

5220148 (2)

PD-AAB-954-B1

UNCLASSIFIED

109p.

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

HONDURAS

PROJECT PAPER

HEALTH SECTOR PLANNING

LAC/DR:79-13

Project Number: 522-~~0000~~<sup>0148</sup>

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT  <b>PROJECT PAPER FACESHEET</b>	1. TRANSACTION CODE <div style="border: 1px solid black; display: inline-block; padding: 2px;">A</div> A ADD C CHANGE D DELETE	<b>PP</b>  2. DOCUMENT CODE <div style="border: 1px solid black; display: inline-block; padding: 2px;">3</div>
--	---	---

3. COUNTRY/ENTITY HONDURAS	4. DOCUMENT REVISION NUMBER <div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></div>
-------------------------------	---

5. PROJECT NUMBER (7 digits) <div style="border: 1px solid black; display: inline-block; padding: 2px;">522-0148</div>	6. BUREAU/OFFICE A. SYMBOL LA	B. CODE <div style="border: 1px solid black; display: inline-block; padding: 2px;">05</div>	7. PROJECT TITLE (Maximum 40 characters) <div style="border: 1px solid black; display: inline-block; padding: 2px;">HEALTH SECTOR PLANNING</div>
---	-------------------------------------	--	---

8. ESTIMATED FY OF PROJECT COMPLETION <div style="border: 1px solid black; display: inline-block; padding: 2px;">8   1</div>	9. ESTIMATED DATE OF OBLIGATION A. INITIAL FY <div style="border: 1px solid black; display: inline-block; padding: 2px;">7   9</div> B. QUARTER <div style="border: 1px solid black; display: inline-block; padding: 2px;">4</div> C. FINAL FY <div style="border: 1px solid black; display: inline-block; padding: 2px;">7   9</div> (Enter 1, 2, 3, or 4)
---	---

10. ESTIMATED COSTS (\$000 OR EQUIVALENT \$) -						
A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. TOTAL	E. FX	F. L/C	G. TOTAL
AID APPROPRIATED TOTAL						
IGRANT:	356	119		356	119	475
ILOAN:						
OTHER						
1. U.S.						
2. U.S.						
HOST COUNTRY		45			212	212
OTHER DONOR(S)						
TOTALS	356	164		356	331	687

11. PROPOSED BUDGET APPROPRIATED FUNDS (\$000)									
A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. 1ST FY <u>79</u>		H. 2ND FY		K. 3RD FY	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	I. GRANT	J. LOAN	L. GRANT	M. LOAN
(1) H	580	520		475					
(2)									
(3)									
(4)									
		TOTALS							

A. APPROPRIATION	N. 4TH FY		O. 5TH FY		LIFE OF PROJECT		12. IN-DEPTH EVALUATION SCHEDULED
	D. GRANT	P. LOAN	R. GRANT	S. LOAN	T. GRANT	U. LOAN	
(1)					475		<div style="border: 1px solid black; display: inline-block; padding: 5px;">           MM YY            09 81         </div>
(2)							
(3)							
(4)							
		TOTALS				475	

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 <div style="text-align: center;"> </div>		15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION <div style="border: 1px solid black; display: inline-block; padding: 2px;">           MM DD YY            08 06 81         </div>
TITLE Act. Director USAID/Honduras	DATE SIGNED <div style="border: 1px solid black; display: inline-block; padding: 2px;">           MM DD YY            07 25 79         </div>	

AGENCY FOR INTERNATIONAL DEVELOPMENT  
**PROJECT IDENTIFICATION DOCUMENT FACESHEET**  
 TO BE COMPLETED BY ORIGINATING OFFICE

1. TRANSACTION CