRANT FUNDS FOR THIS PROJECT FOR FY 77-81 INCLUSIVE (DOLS 100,000 FOR FY 77) - END FYI.

3. AID/W WILL BE PLEASED TO PROVIDE OR ARRANGE TDY OR CONTRACT ASSISTANCE IF USAID REQUESTS TO SATISFY REQUIREMENTS OF REFTELS. IN THIS REGARD, MISSION SHOULD PROVIDE FUNDS FOR SUCH SERVICES UNDER HEALTH SERVICES I PROJECT BUDGET. KISSINGER

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APPROVED BY AA/LA:DMLION, ACTING
LA/DR:CWEINBERG
LA/DR:DLION
LA/DR:PFARLEY (DRAFT)
LA/DR:PVENEZIA (DRAFT)
LA/DR:DERBE (DRAFT)
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UNCLAS STATE 038022

AIDAC

E.O. 11652: N/A

TAGS:

SUBJECT: STRENGTHENING OF HEALTH SERVICES

REF: A. STATE 275799 B. STATE 298278 C. STATE 299383

1. TO CLARIFY ANY MISUNDERSTANDINGS, PRIOR TO PP APPROVAL, REF A REQUIRED MUTUAL UNDERSTANDING WITH GOH THAT FY 77 WOULD BE LAST YEAR FOR GRANT FINANCING OF SNEM OPERATING EXPENSES. LANGUAGE FOR THAT UNDERSTANDING WAS NEGOTIATED BY MISSION WITH GOH, AND WAS APPROVED BY AID/W PER REF C. THEREFORE, SUBJECT PP IS HEREBY APPROVED. HOWEVER SEVERAL OUTSTANDING ISSUES REMAIN TO BE CLARIFIED. OF IMMEDIATE CONCERN ARE THOSE ELEMENTS OF THE PP WHICH RELATE DIRECTLY TO SNEM. ACCORDINGLY, AND FOR THOSE ELEMENTS WHICH RELATE DIRECTLY TO SNEM, AID/W REQUESTS THE MISSION TO RESPOND TO

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PAGE 02 STATE 038022

RELEVANT PORTION OF PARA 3, REF A. THIS INCLUDES PREPARING A TIME-PHASED SCHEDULE OF ACTIVITIES FOR LIFE OF PROJECT, INDICATING:

---A. MAJOR EVENTS WITH EXPECTED BEGINNING, AND COMPLETION DATES OF THOSE EVENTS (E.G. SPECIFIC STUDIES OR ACTIVITIES RELATING TO OUTPUTS SUCH AS STRENGTHENING SNEM'S EPIDEMIOLOGICAL CAPABILITY, ACHIEVEMENT OF ADEQUATE COVERAGE OF MALARIOUS AREAS, EVALUATIONS, INTEGRATION OF SNEM INTO MOPH/P, ETC.);

---B. RESPONSIBLE ACTION AGENT FOR EACH ACTIVITY; AND

---C. SOURCE OF FINANCING (AID, PAHO, GOH, ETC.).

WE WOULD SUGGEST MISSION DEVELOP CHRONOLOGICAL BAR CHART OR NETWORK DIAGRAM COVERING PERIOD OF BRIDGE GRANT, SHOWING ACTIVITIES TO BE FINANCED THEREUNDER. AS DISCUSSED BY VENEZIA DURING TDY, CONCERN IS THAT AID WILL BE ABLE TO DETERMINE DURING LIFE OF BRIDGE GRANT WHETHER THOSE ACTIVITIES WHICH ARE CRITICAL TO ORDERLY AND TIMELY TERMINATION OF BRIDGE FINANCING FOR SNEM ARE ON SCHEDULE, AND IF NOT, WHO IS RESPONSIBLE FOR DELAY. SUCH A SCHEDULE SHOULD HAVE PAHO CONCURRENCE. THIS SCHEDULE SHOULD ALSO BE INCLUDED IN THE NEW PROAG.

2. AID/W UNDERSTANDS THAT THE UNFINISHED PAHO FUNDED MALARIA STUDIES, THE MOPH/P STUDIES (WHICH WILL BE UNDERTAKEN IN PART BY A CONTRACT HEALTH PLANNER) AND THE MALARIA CONTROL PLAN OF OPERATIONS WILL BE FORTHCOMING AS THE RESULTS BECOME AVAILABLE.

3. LA/DP FINANCE OFFICER, PETER BITTNER, PLANNING TDY TO JAMAICA O/A FEBRUARY 23. IF MISSION DESIRES, HE WOULD ALSO BE AVAILABLE FOR CONSULTATION ON THIS PROJECT FOR TWO TO THREE DAYS MAXIMUM. PLEASE ADVISE SOONEST. INGERSOLL

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AIDAC

E.O. 11652: N/A
SUBJECT: RURAL HEALTH DELIVERY SYSTEM PRP - DAEC REVIEW

1. THE DAEC REVIEWED THE SUBJECT PROJECT ON OCTOBER 21, 1976 AND APPROVED INTENSIVE REVIEW OF THE PROJECT. HOWEVER, BECAUSE OF THE RELATIONSHIP OF THE PROJECT TO THE FY 77 PROJECT (YET TO BE DEVELOPED) THE DAEC REQUESTED THAT AN INTERIM REPORT BE SUBMITTED ADDRESSING THE CRITICAL ISSUES CITED IN THE PRP. THE INTERIM REPORT SHOULD BE SUBMITTED TO AID/W BEFORE DECEMBER 31, 1977. THE DAEC REQUESTED THAT SPECIFIC ATTENTION BE GIVEN TO THE FOLLOWING IN DEVELOPMENT OF THE INTERIM REPORT:

-----(A) PROJECT DESIGN: THE DAEC RECOGNIZED THE CLOSE RELATIONSHIP BETWEEN THE FY 77 HEALTH SECTOR LOAN THAT IS NOW BEING DEVELOPED AND THE PROPOSED FY 78 PROJECT. BASED ON THE ANALYSES THAT WILL BE CARRIED OUT DURING FY 77, THE MISSION SHOULD OUTLINE IN THE INTERIM REPORT THE TYPE OF RHDS THAT WILL BE REPLICATED BY THE FY 78 PROJECT AND THE ANTICIPATED PROGRAMMING OF FY 78 FUNDS FOR THIS REPLICATION. AN EXPANDED DESCRIPTION AND JUSTIFICATION OF EACH PROJECT ELEMENT SHOULD ALSO BE PROVIDED ALONG WITH AN ANALYSIS OF HOW EACH ELEMENT WILL ADDRESS PARTICULAR CONSTRAINTS TO EXPANDING HEALTH SERVICES FOR THE HAITIAN RURAL POOR.

-----B. CONTROL OF MALARIA AND INTEGRATION OF SNEM INTO THE RHDS: THE PRP PROPOSES THAT THE RHDS WILL BE DEVELOPED IN AREAS WHERE THE INCIDENCE OF MALARIA IS REDUCED TO A LEVEL THAT WILL FREE SNEM WORKERS AND RESOURCES FOR INTEGRATION INTO THE RHDS. THE INTERIM REPORT SHOULD ASSESS THE FEASIBILITY OF REDUCING MALARIA INCIDENCE TO THE EXTENT NECESSARY TO PERMIT INTRODUCTION OF THE RHDS WITHIN THE TIME FRAME OF THE PROJECT.

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-----C. MINISTRY OF HEALTH ABSORPTIVE CAPACITY: AID FY 76 TECHNICAL ASSISTANCE TO THE MOH PLANNING GROUP HAS BEEN SIGNIFICANTLY DELAYED. IN ADDITION, THE EXISTING MOH ADMINISTRATIVE CAPACITY IS VERY LOW. IN LIGHT OF THIS, THE INTERIM REPORT SHOULD INCLUDE AN INITIAL ANALYSIS OF THE FEASIBILITY OF DEVELOPING THE MOH INSTITUTIONAL CAPACITY NECESSARY TO IMPLEMENT, WITHIN THE TIME PROJECTED IN THE PRP, THE EXPANDED RHDS.

-----D. SCOPE OF SERVICES OF THE RHDS: THE DETAILED SCOPE OF SERVICES WHICH THE RHDS WILL BE DESIGNED TO DELIVER TO THE RURAL POPULATIONS IS STILL TO BE DETERMINED. THE PRP RECOMMENDED THAT DURING INTENSIVE REVIEW AN ANALYSIS OF ALTERNATIVE COMPONENTS SUCH AS WATER SUPPLY AND RURAL SANITATION WOULD BE UNDERTAKEN. THE ANALYSIS MIGHT BE DRAWN FROM PROJECT DEVELOPMENT WORK DONE FOR THE FY 77 PROJECT PAPER AND THE ANALYSIS SHOULD BE INCLUDED IN THE INTERIM REPORT. IF COMPONENTS SUCH AS WATER SUPPLY AND RURAL SANITATION ARE ADDED, THEN THE INTERIM REPORT SHOULD ALSO INDICATE HOW THE ENGINEERING AND OTHER RELATED TECHNICAL PLANNING WILL BE CARRIED OUT BEFORE OBLIGATION IN ACCORD WITH SECTION 611(A).

-----E. FINANCIAL IMPLICATIONS OF RHDS ON GOH BUDGET: IT IS ASSUMED THAT THE RHDS TO BE DEVELOPED IN THE FY 77 AND FY 78 PROJECTS WILL INCREASE GOH BUDGETARY REQUIREMENTS. THE INTERIM REPORT SHOULD INCLUDE AN ASSESSMENT OF THE PROJECTED OVERALL RECURRENT COSTS OF THE RHDS, A GENERAL OVERVIEW OF THE EFFECT THIS AND OTHER LOAN FUNDED PROJECTS WILL HAVE ON THE FUTURE NATIONAL DEBT BURDEN AND A POLICY DISCUSSION ON POSSIBLE SOURCES OF FINANCING, I.E. FEE FOR SERVICE, REALLOCATION WITHIN GOH BUDGET OR LONG TERM BUDGET SUPPORT BY AID OR OTHER EXTERNAL ASSISTANCE.

-----F. MISSION STAFFING: INCREASED AID INVESTMENTS IN THE HAITIAN HEALTH SECTOR MAY REQUIRE MORE MISSION PERSONNEL TO ADEQUATELY MONITOR PROJECTS. INTERIM REPORT SHOULD ASSESS BOTH DIRECT-HIRE AND CONTRACT PERSONNEL NEEDS TO DEVELOP AND MONITOR HEALTH, NUTRITION AND POPULATION PROJECTS.

2. AA/LA APPROVED NEGATIVE DETERMINATION RECOMMENDED IN MISSION'S IEE. ROBINSON

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SUBJECT: DAC Review of Health Services II PP

[illegible] REVIEWED THE SUBJECT PP [illegible] AND DETERMINED [illegible] REFLECT THE DEGREE OF PLANNING [illegible] REQUESTED OR PROVIDE A BASIS FOR A JUDGMENT THAT PROJECT HAS BEEN [illegible] IMPLEMENTED.

[illegible] ADDITIONAL [illegible] THE DAC [illegible] WITH RESPECT [illegible] TO EX- [illegible] YET [illegible] AND [illegible] THE [illegible] AT [illegible] TO THE [illegible] CASES [illegible] ENDOWED [illegible] FUNDING.

[illegible] ISSUE OF [illegible] SUCH DATE [illegible] A VEHICLE [illegible] WITHDRAWAL [illegible] SUBJECT [illegible] PP [illegible] A PROJ- [illegible] THE [illegible] DISTRICT. [illegible] THE [illegible] THE [illegible] REQUIRED, [illegible] THIS DEVELOPMENT PROCESS.

[illegible] SYSTEM [illegible] DEVELOPMENT [illegible] THE [illegible] DETAILED [illegible] PARA- [illegible] AS IT REFERS [illegible] TYPE OF [illegible] TYPE OF [illegible] SERVICES [illegible] RELATIONSHIP [illegible] TYPES [illegible]

BE FUNDED UNDER THE PROJECT SHOULD BE DESCRIBED - WHAT ELEMENTS HAVE NOT YET BEEN DETERMINED, HOW THESE ELEMENTS WILL BE DETERMINED AND BY WHAT APPROXIMATE DATES. THE OPERATIONS OF RHDS SHOULD BE ILLUSTRATED BY SHOWING STAFFING, COST OPERATIONS, SERVICES TO BE PROVIDED, ETC.

B) DESCRIBE AND ITEMIZE ALL COST ESTIMATES OF OPERATING AND STAFFING THE PROTOTYPE RHDS AND SHOW BASIS FOR DETERMINING THOSE COSTS. ELEMENTS SHOULD INCLUDE: 1) DESCRIPTION AND MAGNITUDE OF BUDGET SUPPORT REQUIRED; 2) TRAINING - PARTICULARLY DETAILS ON TRAINING TO BE CARRIED OUT AT PETIT GROVE AND CROIX-DES-BOUQUETS, UNDER THOSE TWO ONGOING PROJECTS, INCLUDING THAT PROVIDED UNDER OTHER SOURCES OF FUNDING, 3) ESTABLISHMENT OF THE DEPARTMENT OF COMMUNITY MEDICINE AND THE TECHNICAL EXCHANGE PROGRAM, 4) TECHNICAL ASSISTANCE, IF ANY, PLANNED AT THIS STAGE FOR DEVELOPMENT AND IMPLEMENTATION OF RHDS, 5) VEHICLES AND OTHER COMMODITIES.

C) DESCRIBE GENERAL CATEGORIES, QUANTITIES OF DRUGS, SUPPLIES AND MEDICAL EQUIPMENT PLANNED FOR THE PROTOTYPE RHDS'S. INCLUDE: 1) RELATIONSHIP TYPE OF DRUGS, SUPPLIES AND MEDICAL EQUIPMENT SELECTED TO DISEASE PATTERNS AND SERVICES TO BE PROVIDED; 2) DISCUSS IMMEDIATE NEEDS AND PROJECTED PIPELINE FOR PLANNED PHASE III, EXPANSION OF RHDS; 3) BASIS FOR CALCULATING DRUGS, SUPPLIES AND MEDICAL EQUIPMENT REQUIREMENTS - E.G., NUMBER OF PEOPLE TO BE SERVED, INVENTORY LEVEL AT DISPENSARY, ETC.

D) ALSO PROVIDE BASIS FOR COST ESTIMATES FOR DRUGS/SUPPLIES AND MEDICAL EQUIPMENT, INCLUDING RATIONALE FOR AMOUNTS PER YEAR, WHICH WILL BE PURCHASED UNDER THIS PROJECT AND STOCKPILED FOR USE IN THE FUTURE EXPANSION OF THE RHDS BEYOND THE PROTOTYPES.

3. TECHNICAL ASSISTANCE: (TO THE DSPP)

A) PROVIDE A DESCRIPTION OF ONGOING TA ACTIVITIES UNDER WESTINGHOUSE CONTRACT AND A CLEAR DISTINCTION BETWEEN THOSE ACTIVITIES AND FUTURE REQUIREMENTS TO BE FUNDED BY THIS PROJECT (PHASE III).

B) SPECIFY TYPE OF TECHNICAL ASSISTANCE NEEDED FOR EACH PHASE OF THE PROJECT (I.E., DEVELOPMENT OF THE RHDS, PLANNING AND ADMINISTRATIVE CAPACITY OF DSPP THE DEPARTMENT OF MEDICINE) APPROXIMATE DURATION, POTENTIAL OR PROPOSED SOURCES, AND RELATIONSHIP OF TA TO THE DEVELOPMENT OF THE RHDS.

C) PROVIDE COST ESTIMATES FOR TYPE OF TECHNICAL ASSISTANCE AND THE BASIS FOR THE ESTIMATES.

4. TRANSPORTATION: EXPLAIN HOW THE TRANSPORTATION REQUIREMENTS (VEHICLES, FUEL, SPARE PARTS AND MAINTENANCE EXPENSES) FOR DSPP AND RHDS FOR THIS YEAR AND FUTURE YEARS HAVE BEEN ESTIMATED PRIOR TO COMPLETION OF THE DEVELOPMENT OF THE RHDS. PROVIDE THE BASIS FOR THE REQUIREMENTS PROJECTED IN ANNEX D AND CLARIFY THE DISCREPANCIES IN THE TOTAL VEHICLE REQUIREMENTS. ALSO CLARIFY THE REQUIREMENT FOR MOTORCYCLES AND THE PROVISION OF SPARE PARTS (ASSUMED BY INCLUSION IN PRICE OF VEHICLES). IF NON-LOCAL SOURCE MOTORCYCLES ARE TO BE PURCHASED, A WAIVER SHOULD BE REQUESTED AND THE JUSTIFICATION FOR THE WAIVER STATED. TO HELP EXPLAIN THESE MAINTENANCE COSTS WHICH ARE SIMILAR TO COMPARABLE [illegible], WE SUGGEST YOU REFER TO THE APPROPRIATE [illegible] OF THE [illegible] WHERE THESE COSTS ARE BUDGETED

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. THEN DELINEATE THE COSTS IN THE PP.

5. FACILITY CONSTRUCTION AND RENOVATION: DESCRIBE THE PLANNING INVOLVED IN DETERMINING THE APPROPRIATE TYPE, SIZE AND CAPACITY OF THE NEW WAREHOUSE AND GARAGE FACILITY EXTENSION. CLARIFY THE BASIS FOR THE COST .STIMATE FOR RENOVATING 15 (NOT 5) RURAL DISPENSARIES

AND ALSO EXPLAIN HOW THIS RENOVATION RELATES TO STARTING UP THE RHDS, WHERE THESE DISPENSARIES ARE LOCATED (IF KNOWN), AND EXPLAIN WHY 15 (WHY NOT 2 OR 30). WHAT FEASIBILITY STUDIES FOR RENOVATION OF THE RURAL DISPENSARIES HAVE BEEN COMPLETED.

6. COMMUNICATION EQUIPMENT: THE PRESENTATION IN ANNEX D IS CONFUSING. CLARIFY THE REQUIREMENTS FOR COMMUNICATIONS EQUIPMENT BY INDICATING SPECIFICALLY WHAT TYPE OF EQUIPMENT WILL BE PURCHASED UNDER PHASE I AND WHAT TYPE UNDER THE PROPOSED PROJECT. ALSO PRESENT TECHNICAL RATIONALE FOR TYPE OF EQUIPMENT TO BE USED AND DESCRIBE THE PLANNING TO DETERMINE THE TECHNICAL FEASIBILITY OF HE SYSTEM TO BE ESTABLISHED.

. BUDGET SUPPORT FOR DSPP: THE FINANCING PLAN INCLUDES CONSIDERABLE FUNDING FOR PERSONNEL, TRAINING AND OPERATING COSTS FOR DSPP. THERE IS NO SUPPORTING INFORMATION ON HOW THESE COSTS WERE CALCULATED. FOR EXAMPLE, WHAT IS THE STAFFING AND SALARY COSTS OF THE BUREAU OF PLANNING, WHAT OPERATING COSTS WILL BE FUNDED, HOW MANY MONTHS OF TRAINING, IN WHAT AREAS, AND HOW MANY PEOPLE WILL BE REQUIRED? IT WOULD BE USEFUL TO ITEMIZE DSPP'S TOTAL BUDGETARY REQUIREMENTS AND SHOW THAT PORTION WHICH AID WILL FUND.

8. SNEM: THE PP DOES NOT INCLUDE SUFFICIENT DETAIL TO SUPPORT THE 6 MILLION DOL. BUDGETED FOR SNEM OPERATIONS. SINCE THESE REQUIREMENTS ARE BASED ON SNEM'S 5 YEAR PLAN OF OPERATIONS, IT WOULD BE USEFUL TO EXTRACT AND SYNTHESIZE KEY ELEMENTS OF THIS PLAN INTO SUPPORTING ANNEXES, PROVIDING FURTHER DETAIL AS TO PERSONNEL, ALLOWANCE, PER DIEM, LUBRICANTS, POL AND OTHER EXPENSES WHICH AID WILL BE FUNDING.

9. TRAINING: PAGE 32 OF THE PP SAYS THAT ANY SPECULATION ON THE TRAINING INPUT AND TIMING WOULD BE "PREMATURE AND UNINFORMATIVE". SPECIFY THE TRAINING REQUIREMENTS FOR WHICH PLANNING IS COMPLETE AND COST ESTIMATES KNOWN, AND THE TRAINING REQUIREMENTS FOR WHICH PLANNING AND COST ESTIMATES ARE INCOMPLETE. WITH RESPECT TO THE LATTER TRAINING REQUIREMENTS, INDICATE WHEN SUFFICIENT PLANNING AND FIRM COST ESTIMATES WILL BE COMPLETED.

10. ALTHOUGH MOST OF THE ADDITIONAL INFORMATION WE ARE REQUESTING CAN BE SUMMARIZED IN RELATED ANNEXES, THE MISSION PROJECT COMMITTEE SHOULD ALSO REVIEW THE ENTIRE PP TO ASSURE CONSISTENCY AND TO ELEMINATE REDUNDANT PORTIONS OF THE TEXT. PARTICULAR ATTENTION SHOULD BE GIVEN

TO PAGES 31 THROUGH 33 WHICH CONTAIN NUMEROUS STATEMENTS APPARENTLY INCONSISTENT WITH THE ACTUAL PROJECT PLANNING COMPLETED.

11. LA/DR HEALTH OFFICE STAFF IS AVAILABLE TO ASSIST MISSION WITH NECESSARY REVISIONS IF REQUESTED. VANCE

RECEIVED DATE

List of Contents

Annex B - Technical

Exhibit 1 : Initial Environmental Examination

ENVIRONMENTAL THRESHOLD DECISION

Location : Haiti

Project Title : Strengthening Health Services II - 521-0086

Funding : FY 77 - Grant LOP $7.525 million

Life of Project : 5 years

DAEC Recommendations: Pursuant to the requirements of A.I.D.'s Environmental Regulations published in the Federal Register on June 30, 1976 (TAB A) and the findings of the Environmental Impact Statement on the A.I.D. Pest Management Program issued May 13, 1977, the DAEC concludes that the malaria control spraying portion of this project, including the use of DDT and Malathion, is covered by an Environmental Programmatic Statement. Therefore a Negative Declaration is recommended. For all other project activities not involving malaria control spraying, the DAEC concurs in the Mission's recommendation that these activities will not have a significant effect on the human environment. Therefore, a Negative Determination is recommended for all other activities not directly involving malaria control.

The Latin America Bureau's Environmental Committee, after consultations with A.I.D.'s Environmental Coordinator, GC/LA, TAB/HEALTH and TAB/AG concur in the recommendations for both a Negative Declaration and a Negative Determination for this project.

AA/LA Decision: Pursuant to the authority vested in the Assistant Administrator for Latin America under Title 22, Part 216.4a Environmental Procedures, based upon the above recommendations, I hereby determine the following: (1) the malaria spraying portion of the program involving the use of DDT and Malathion is covered by an Environmental Impact Statement on the A.I.D. Pest Management Program, and (2) other elements of the project will not have a significant effect on the human environment, and therefore are not actions for which an Environmental Impact Statement or an Environmental Assessment will be required.

Edward Wilson for
Assistant Administrator
for Latin America

August 25 1977
Date

Clearance:
DAEC Chairman-CBWeinberg
LA Environmental Coordinator-HHasan(Draft)
GWein

TAB/OST:MKux(Draft)
TAB/H:JKaram(Subs)
DBonnet(Subs)
TAB/AG:FWhittemore(Draft)
LA/DR:BSandoval(Draft)
LA/GC:TGeiger(Draft)
JKessler(Draft)

ENVIRONMENTAL THRESHOLD DECISION

Location : Haiti

Project Title : Strengthening Health Services II - 521-0086

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AA/LA Decision: Pursuant to the authority vested in the Assistant Administrator for Latin America under Title 22, Part 216.4a Environmental Procedures, based upon the above recommendations, I hereby determine the following: (1) the malaria spraying portion of the program involving the use of DDT and Malathion is covered by an Environmental Impact Statement on the A.I.D. Pest Management Program, and (2) other elements of the project will not have a significant effect on the human environment, and therefore are not actions for which an Environmental Impact Statement or an Environmental Assessment will be required.

Edward Lewis, Jr.
Assistant Administrator
for Latin America

August 25, 1977
Date

Clearance:
DAEC Chairman-CBWeinberg
LA Environmental Coordinator-HHasan(Draft)
GWein

TAB/OST:MKux(Draft)
TAB/H:JKaram(Subs)
DBonnet(Subs)
TAB/AG:FWhittemore(Draft)
LA/DR:BSandoval(Draft)
LA/GC:TGeiger(Draft)
JKessler(Draft)

INITIAL ENVIRONMENTAL EXAMINATION

PROJECT LOCATION : HAITI

PROJECT TITLE : 521-0086 - Strengthening Health Services II

FUNDING : FY 77 - Grant LOP $7.525 million

LIFE OF PROJECT : 5 years

IEE PREPARED : Linda Morse, USAID Public Health Office

January 7, 1977

THRESHOLD DECISION: Pursuant to the authority delegated to the Assistant Administrator for Latin America and based upon an Initial Environmental Examination for the proposed Strengthening Health Services II Project, I hereby make the following determination and decision:

The proposed action is not an action which will have a significant effect on human environment over and above that described below and is, therefore, an action for which an Environmental Impact Statement or an Environmental Assessment will not be required.

Dr. Charles WELDON
Public Health Officer

Date January 13, 1977

Concurrence:

Raymond DOUGLASS
Environmental Coordinator

Date January 13, 1977

Scott L. BEHOTEGUY
USAID Director

Date January 13, 1977

PART II - DESCRIPTION OF THE PROJECT

This Project constitutes Phase II of a 3-phase health sector program to create an integrated rural health delivery system which, when operational, will make available to the rural population both curative and preventive health services.

Program funds will be used to support the comprehensive malaria control program conducted by the "Service National des Endémies Majeures" (SNEM). The next 5 year Plan of Operations for SNEM will encompass a variety of alternative and supplementary malaria control methods including: residual spraying, drug treatment, adulticiding by space spraying, larviciding and source reduction.

Funds for non-malaria control activities (primarily grant) will be used to initiate planning and implementation of the nationwide rural health delivery system including:

(a) strengthening the central Ministry's planning and administrative capability.

(b) training and retraining of health personnel

(c) final designs and initial implementation of the rural health delivery system including a logistics and supply system, transportation and communication system facility and equipment maintenance system, etc.

PART III - IMPACT IDENTIFICATION AND EVALUATION FORM

Impact Areas and Sub-areas	1/ Impact Identification and Evaluation
A. LAND USE	
1. Changing the character of the land through:	

1/ Use the following symbols: N - No environmental impact
L - Little environmental impact
M - Moderate environmental impact
H - High environmental impact
U - Unknown environmental impact

a. Increasing the population _____ N

b. Extracting natural resources _____ N

c. Land clearing _____ N-L

d. Changing soil character _____ N

2. Altering natural defenses _____ N

3. Foreclosing important uses _____ N

4. Jeopardizing man or his works _____ N

5. Other factors

_____ _____

_____ _____

B. WATER QUALITY

1. Physical state of water _____ N

2. Chemical and biological states _____ L

3. Ecological balance _____ L

4. Other factors

_____ _____

_____ _____

C. ATMOSPHERIC

1. Air additives _____ L

2. Air pollution _____ N

3. Noise pollution _____ N

4. Other factors

_____ _____

_____ _____

D. NATURAL RESOURCES

1. Diversion, altered use of water _____ N-L

2. Irreversible, inefficient commitments _____ N

3. Other factors

_____ _____

_____ _____

E. CULTURAL

1. Altering physical symbols _____ N

2. Dilution of cultural traditions _____ N

3. Other factors

Introduction of modern health services _____ L

_____ _____

F. SOCIOECONOMIC

1. Changes in economic/employment patterns _____ N

2. Changes in population _____ N

3. Changes in cultural patterns _____ L

4. Other factors

_____ _____

_____ _____

G. HEALTH

1. Changing a natural environment _____ L

2. Eliminating an ecosystem element _____ L

3. Other factors

_____ _____

_____ _____

H. GENERAL

1. International impacts _____ N

2. Controversial impacts _____ N

3. Larger program impacts _____ N

4. Other factors

_____ _____

_____ _____

I. OTHER POSSIBLE IMPACTS (Not listed above)

_____ _____

_____ _____

_____ _____

PART IV - DISCUSSION OF IMPACTS

Impacts cited under water quality and or health all relate to use of pesticides for the malaria control activities funded under this project. AID/W has previously determined that pesticide use for malaria control programs warrants a negative environmental determination, as reflected in the AID's Interim Pesticide Regulations published in the Federal Register of January 7, 1976 and Agency's Environmental Impact Statement on the AID Pest Management Program dated and issued May 13, 1977. This EIS concluded that DDT would be used in Haiti only where it is still effective for malaria control and where the Agency has some control on how and where DDT is applied. The Mission, in consultation with GOH and PAHO officials, have determined that DDT is still effective against the vector in question but will be conducting further investigations with a view toward using Malathion in some locations if necessary. In this regard, SNEM personnel will receive substantial technical assistance and training from PAHO advisors in the appropriate utilization of DDT (and Malathion) in accordance with WHO/PAHO care and safety precautions.

The Mission in consultation with AID/W has also considered and reviewed the potential impact of other malaria source reduction and control activities, such as larviciding with Abate, gas and oil, the stocking of pools with larva eating fish and

filling and draining of some small breeding pools. Based on review and consideration of actual experience in Haiti in these activities, AID, the GOH and PAHO have concluded they will have no substantial impact on the human environment.

In sum, this proposed project is not an action which will have a significant effect on the human environment and therefore is not an action for which an environmental impact statement or an environmental assessment will be required. Hence, it is recommended that a Negative Determination be made for the project as a whole.

List of Contents

Annex C - Institutional

Exhibit I : Health Manpower Analysis (draft submitted by Westinghouse 4/77

Exhibit 2 : Pro-Ag 77-5 including Organization Plan for DSPP, Bureau of Health Planning and Evaluation

Exhibit 3 : Tentative Westinghouse work plan for contract financed under Strengthening Health Services

ANNEX C

Exhibit 1

Sharon AUSSAL

22 April 1977

USAID, Port-au-Prince

I.- INTRODUCTION

The following are some descriptive notes for use in preparation of USAID's Project paper. The notes are based on work in progress under Westinghouse Health Systems contract to provide Technical Assistance to the Bureau of Health Planning and Evaluation of the DSPP. As part of that contract' effort, since 20 March 1977, the author has been engaged in conducting an analysis of Haiti's health manpower situation in general and of needs with the DSPP in particular. A detailed technical analysis is in preparation and may be available to serve as more complete documentation of Haiti's Health manpower situation for use during AID's Project Review process.

The first three sections of the following material are completed drafts of sections of the technical analysis and consequently probably contain more detail than is of interest to AID at this point. The material beginning, "Haiti's Health Manpower : Overview represents summary notes prepared expressly as P.P. input.

II.- DATA FOR HEALTH MANPOWER ANALYSIS AND PLANNING

Data Sources for Planning

As has been noted in numerous other consultant reports, and as the DSPP is well aware, the kind of precise data desirable for rational health manpower planning are generally not routinely collected in Haiti. While, as is often the case, some data exist in raw, untabulated form, these data are not in uniform format, not all desirable information is included, and reporting may be sporadic and incomplete. Such sources of information are inadequate for the ongoing national health planning process.. It is, precisely, to remedy this situation, that plans for the design and execution of a health manpower inventory are being developed within the BHP/E in conjunction with the Westinghouse HS contract, as part of baseline data collection activities. In addition, contract activities to strengthen management information systems reporting and statistical analysis will address the ongoing health manpower information needs.

Sources and Methodology for this Report

Existing raw data sources do, however, in some instances, provide a level of information which permits construction of interim indices. These are useful for developing a strategic overview of the health manpower situation and for moving beyond "generalities" to a more precise level of problem identification. Thus, for example, the National Budget (Le Moniteur); the record book of all DSPP personnel hires, dossiers of "changements du Personnel" by year, a Folder of reports from an undetermined number health establishment officers, reporting names, occupations and location of employees, (all to be found in the DSPP personnel office); and records of the Nursing Bureau are among the types of sources which have been used in the preparation of this report to develop such indices as DSPP labor turnover, absenteeism rates, salary figures.

Other data desirable for this preliminary health manpower analysis have been collected by the Westinghouse HS team during the information gathering visit. Health Manpower institution enrollment data and the derived attrition rates for projections are examples of this type. In many instances, raw-form data for cursory analysis simply does not exist at present or time has not permitted the type of data collation and analysis necessary to enable even rough quantification of the desired indices. For this sort of information (eg. health manpower outmigration, actual number of DSPP personnel), the experience and impressions of DSPP officials and foreigners active in Haiti's Health Sector, other consultant reports, published documents, and unpublished sources have been tapped. Wherever it is deemed particularly relevant, specific data sources will be mentioned.

Potential Data Sources

It should be noted in passing that some data collection activities currently underway represent potential sources of health manpower information which might be useful to the BHP in its planning activities. Principally, inventories are being conducted in the North and South Regions by Health District officials and PAHO in connection with administration of the Inter-American Development Bank (IDB) loan projects; an inventory of all DSPP Nursing personnel has been ongoing for a period of time under the auspices of the Nursing Bureau of the DSPP.

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III.- GENERAL LABOR FORCE DYNAMICS : CONTEXT FOR THE HEALTH MANPOWER SITUATION

The Haitian Institute for statistics (IHS) and the Area Handbook for Haiti were the principal data sources consulted for information on the General Labor Force of Haiti.

Calculations using IHS data show 1,933,183 persons over 14 years of age in The Labor Force, with 83% of those concentrated in agricultural and commercial (including individual vending) activities. The total labor Force represents 44% of the total population, according to IHS data; International Labor Organisation (ILO)data reported in the area Handbook places the population participation figure at about 57% . By comparaison, the ILO Latin American average is estimated to have been 31% in 1970.

This relatively high rate of labor force participation (which is particularly notable given estimates that 41% of the population is under 14) has been attributed in large part to the active participation of women in the labor force : women comprise between 45% (IHS estimate) and 46% (ILO estimate) of all employed persons. Further calculation with data indicates that 65% of women (and 88% of men) over 14 years of age are employed. Haitian cultural traditions, which generally are supportive of female participation in the work force together with male outmigration and family unit patterns, partly help to explain the observed female participation rates. However, if greater note both for purposes of explaining female participation and for understanding the dynamics between the general labor force and the health manpower situation -- is the fact of widespread "underemployment", reflected in low salaries and multiple job holding. Underemployment, together with limited opportunities in the developing private sector, combine to put tremendous pressures on Government to provide employment opportunities.

The fact that Government is probably the "employer of first resort" helps to explain some of the conditions of personnel and employment within the Department de la Sante Publique et de la Population (DSPP) which will be discussed elsewhere in this report (eg. growth in the size of the DSPP and low labor turnover, despite low salaries.)

Policy options and solution strategies available to the DSPP in its effort to solve personnel problems must be considered in light of the political and economic contraints imposed by the general labor force phenomena sketched here.

IV.- GENERAL EDUCATIONAL AND TRAINING CONTEXT

Overview

Both the State and private institutions (many with religious affiliation) sponsor schools for general educational preparation at the elementary and secondary levels. [Table 1] outlines the typical pattern and prevailing terminology of the state sponsored school system, in order to provide a common frame of reference for understanding the qualifications which may be required for entry to health manpower training programs. Urban General Education is the responsibility of the Département de l'Education Nationale, while the system of rural schools are under the auspices of the Département de l'Agriculture. The Département d'Affairs Sociales is also active in the "recyclage" (continuing education or retraining) of workers and in sponsorship of vocational education programs. The office of Adult Education in the Département of Education and the Department of Agriculture have sponsored adult literacy programs in both urban and rural areas.

Data on enrollment ratios by educational level and adult literacy program enrollments are available from the Statistics divisions of the various Departments, but have not yet been received for analysis by the Westinghouse Health Systems team at this writing. With regard to the interaction of the general educational systems and the health manpower training situation, it is sufficient to note that there is no apparent difficulty in finding qualified applicants for health occupations training among the population completing school. On the contrary, all health training institution directors interviewed (in Port-au-Prince) report being flooded with applicants. Because field visits were not made during this information - gathering visit, and before analysis of rural enrollment data, it is difficult to assert that this availability of qualified applicants extends to rural school - completers. But the observation that the great proportion of entrants to Port-au-Prince health training institutions are from the city appears to result more from proximity and recruitment practices, than from any major "bottle neck" or unavailability of qualified rural-resident applicants.

The picture may be somewhat different with regard to the availability of rural residents (particularly out of school adults) who can read or write, for entry into proposed basic level health worker training to extend coverage of the health system. At this writing (again, without rural literacy program or school enrollment data at ~~head~~ hand) it is difficult

to project objectively what the availability or unavailability of such persons might be. However aggregate national literacy data (Table II) and anecdotal evidence from the Croix des Bouquets and Petit Goave training programs suggest that literate community residents can be found fairly readily. The one bottle neck reported (at Petit Goave) was in the availability of literate females; and in this case, both illéteracy and socio-cultural norms regarding the entry of young women into the program were factors in the recruitment difficulties encountered.

Availability of Specialized Training of Relevance to DSPP

Health

The Westinghouse HS team is in the process of compiling for the HHP/E a roster of both health - and potentially health - related educational and training institution resources available locally in Haiti. (See Appendix I for partial listing).* This effort has been undertaken, first of all, because of is useful to have such a reference at hand (albeit more useful to expatriots than to Haitian Officials, who are intimately familiar with such resources.) But secondly, it has been the team's impression that consultant reports have tended to generalize rather grossly about a "lack of qualified people" and a "need for training". While in some instances this may be true (and the need for overseas training is then clear,) in other cases it would appear that generalization has led to a misspecification of the problem". For example, people trained and qualified in general administration or clerical skills or auto mechanics are prepared in local institutions and are readily available for hire -- but not at the wages offerred by the DSPP. In a number of health skill areas there are persons trained in excellent (and ongoing) programs conducted by PVOS. Many of these people would be available to the DSPP even at existing wages. However, DSPP budget and/or personnel conditions (discussed in subsequent sections) mitigate against hiring, and as a consequence retraining or recyclage of existing workers will be necessary -- but again, many of those training resources can be found locally. A policy of support for local training resources, wherever and whenever feasible can be made explicit. These observations concerning "the training situation" form the backdrop for discussions of more specific training needs which appear elsewhere in this report.

The location of Health Manpower Training Institutions in Haiti's Educational Structure.

While virtually all of the Departments active in education and training (Education, Agriculture, Social Affairs) have been or are currently involved in training wo rkers who have some health skills preparatio n, and while legal responsibility for formal training of health workers (MDs, Nurses, Auxiliary Nurses, etc.) is shared jointly by the Départments de l'Education and de la Santé Publique et de la Population, it is, effectively, the latter (the DSPP) which has authority and control over health manpower preparation. The Medical and Nursing Schools and related health manpower training programs are funded by or through the DSPP and

[illegible] the DSPP which has effective determination over curriculum [illegible] development. Le Conseil de l'Enseignement des Sciences [illegible], which includes representatives of the Department of [illegible]tion, and is the formal council to be consulted regarding pro[illegible] and modifications, is legally situated within the DSPP. [illegible] while some interministerial responsibility and multi-ministe[illegible]ivity in the health manpower development area is evident, [illegible] not appear at present to constitute "overlap" or dupli[illegible] of effort. Policy decisions regarding h ealth manpower can [illegible] are readily taken and effected through the DSPP.

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Auxiliary Nurses

Auxiliary Nurses (practical nurses) are formally trained in an 8 1/2 month program at l'Ecole Nationale des' Infirmieres Auxiliares Polyvalents. The main campus at Port-au-Prince in recent years has produced an average of 75 graduated annually, after an average drop out rate of 20%. The smaller program at Cayes produces about 30 Auxiliary Nurses annually and a third training program, planned to commence at Cap Haitien (with impetus from the IDB/PAHO regional development loan project) is expected to produce another 30 Auxiliary nurses yearly. Curriculum development at the auxiliary nurse level has been geared toward strengthening the community health orientation and work toward this objective is expected to continue under the IDB/PAHO training-assistance activities.

Other types of Health manpower prepared by Institutionalized Training Programs

Pharmacists are prepared in a 3 year post baccalaureate program in the Faculte of Medicine. Post-graduate training in pharmacy (at the MS or PHD level) is not available.

Midwives are prepared in a 2 year post-basic obstetrical nursing program sponsored by the medical faculty.

Public Health Nursing training has been available in the 9 month post-basic "Infirmiere Hygieniste program under the auspices of the Division d'Hygiene Publique. This program has reportedly been accepted, under CIDA sponsorship, to be developed into a program in Community Health Nursing, which will prepare RNs in comprehensive community health. Recristment will give preference to nurses already working in the regions.

Medical Technicians are prepared in a number of technical areas in practical programs attached to the University Hospital. A small number of students are accepted after the Baccalaureat 1ere partie or 2 years of training.

Environmental Sanitation training is conducted under the Division of Public Hygiene in programs at these levels : Health officer sanitarian), Health Inspector, and Auxiliaries.

Training of Health Manpower under non-institutionalized programs

A number of training activities developed under bi-or multi-lateral assistance have prepared a finite number of special types of community health workers. The variety of these types and the variability of their levels of qualifications should not lead the casual observer to construe this multiplicity as undesirable duplication or fragmentation. Rather, these characteristics would seem to result from the fact that Haiti has seized the opportunities of assistance to experiment with various types and levels of community workers in order to choose the model most appropriate for the basic health worker to extend health services. Looked at from this perspective, Haiti's Department of Health has built up an impressive body of experience in the design and implementation of rural community health worker training. At the same time, the several divisions within the DSPP which have been the principal sponsors of these training initiatives have shown every willingness to halt certain programs, the graduates of which have been found to be less useful or unacceptable to the community. Plans are now underway to consolidate resources into the formation of a basic level rural community health worker. An explication and enumeration of the various new cadres already trained will be included in the later, more detailed report on health manpower. At this moment, it will suffice to say that a set of desirable characteristics for the basic level health worker has begun to emerge. He or she would be an individual drawn from the community, with minimal if any formal qualifications (ie possibly no more than the ability to read and write). Expected functions would include; health promotion and health education, reporting of births, deaths , illness, and referral to government health

Physicians

M.Ds have been graduated from the Faculte de Medecine de l' Universite at the rate of about 65 per year upto 1973 and about 100 per year since 1973. According to the 1971 Loi Organique, all health manpower receiving training in State Institution are required to spend two years in social service prior to licensure. In recognition of Haiti's need for health manpower whose preparation is more precisely suited to the country's health problems, the Medical School has recently proposed a new residency program which is intended to provide a meaningbul structure for the period of social service. The proposed program will offer residencies in General Medicine and Rural Medicine with a community health orientation, as well as Hospital-based residency. Implementation of the proposed program would require development of the Department of Community Medicine, as well as continued strengthening of the Basic Sciences curriculum.

Outmigration of physicians has, in the past, been estimated to be as high as 50% of output. However, possibly in response to restriction on Foreign Medical Graduates imposed even prior to enactment of the United States recent Health Manpower legislation, the rate of outmigration appears to have lessened marhedly in the past year or two. The increased class sizes since 1973 coupled with reductions in outmigration in recent years, have resulted in the situation that the DSPP (which' is the principal employer of Haiti's health training institution graduates is unable, for budgetary reasons, to absorb all the physicians completing social service. Beckles has already noted that some 60-80 recent MD graduates who have completed social service are now unemployed, although other observers in the DSPP place the number at closer to 30. In any event, the medical school may be advised to consider enacting a policy to reduce intake.

Nurses

Within the past several weeks, all Nursing schools have been placed under the responsibility of the Dean of the Medical School and are now part of the University.

Professional Nurses

Professional Nurses (PNs) are prepared in a 3 year program at l'Ecole Nationale des Infirmieres, with the principal campus at Port-au-Prince graduaty approximately 65-70 students per year. The small campuses at Cap Haitien and Cayes graduate approximatif 15 students per year. Preliminary analyses indicate that an average of 36% of any entering class will drop out during the training period. Nurses, like physicians, are required to perform two years of social service prior to licensure.

Formerly, nurse outmigration was reported to run at the rate of 40%. Within the past year or two, (and again, linked to the changing climate of receptivity to foreign medical personnel by U.S. institutions), nurse outmigration in thought' to have dropped to the range of 10% - 20%. With the DSPP, as the principal employer, able to absorb only about 50% of those completing social service, the number of nurses reportedly unable to final work either in the government or in the private sector is thought to be substantial.

Like the Medical school, the nursing school is taking steps, with technical assistance from PAHO, to orient its curriculum toward community health problems.

services, and the provision of simple curative services. For the most part, it is envisioned that the basic worker would be an employee of the DSPP at the minimum salary of $ 40/month; responsible to the auxiliary nurse (s) who staff the dispensary, but themselves based in the community. The possibility of recruiting basic health workers, at least, in part, from among traditional Haitian Health practioners has been under discussion, although this in an issue on which there is not consensus. There have been a few experiences with the recruitment of such practitioners into some past training programs, and matrones (traditional midwives) continue to be trained for the improved performance of their usual functions. Undoubtedly, the DSPP will review and conduct more thorough evaluation of these experiences as it defines plans for the extension of health services coverage.

Summary of General Health Manpower Issues and Implications for AID Policy and Programming

This overview has focused on a description of conditions and issues which pertain to health manpower supply. The detailed manpower analysis will contain a balancing discussion of "demand". At this point, only the thrust of that argument to be made will be outlined. The "adequacy" of institutional output (or health manpower "needs") cannot be measured against "demand" as estimated by standard ratios to population or even "demand" as estimated by deficiencies in staffing patterns of existing health establishments -- and the absence of a precise inventory is only part of the reason this is true. Rather, "demand" in the Haitian context must be estimated by the budgetary capacity of the DSPP to absorb the products of its health training institutions. By this criterion and for reasons which will become more apparent in the following section, the output of existing formal training institutions may be considered "adequate". A policy of support to strengthen existing formal institutions is entirely justified. DSPP recognition of the need for community oriented health workers at all levels is high. The unanimity ~~of support for~~ the objectives of extended coverage and community health among directors of formal training institutions and DSPP officials is impressive and these factors suggest that support for existing training institutions (be it in the form of assistance in carrying out projected program improvements and/or in the sponsorship of specialized training -- such as for community health nursing educators) will be well applied. But "STRENGTHENING" of these institutions should not be construed to mean "expansion". The detailed manpower report to follow is likely, on the contrary, to provide a rationale for recommending reduction of medical school class size and recruitment of DSPP employees to fill existing training slots whenever possible.

The readiness of the DSPP to embark on plans to develop rural health services through the training of basic level health workers, together with the fund of previous experience in this area points to the desirability and probable efficacy of support to further such activities. As part of this effort, the funding of "recyclage" or in-service training for the currently - employed auxiliary nurses who are likely to interface with the basic health workers

HAITI's HEALTH MANPOWER : OVERVIEW

As has been noted under observations about health manpower data, precise information concerning each type of health manpower are not presently available. Information concerning the total national stock of health manpower, in governmental, private, and P.V.O. subsectors should be provided under surveys carried out as part of the health planning process. Even prior to the availability of such resources inventory data, more detailed calculations of the flow of supply from health training institutions will be presented as part of the technical manpower analysis in preparation. Comments here are limited to a summary of initial findings and a discussion of key issues.

Supply

Previously published reports of Haiti's National health manpower stock conform so closely to the number of personnel of these types in the DSPP, that it is likely that what has been reported reflects only the governmental sector. (Table III) presents several alternative estimates.

Health Manpower in Haiti

	As per IDB Project Paper Oct. 1975, p.7 presented as national Supply	As per 1975 Plan de Sante DSPP only	As per IDB Project paper Oct 1975, p27 presented as DSPP only
MDs	400	207 (full qual) 221 (residents) 428	530
DDs	60	33 (full qual) 24 (residents) 57	65
Prof. Nurses	500	273 (diplomees) 211 (resident) 484	485
Aux. Nurses	990	219 (Diplomees) 870 (non-diplomees) 1089	1068

As has been repeatedly noted and as detailed analysis of available distribution patterns bears ~~and~~, all health manpower types are geographically concentrated to a greater or lesser extent in Port-au-Prince (eg 13% of population and 84% of physicians are in the capital city;

Annex C - Exhibit 2

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PROJECT AGREEMENT

BETWEEN THE DEPARTMENT OF STATE, AGENCY FOR INTERNATIONAL DEVELOPMENT (AID), AN AGENCY OF THE GOVERNMENT OF THE UNITED STATES OF AMERICA, AND

SEVERAL AGENCIES

AN AGENCY OF THE GOVERNMENT OF The Republic of Haiti

The above-named parties hereby mutually agree to carry out a project in accordance with the terms set forth herein and the terms set forth in any annexes attached hereto, as checked below:

[X] Project Description Annex A
[ ] Foreign Currency Standard Provisions Annex
[X] Standard Provisions Annex
[ ] Special Loan Provisions Annex

This Project Agreement is further subject to the terms of the following agreement between the two governments, as modified and supplemented:

[ ] General Agreement for Technical Cooperation — Date
[ ] Economic Cooperation Agreement — Date
[X] (other) Prog 76-5 Rev 1, Prog 76-5 Rev 3 — Date 3/25/76, 5/31/76

1. Project/Activity No. 521-11-510-070
2. Agreement No. TT-5
3. [illegible]
4. Project/Activity Title: STRENGTHENING HUMAN SERVICES (HEALTH PLANNING ACTIVITY).
5. Project Description and Explanation (See Annex A attached)
6. AID Appropriation Symbol: 12-1211024
7. AID Allotment Symbol: [illegible]

8. AID FINANCING [ ] Dollars [ ] Local Currency	Previous Total (A)	Increase (B)	Decrease (C)	Total to Date (D)
(a) Total		40,000		40,000
(b) Contract Services				
(c) Commodities				
(d) Other Costs		40,000		40,000
9. COOPERATING AGENCY FINANCING Dollar Equivalent 1,000				
(a) Total				
(b) Technical and Other Services				
(c) Commodities				
(d) Other Costs				

10. Special Provisions (Use Additional Continuation Sheets, if Necessary)

See Continuation Sheet

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11. Date of Original Agreement: March 9, 1977
12. Date of This Revision:
13. Estimated Final Contribution Date: January 1, 1979

14. For the Cooperating Government or Agency
SIGNATURE: See page 2 DATE:
TITLE:

15. For the Agency for International Development
SIGNATURE: Scott L. Behrstock DATE: 5/31/77

CAUTION · Remove protector sheet before typing · replace when typed

	PROJECT AGREEMENT BETWEEN AID AND SEVERAL AGENCIES AN AGENCY OF THE GOVERNMENT OF The Republic of Haiti	1. Project/Activity No. 521-11-510-070	PAGE 2 OF 4 PAGES
		2. Agreement No. 77-5	3. [x] Original or Revision No.
		3. Project/Activity Title. STRENGTHENING HEALTH SERVICES (Health Planning Activity)	

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Dr. Willy VERRIER
Secretary of State
Department of Public Health
and Population

9 Mars 1977
Date

Mr. Emmanuel BROS
Secretary of State
Department of Finance and
Economic Affairs

9 Mars 1977
Date

(Block 10 continued)

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1. Health Planning Activity

The Strengthening Health Service Project consists of two principal activities: malaria control and health planning. This ProAg concerns only the health planning activity; malaria control shall be the subject of subsequent revisions to this ProAg.

2. The budget and organizational proposal of the Department of Public Health and Population dated January 10, 1977 and transmitted to the Director of USAID/Haiti on February 8, 1977 is incorporated into and made a part of this Project Agreement as Annex 3.

3. With reference to the aforesaid budget, the U.S. Government agrees to provide budgetary support for personnel costs of the Planning Section during 1977 up to the following levels:

1) Permanent and Full Time Personnel

Function		
1 Chief of Section	$ 10,200.00	
1 Assigned Physician	6,000.00	
1 Ministry Advisor	3,000.00	
1 Nurse	1,800.00	
1 Bilingual Secretary	1,800.00	
1 Typist	1,200.00	
1 Auxiliary for demographic statistics	1,800.00	
1 Accountant	1,800.00	
1 Driver	1,200.00	
Sub-Total		$28,800.00

2) Advisors

1 Chief Sect. Center Ext. Assist.	$2,400.00
1 Director Executive Office-BID	2,400.00
1 Chief Medical Training Section	2,400.00
1 Chief Dept.Prev.Med.Sec.Med.Fac.	2,400.00
1 Administration Advisor	2,400.00
Sub-total	$12,000.00
GRAND TOTAL	$40,800.00

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The above line items are illustrative and may be revised upon consultation between representatives of the two governments.

3. Financial Procedures

The funds obligated by this ProAg shall be provided on a direct reimbursement basis in accordance with the procedures established for the health planning activity by ProAg 76-5 revision No. 1, special provisions annex Section B page 11-12.

ANNEX B to ProAg 77-5

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REPUBLIQUE D'HAITI

DEPARTEMENT DE LA SANTE PUBLIQUE ET DE LA POPULATION

No. 1460

PORT-AU-PRINCE, LE ..... 19.....

Mr Scott DEHOTHAUY
Directeur de l'AID
c/o Ambassade des Etats-Unis
d'Amérique du Nord
Port-au-Prince, HAITI

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Monsieur le Directeur,

J'ai l'avantage de vous communiquer, à toutes fins utiles, le texte ci-joint qui a été élaboré par la section compétente du Département de la Santé Publique et de la Population à l'effet de présenter le schéma d'organisation structurelle de la SECTION DE PLANIFICATION ET D'EVALUATION, qui sera opportunément inséré dans les Règlements Généraux de ce Département.

Je demeure persuadé que l'AID apportera au Département de la Santé Publique et de la Population sa pleine coopération habituelle pour un fonctionnement efficace de la susdite Section et saisis cette occasion pour vous exprimer, Monsieur le Directeur, l'assurance renouvelée de ma très distinguée considération.

Dr Willy MERRIER
Secrétaire d'Etat

ACTION
TAKEN
BY

SCHEMA D'ORGANISATION DE LA SECTION DE PLANIFICATION ET D'EVALUATION DU DEPARTEMENT DE LA SANTE PUBLIQUE ET DE LA POPULATION

FONDEMENTS LEGAUX.

D'après la loi organique d'Août 1971 du Département de la Santé Publique et de la Population, complétée par le décret du 31 Octobre 1975 la Section de Planification et d'Evaluation a pour attributions:

1o) De préparer et de reviser périodiquement un plan de santé qui mette en évidence les principaux problèmes de Santé, les priorités à accorder et la meilleure utilisation des ressources disponibles.

2o) D'étudier et d'évaluer périodiquement des programmes spécifiques de santé.

Etant donné l'obligation légale d'établir dans le cadre du Secteur Santé une Unité de programmation chargée de maintenir le contact avec les techniciens du CONADEP et de discuter avec eux les plans élaborés au niveau du Département de la Santé Publique et de la Population, il s'ensuit que cette Unité de programmation et la Section de planification et d'évaluation prévue dans la loi organique ne peuvent avoir que des attributions identiques et, en conséquence, peuvent être confondues en un même office.

Il importe donc de bien organiser cette Section en vue d'augmenter ses capacités techniques et fonctionnelles et de lui permettre de bien remplir son rôle au sein du Département.

Cette organisation s'avère d'autant plus urgente qu'un contrat a été récemment signé par la Secrétairerie d'Etat de la Santé Publique et de la Population avec l'AID, en vue d'engager une firme spécialisée qui assisterait techniquement le Gouvernement d'Haiti dans le renforcement des services de santé du pays. Cette firme devra travailler au niveau de la Section de Planification et d'Evaluation du Département et en collaboration avec ses membres.

FONCTIONS DE LA SECTION DE PLANIFICATION ET D'EVALUATION

Des Textes de loi mentionnés ci-dessus, il ressort que les fonctions de la Section de Planification et d'Evaluation sont les suivantes:-

1o) Déterminer et définir, en accord avec la Secrétairerie d'Etat de la Santé Publique et de la Population et la Direction Générale de la Santé Publique, la politique de Santé à adopter par le Département de la Santé Publique et de la Population.

2o) Elaborer des plans de santé à court, à moyen et à long terme en accord avec la politique de santé en vigueur.

3o) Reviser et évaluer périodiquement les plans et programmes établis en vue de proposer toute modification jugée nécessaire.

4o) Etudier, avec les services et organismes compétents du Département de la Santé Publique et de la Population ainsi qu'avec toutes autres institutions intéressées, les plans et programmes spécifiques touchant le secteur santé, et soumettre les rapports et recommandations nécessaires au Secrétaire d'Etat de la Santé Publique et de la Population

5o) Représenter le Département de la Santé Publique et de la Population aux réunions du CONADEP qui intéressent le Secteur Santé

Sa Position dans le cadre administratif et technique du Département de la Santé Publique et de la Population

Suivant l'organigramme établi conformement à la loi organique d'Août 1971 et au décret du 31 octobre 1975, la section de Planification et d'Evaluation est directement rattachée à la Secretairerie d'Etat dont elle constitue l'un des services techniques.

Toutefois, pour remplir adéquatement ses fonctions, la Section de Planification devra maintenir des rapports étroits et constants avec la Direction Générale de la Santé Publique, les services administratifs et les services spéciaux ainsi qu'avec les Divisions techniques du Département.

Sa Composition

La Section de Planification et d'Evaluation ou Unité de programmation du Département de la Santé Publique et de la Population comprend:

A) Un Bureau du Plan

B) Un groupe de travail

C) Un Conseil Consultatif

D) Un groupe de Consultants

En outre il est formé un Conseil Supérieur de Planification et d'Evaluation qui servira d'organisme de consultation pour les grandes options ou décisions techniques importantes du Département.

A) Le Bureau du Plan est composé de membres à plein temps qui forment le cadre permanent de la Section de Planification et d'Evaluation. Ils sont employés à temps complet au Département de la Santé Publique où ils n'ont d'autres activités que celle se rapportant à la Planification et à l'Evaluation. Ce cadre comprend:

1o) Un médecin, Chef de l'Unité de Programmation ou Section de Planification et d'Evaluation.

2o) Un médecin hygiéniste ou épidémiologiste

3o) un médecin de Santé Publique

4o) Une Auxiliaire de statistique-Démographe

5o) Une Infirmière hygiéniste

6o) Un comptable ayant reçu une orientation vers l'analyse financière et l'analyse des programmes.

7o) Un Consultant International (MD)

Le Bureau du Plan est assisté d'un personnel administratif employé à plein temps et comprenant:

1o) Une Secrétaire bilingue

2o) Une Dactylographe

3o) Un chauffeur

4o) Un messager

Le Bureau du Plan ainsi que le personnel administratif travailleront aux heures normales de Bureau du Département de la Santé Publique et de la Population, c'est-à-dire, de 8 hres a.m. à 2 hres. P.M. de 3 hres à 5 hres P.M. à l'exception du Médecin de Santé Publique qui ne travaillera que de 8 hres A.M. à 2 hres P.M.

B) Du Groupe de Travail

Le Groupe de travail est formé des techniciens du Département de la Santé Publique et de la Population qui, de par leurs fonctions, sont appelés à collaborer avec la Section de Planification et d'Evaluation. Ce sont:-

1o) Le Directeur de l'Unité d'Exécution du Projet BID
2o) Le Chef de la Section de Contrôle de l'Assistance Extérieure
3o) Le Chef de la Section d'Education Médicale et Paramédicale
4o) Le Chef de la Division "Administration et Finances"
5o) Le Secrétaire Général au Département de la Santé Publique et de la Population

Les Techniciens de la Section de Planification et d'Evaluation se réunissent normalement deux fois par semaine avec le Groupe de travail toutes les fois que les circonstances l'exigent, pour discuter de questions techniques et administratives ayant trait à l'élaboration et à l'exécution de plans ou de programmes de santé. Par ailleurs, le Chef de la Section pourra entrer en contact avec les membres du groupe de travail individuellement, toutes les fois qu'il le jugera nécessaire.

C) Du Conseil Consultatif

Le Conseil Consultatif de la Section de Planification et d'Evaluation comprend:-

- Le Secrétaire d'Etat de la Santé Publique et de la Population
- Le Sous-Secrétaire d'Etat de la Santé Publique et de la Population
- Le Directeur Général de la Santé Publique et de la Population
- Le Chef du Département de Médecine Préventive, Sociale et Communautaire à la Faculté de Médecine et de Pharmacie

Le Chef de la Section de Planification et d'Evaluation devra maintenir un contact constant et très étroit avec ce Conseil Consultatif de façon à établir les grandes lignes d'orientation du Département pour les réunions avec le personnel du Département de la Santé Publique et de la Population ou avec les membres du COMDEP. Il sollicitera également l'opinion du Conseil Consultatif sur toutes questions relatives au bon fonctionnement de la Section et aux décisions techniques à envisager.

D) Du Groupe de Consultants

Le Groupe de Consultants est composé de tous les Chefs de Division du Département de la Santé Publique et de la Population.

DU CONSEIL SUPERIEUR DE PLANIFICATION ET D'EVALUATION

Le Conseil Supérieur de Planification et d'Evaluation du Département de la Santé Publique et de la Population est formé:

a) Des Secrétaire et Sous-Secrétaire d'Etat de la Santé Publique et de la Population
b) Du Directeur Général de la Santé Publique
c) Des Membres du Bureaux du Plan de la Section de Planification et d'Evaluation
d) Des membres du groupe de Travail
e) Des Chefs de Divisions Techniques du Département de la Santé Publique et de la Population.
f) Du Directeur du Bureau de Nutrition
g) Du Chef de la Section de Statistiques et d'Evaluation

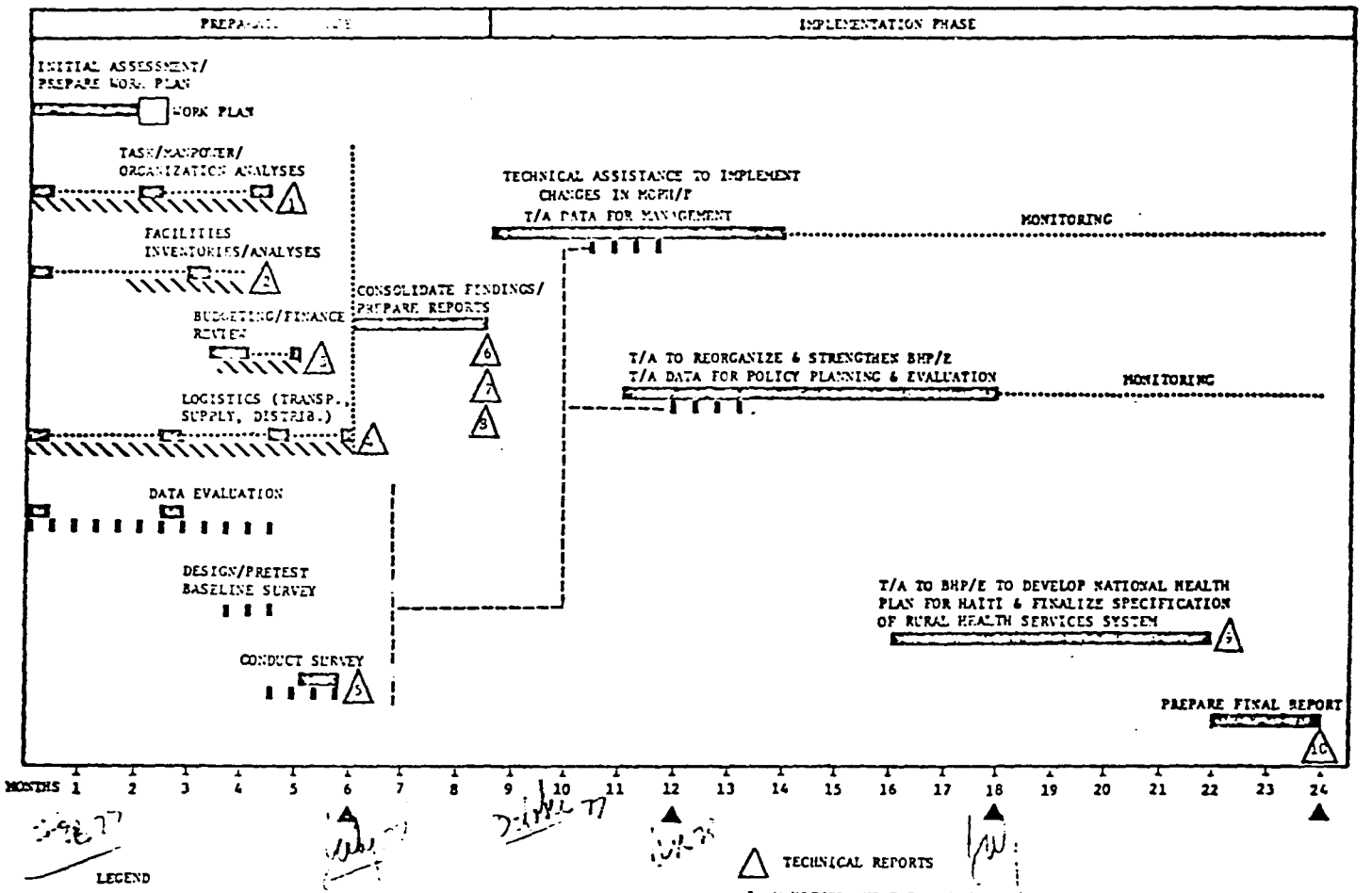
Le Conseil Supérieur de planification et d'Evaluation se réunit sur convocation spéciale du Secrétaire d'Etat de la Santé Publique et de la Population, toutes les fois que ce dernier le jugera nécessaire, et notamment pour les grandes options ou décisions techniques du Département

N.B. Ce Schéma d'organisation de la Sedtion de Planification et d'Evaluation constituera les bases de fonctionnement de la dite Section et sera inséré dans les règlements généraux du Département de la Santé Publique et de la Population

Annex C - Exhibit 2

FIGURE 1.

SEQUENTIAL ACTIVITIES TIME CHART FOR PROVISION OF TECHNICAL ASSISTANCE TO THE GOVERNMENT OF HAITI IN ITS PROGRAM TO STRENGTHEN HEALTH SERVICES



LEGEND

- CHIEF-OF-PARTY INTENSIVE ACTIVITY
- CHIEF-OF-PARTY MONITORING TA
- BIOSTATISTICIAN
- OTHER CONSULTANTS
- WORK PLAN
- SEMI ANNUAL PROGRESS REPORTS & PROJECT REVIEWS

TECHNICAL REPORTS

1. MANPOWER AND TASK ANALYSES (RFP REPORT g, iii, & b; CONSULTANT RECOMMENDATIONS FOR REPORTS a, c, f)
2. FACILITIES INVENTORIES AND ANALYSES (RFP REPORT g.iv)
3. BUDGETING & FINANCE REPORT(RFP REPORT g.i)
4. LOGISTICS, TRANSPORTATION, ETC., DRUG AND SUPPLY SYSTEMS (RFP REPORTS g, iii & v)
5. SUMMARY RESULTS BASELINE SURVEY (RFP REPORT c)
6. PLAN FOR IMPROVED ADMINISTRATION OF MOPH/P (RFP REPORT e, INCLUDING g.i-v, 1-4 ABOVE)
7. PLAN FOR REORGANIZATION AND PERSONNEL TRAINING OF BHP/E (RFP REPORTS a & b, INCLUDING 1.ABOVE)
8. PLAN FOR INTEGRATION OF SNEM INTO MOPH/P (RFP REPORT f)
9. NATIONAL HEALTH PLAN FOR HAITI (RFP REPORT d)
10. FINAL REPORT (RFP REPORT h)

LIST OF CONTENTS

ANNEX D
Financial Estimates

I Technical Assistance

II Design of the Rural Health Delivery System

III Budget Support for DSPP

IV Detailed SNEM Budget

ANNEX D:

I. Technical Assistance:

DSPP: For strengthening the administrative, planning, and statistical sections of the DSPP the technical assistance activities will be carried out under contract, described on page 48 of the text of the project paper. The contract will be for approximately $320,000.

RHDS: Technical assistance for the RHDS will not be discretely funded, but will be furnished by the USAID Public Health Officer, Project Manager, and the team leader of the technical assistance contractor for the DSPP. If it is determined that additional technical assistance is needed, it will be funded under the Phase III project.

SNEM: Technical assistance for SNEM will be $60,000. This will provide for a medical entomologist, who will serve as senior management and administrative advisor to the Director of SNEM.

SNEM/DSPP Integrations: $20,000 has been allocated for technical assistance to advise on a plan for the eventual integration of SNEM with the DSPP. Details of the plan are contained on page 5 of the text.

II. Design of Rural Health Delivery System (RHDS). The following is a description of the RHDS, based upon over a year and one half discussion with the DSPP and USAID/H.

Rural Health Delivery System:

A low level health auxiliary indigenous to the community will act as a motivator, organizer, and dispenser of health services. Training courses are adapted to the level of basic education. Training continues indefinitely, with planned periodic recycling of the basic health

worker. The peripheral program at the community level is based on the existing physical infrastructure. The rural dispensary will be used for coordination, supervision, logistic and administrative support, and for referral. An annual health plan of action is developed at the regional level by the regional health officer with technical assistance from central level of DSP/P. (Until regionalization is complete, district health officers will have this responsibility in "unregionalized" districts).

The final form of the annual plan of action is made in accordance with allocation of resources from central level to region and district, i.e., in accordance with national plan, resources and priorities.

The health facilities system in Haiti is a compact system organizationally, with four levels of facilities. The system is divided into two vertical parts: the Public Sector, funded by the DSSPP, which is made up of DSP/P facilities and mixed funding facilities, and the Private Sector, funded by private voluntary organizations. Vertically, the system is topped by the health district hospitals (16), usually located in the principle cities of the health regions, and five located in Port-au-Prince. The secondary level are health centers with beds (15), which usually have between 12 and 20 beds. These are located in other cities in the health regions, with none in Port-au-Prince. The next level of facility is the health center without beds, a community out-patient facility. There are nine of these in the Metropolitan District. The other seven are located in the countryside.

Most important to rural health area delivery are the dispensaries, which are simple (two room usually) health stations. Of the 139 dispensaries in Haiti, only five are in the Metropolitan District.

From an operational stand-point the services are established according to the following schema. Epidemiologic and demographic survey-analysis and identification of health problems specific to the community; establishment of feasibility of resolution by RHDS methodology; translation of priorities into tasks and course outlines; training implementation, evaluation, modification, etc.

The final design of this model is to be completed by October of this year and training will start immediately after its completion. Course outlines for training are presently being modified from those developed in conjunction with the on-going MCH/FP, Petit-Goave and Croix-des-Bouquets programs. The physical facilities and training staff are already in place at Croix-des-Bouquets and the initial training course will last about 3 months. The survey work will be done concurrently with the training, and implementation should start in the first quarter of 1978.

The first 15 dispensaries in which the trained auxiliaries will be placed, will be in areas that have been surveyed to determine the specific health problems of the community.

Evaluation of tasks performed will be done on a continuing basis and necessary adjustments made.

The RHDS will be based on the community worker who refers patients and problems to the dispensary staffed by a nurse auxiliary. The dispensary is linked to a health center which in turn is linked to the district hospital.

The role envisioned for the community worker is a mixed one of both preventive (i.e., education), and simple curative measures.

Cost projections on actual implementation of the RHDS will be one of the items developed under this project and available for the planning for Strengthening Rural Health System III Project. However, there are some cost estimates available for some elements of the program. Based on the experience gained at Petit-Goave and Croix-des-Bouquets, approximately $400 a month is needed for expendable supplies per service area. The salary of the community worker is expected to be $50 a month. These, of course, are not the only costs for the system. Supervision and other general support costs cannot be estimated at this time. They are not relevant to the pilot efforts and will be affected by economies of scale as the system is expanded nation-wide.

III. BUDGET SUPPORT FOR DSP/P

Budget support costs consisting of personnel, operating expenses and office supplies will be provided to three sections of DSP/P.

The section of Planning consists of:

- 1 chief of section
- 1 physician
- 1 Ministry advisor
- 1 bilingual secretary
- 1 typist
- 1 statistics assistant
- 1 accountant
- 1 driver

The full salaries of the above personnel are being paid under Rural Health I and are to continue under this project. In addition, supplements to the salary for five DSP/P specialists are paid to gain their part-time assistance. Total annual cost of both categories has been $40,000.

The section for Administration and Statistics will be staffed under this project. Staff planned to consist of:

1 chief of the Division of Administration at	$300.00/month
1 assistant chief of the Division	150.00/ "
1 chief of the bookkeeping section	200.00/ "
1 chief of the buying & supplying section	150.00/ "
1 assistant chief of the buying section	100.00/ "
1 chief of the personnel section	150.00/ "
1 assistant chief of the bookkeeping section	100.00/ "
1 chief of the juridical section	150.00/ "

The staffing needs for the supply section have not yet been determined. One of the products of the Westinghouse contract expected by December 1977, includes these staff projections. Consequently, funding is only estimated and planned not to begin until the second year.

Further support to the DSP/P is for in-service training for staff. Actual details of the training requirements are to be determined under the Westinghouse contract. This is also expected by December 1977. The training costs shown in the PP are estimates based on $2,500/year for local training and two short term courses overseas at $3,000 per year per course.

EXHIBIT IV. A Detailed SNEM Budget is

Contained on the Next

Six Tables

RENFORCEMENT DES SERVICES DE SANTE

CALENDRIER DES DEPENSES

TABLEAU No. 1

ANNEXE I

		Année I	Année II	Année III	Année IV	Année V	TOTAL
	Sous-total AID	3451	3293	1725	1063	968	10500
DS PP	Assistance Technique	132	267	120	-	-	519
	Formation (entrainement, échange technique Croix-des-Bouquets & Petit-Goâve)	215	379	51	42	44	730
	Personnel	86	132	99	102	106	525
	Dépenses administratives	161	132	20	20	22	355
	marchandises	828	564	7	-	-	1399
	(Equipement & Matériel)	(87)	(45)	(7)	(-)	(-)	(139)
	(médicaments et autres produits pharmaceut.)	(300)	(250)	(-)	(-)	(-)	(550)
	(Véhicules et pièces de rechange)	(441)	(269)	(-)	(-)	(-)	(710)
	construction /réparation de locaux	330	150	-	-	-	480
	Contingence/inflation	192	182	77	17	17	492
SNEM	Personnel (salaires, frais,journaliers	1342	1366	1285	810	700	5503
	Dépenses administratives (lubrifiant & POL)	55	60	66	72	79	332
	Frais Divers	110	55	-	-	-	165
	GOH SOUS-TOTAL	920	1020	1120	1220	1320	5600
SNEM	Assistance Technique	61	62	60	60	56	299
	Personnel	-	-	-	413	532	945
	Dépenses Administratives	203	260	366	356	357	1542
	Marchandises	656	698	694	391	375	2814
	(equipement & matériel)	(149)	(145)	(235)	(2)	(1)	(532)
	(médicaments & autres produits pharm.)	(200)	(220)	(150)	(110)	(100)	(780)
	(insecticides & larvicides)	(245)	(274)	(254)	(222)	(216)	(1211)
	(véhicules & pièces de rechange)	(62)	(59)	(55)	(57)	(58)	(291)
	PAHO sous-total	186	154	160	171	181	852
SNEM	(Assistance Technique	(186)	(154)	(160)	(171)	(181)	(852)
	Dépenses totales pour le project	4552	4467	3005	2454	2465	16952

PROJET DE BUDGET POUR L'ANNEE [illegible]

(Du 1er Janvier au 31 décembre [illegible])

R E S U M E

(Volumes exprimés en [illegible] Dollars)

	ADMINISTRATION				EPIJEPIOLOGIE					OPERATIONS DE CAMPAGNE						GRAND TOTAL
	REG.	ADM. FEDERAUX	TRANSP. GARAGE	TOTAL	ENTRET. GEAL. CENTR.	MOTOR.	[illegible]	LABO.	TOTAL	FILED F. OP.	ADP. LABO. & FORCE.	MENT. REG.	ARRAIN.	ELF	TOTAL	
A- RELATIONS	47.[illegible]	[illegible]	86.500	[illegible]	171.132	39.436	36.378	55.055	261.996	863.539	138.512	222.112	-	-	[illegible]	1.[illegible]
B- ALLOCATIONS	3.[illegible]	[illegible]	1.[illegible]	5.[illegible]	37.632	-	-	-	37.632	-	35.[illegible]	45.280	-	-	[illegible]	[illegible]
C- FRAIS DE VOYAGE, CURSE FELLOWS	4.000	900	4.000	8.900	9.346	7.400	14.000	1.300	32.046	48.820	-	-	-	-	48.820	89.766
D- MATERIEL, [illegible]	-	10.000	-	10.000	-	-	-	-	-	6.778	-	-	-	-	6.778	16.778
E- MATERIEL COST. - OFFIRA ASS. VOL. PERSONNEL DE SERV. TRAV. SOCIAL	1.[illegible]	3.300	3.000	7.480	3.800	590	930	22.700	27.800	32.080	-	-	-	-	[illegible]	47.480
	-	-	7.300	7.300	-	2.000	-	-	2.000	-	-	-	-	6.000	6.000	13.300
F- SERVICES TECHNIQUES	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
— Conférences & Cours	-	-	55.000	55.000	-	-	-	-	-	-	-	-	-	-	-	55.000
— [illegible]	-	-	-	—	-	-	-	-	-	-	-	200.000	-	-	[illegible]	200.000
— Filaire [illegible] Vélo[illegible]	-	-	50.000	50.000	-	-	-	-	-	-	-	-	-	-	-	50.000
— [illegible] - Fièvre	-	-	12.100	12.100	-	-	-	-	-	-	-	-	-	-	-	12.100
— [illegible]	-	13.[illegible]	-	13.[illegible]	-	-	-	-	-	-	-	-	-	-	-	13.[illegible]
— Gas oil & [illegible]	-	-	-	-	-	39.700	-	-	39.700	-	-	-	-	-	-	39.700
— Gas oil [illegible]	-	-	-	-	-	-	-	-	-	3.000	-	-	-	-	3.000	3.000
— [illegible]	-	-	-	-	-	5.040	-	-	5.040	-	200.800	-	-	7.300	[illegible]	[illegible]
G- [illegible]	-	2.[illegible]	-	2.[illegible]	-	7.000	-	200	7.200	-	-	-	-	-	-	9.[illegible]
— [illegible]	-	-	140.000	140.000	-	-	-	-	-	-	-	-	-	-	-	140.000
[illegible]	[illegible]	[illegible]	[illegible]	1.[illegible]	[illegible]	1.[illegible]	[illegible]	[illegible]	1.[illegible]	-	-	-	[illegible]	-	[illegible]	[illegible]
	51.[illegible]	140.[illegible]	[illegible]	[illegible]	[illegible]	72.[illegible]	51.[illegible]	79.[illegible]	[illegible]	534.337	364.800	467.392	[illegible]	[illegible]	[illegible]	[illegible]

PROJET DE BUDGET POUR L'ANNEE 1979

(Du 1er Janvier au 31 Décembre 1979)

R E S U M E

(Valeurs exprimées en US Dollars)

	ADMINISTRATION				EPIDEMIOLOGIE					OPERATIONS DE CAMPAGNE						GRAND TOTAL
	DIR.	ADM. FINANCIER	TRANSP. GARAGE	TOTAL	DIRECT. EPAL. STATIS.	ENTOM.	IMPUETS.	LABO.	TOTAL	FIXED F. OP.	AEP. LABY. & FUM.	SUPT. LEG.	ANNAIN.	SLF	TOTAL	
A- [illegible]	43.722.—	103.533.—	87.837.—	235.092.—	174.854.—	20.931.—	37.239.—	56.011.—	289.035.—	266.051.—	135.897.—	223.608.—	-	-	605.576.—	1.129.702.—
B- [illegible]	3.000.—	420.—	1.884.—	5.304.—	37.639.—	-	-	-	37.639.—	-	35.168.—	65.280.—	-	-	100.768.—	143.704.—
B- [illegible]	6.608.—	500.—	6.600.—	9.700.—	9.546.—	8.200.—	14.000.—	1.210.—	32.956.—	48.820.—	-	-	-	-	48.820.—	91.476.—
B- [illegible]	-	19.200.—	-	19.200.—	-	-	-	-	-	9.655.—	-	-	-	-	9.655.—	28.855.—
B- [illegible]	1.500.—	3.500.—	3.000.—	8.000.—	4.500.—	650.—	930.—	20.700.—	26.780.—	12.400.—	-	-	-	-	12.400.—	47.800.—
	-	-	7.200.—	7.200.—	-	3.000.—	-	-	3.000.—	-	-	-	-	4.400.—	4.400.—	14.600.—
B- [illegible]	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	-	-	60.000.—	60.000.—	-	-	-	-	-	-	-	-	-	-	-	60.000.—
[illegible]	-	-	-	-	-	-	-	-	-	-	-	220.000.—	-	-	220.000.—	220.000.—
[illegible]	-	-	45.000.—	45.000.—	-	-	-	-	-	-	-	-	-	-	-	45.000.—
[illegible]	-	-	13.640.—	13.640.—	-	-	-	-	-	-	-	-	-	-	-	13.640.—
[illegible]	-	13.814.—	-	13.814.—	-	-	-	-	-	-	-	-	-	-	-	13.814.—
[illegible]	-	-	-	-	-	37.100.—	-	-	37.100.—	-	-	-	-	-	-	37.100.—
[illegible]	-	-	-	-	-	-	-	-	-	-	3.300.—	-	-	-	3.300.—	3.300.—
[illegible]	-	-	-	-	-	5.544.—	-	-	5.544.—	-	220.000.—	-	-	8.250.—	228.250.—	233.794.—
B- [illegible]	-	2.000.—	-	2.000.—	-	3.000.—	-	200.—	3.200.—	-	-	-	-	-	-	5.200.—
[illegible]	-	-	140.000.—	140.000.—	-	-	-	-	-	-	-	-	-	-	-	140.000.—
B- [illegible]	300.—	500.—	500.—	1.300.—	200.—	1.000.—	300.—	250.—	1.750.—	-	-	-	670.000.—	-	670.000.—	672.950.—
	58.799.—	143.887.—	363.461.—	560.147.—	226.732.—	79.425.—	52.469.—	78.371.—	436.997.—	316.926.—	394.465.—	509.108.—	270.000.—	12.650.—	1.503.149.—	2.500.333.—

[illegible]

[illegible]

[illegible]

	[illegible]				[illegible]					[illegible]						[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
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PROJET DE BUDGET POUR L'ANNEE [illegible]

(du 1er Janvier au 31 Décembre [illegible])

R E S U M E

(Valeurs exprimées en US Dollars)

	ADMINISTRATION				EPIDEMIOLOGIE					OPERATIONS DE CAMPAGNE						GRAND TOTAL
	REG.	REG. FRANCOS	TRANSPORT CARGO	TOTAL	[illegible] HAL. MATER.	[illegible]	[illegible]	LABO.	TOTAL	FIXED I. W.	[illegible]	[illegible]	[illegible]	[illegible]	TOTAL	
A- SALAIRES	45.430,—	107.677,—	91.687,—	244.730,—	168.825,—	24.233,—	38.948,—	58.359,—	303.365,—	888.797,—	140.303,—	122.770,—	-	-	1.151.870,—	1.660.[illegible],—
B- ALLOCATIONS	3.000,—	420,—	1.884,—	5.304,—	37.432,—	-	-	-	37.432,—	-	34.352,—	38.000,—	-	-	72.352,—	115.088,—
D- FRAIS DE VOYAGE - [illegible] PERSONS	5.384,—	900,—	5.384,—	11.568,—	30.584,—	10.600,—	14.800,—	1.644,—	56.380,—	68.088,—	-	-	-	-	68.088,—	93.068,—
E- MATERIEL ADMV.- ELECT.	-	23.972,—	-	23.972,—	-	-	-	-	-	11.688,—	-	-	-	-	11.688,—	35.[illegible],—
F- ADMV. COST.- CF/ERA ADM. TEL.- FRAIS DE ELF TRAV. [illegible]	1.760,—	4.880,—	3.080,—	8.960,—	7.300,—	750,—	970,—	-	9.020,—	11.320,—	-	-	-	-	11.320,—	20.[illegible],—
	-	-	7.380,—	7.380,—	-	3.000,—	-	15.700,—	18.700,—	-	-	-	-	3.[illegible],—	3.[illegible],—	26.[illegible],—
H- [illegible] FONCIERES	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
- Carburants & Lubrifiants	-	-	72.000,—	72.000,—	-	-	-	-	-	-	-	-	-	-	-	72.000,—
- Bâtiments	-	-	-	-	-	-	-	-	-	-	-	130.000,—	-	-	130.000,—	130.000,—
- Pièces Rech. Veh.	-	-	60.000,—	60.000,—	-	-	-	-	-	-	-	-	-	-	-	60.000,—
- Batteries - Piles	-	-	16.500,—	16.500,—	-	-	-	-	-	-	-	-	-	-	-	16.500,—
- Ex. App.Pesan.Bur. & autres	-	12.652,—	-	12.652,—	-	-	-	-	-	-	-	-	-	-	-	12.652,—
- Gas oil & Essel.Lorvisiéres	-	-	-	-	-	41.652,—	-	-	41.652,—	-	-	-	-	-	-	41.652,—
- Gas oil solution	-	-	-	-	-	-	-	-	-	-	3.373,—	-	-	-	3.373,—	3.373,—
- Solution [illegible]	-	-	-	-	-	6.708,—	-	-	6.708,—	-	160.000,—	-	-	30.000,—	190.000,—	196.708,—
G- [illegible]	-	500,—	-	500,—	1.000,—	-	-	300,—	1.300,—	-	-	-	-	-	-	1.800,—
- [illegible]	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
H- [illegible]	240,—	300,—	500,—	1.040,—	800,—	1.000,—	300,—	400,—	1.900,—	-	-	-	[illegible]	-	[illegible]	[illegible]
	55.404,—	150.477,—	208.485,—	444.406,—	[illegible]	87.743,—	54.338,—	76.323,—	437.387,—	380.832,—	340.388,—	845.770,—	[illegible]	33.300,—	[illegible]	[illegible]

PROJET DE BUDGET POUR L'ANNEE 1982

(Du 1er Janvier au 31 Décembre 1982)

R E S U M E

(Valeurs exprimées en US Dollars)

	ADMINISTRATION				EPIDEMIOLOGIE					OPERATIONS DE CAMPAGNE						GRAND TOTAL
	REM.	ADM. FINANCES	TRANSPORT GARAGE	TOTAL	DETECT. EVAL. STATIS.	INFORM.	DIAGNOS.	LABO.	TOTAL	FIXED P. OP.	ADP.	REMB. DIV.	ABRATIES.	ULV	TOTAL	
A- SALAIRES	46.324.—	110.000.—	96.461.—	252.824.—	186.232.—	24.752.—	39.852.—	59.631.—	310.427.—	263.938.—	123.072.—	132.860.—	-	-	520.869.—	1.083.120.—
B- ALLOCATIONS	3.000.—	420.—	1.884.—	5.304.—	37.632.—	-	-	-	37.632.—	-	31.200.—	29.376.—	-	-	60.576.—	103.512.—
C- FRAIS DE VOYAGE- SEMCE PERMTS	5.856.—	900.—	5.856.—	12.612.—	8.500.—	10.400.—	14.000.—	1.610.—	34.510.—	52.811.—	-	-	-	-	52.811.—	99.933.—
D- LOCAUX- ENTRT.- REPARAT.	-	25.745.—	-	25.745.—	-	-	-	-	-	12.788.—	-	-	-	-	12.788.—	38.533.—
E- ENTRT. CONT.- OPAMA ADM. VEH.-PIECES CY- ULV TRAV. ENTRPR.	1.800.—	5.286.—	3.000.—	10.086.—	8.208.—	800.—	990.—	1.800.—	11.790.—	12.250.—	-	-	-	-	12.250.—	34.126.—
	-	-	7.200.—	7.200.—	-	3.000.—	-	6.200.—	9.200.—	-	-	-	-	5.600.—	5.600.—	[illegible]
F- DEPENS FONCIERES	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
-Carburants & Graisse	-	-	79.200.—	79.200.—	-	-	-	-	-	-	-	-	-	-	-	79.200.—
-Médicaments	-	-	-	-	-	-	-	-	-	-	-	300.000.—	-	-	300.000.—	300.000.—
-Pièces Rech. Veh.	-	-	40.000.—	40.000.—	-	-	-	-	-	-	-	-	-	-	-	40.000.—
-Batteries- Pneus	-	-	18.150.—	18.150.—	-	-	-	-	-	-	-	-	-	-	-	18.150.—
-Ex-App.Pneus.Bur. & autres	-	10.000.—	-	10.000.—	-	-	-	-	-	-	-	-	-	-	-	10.000.—
-Gas oil & Essol.Larvicides	-	-	-	-	-	43.817.—	-	-	43.817.—	-	-	-	-	-	-	43.817.—
-Gas oil solution	-	-	-	-	-	-	-	-	-	3.732.—	-	-	-	-	3.732.—	3.732.—
-Malathion-MLU-Abate-DDT	-	-	-	-	-	7.378.—	-	-	7.378.—	-	148.800.—	-	-	27.000.—	159.000.—	166.378.—
G- [illegible] -Equip.	-	500.—	-	500.—	-	-	-	-	-	-	-	-	-	-	-	500.—
H- AUTRES- [illegible]	250.—	300.—	500.—	1.050.—	200.—	1.000.—	300.—	164.—	1.664.—	-	-	-	80250.000.—	1.000.—	251.000.—	251.714.—
	57.030.—	153.170.—	252.471.—	462.671.—	240.744.—	93.147.—	55.122.—	69.405.—	458.418.—	345.513.—	304.272.—	462.236.—	250.000.—	23.000.—	1.377.021.—	[illegible]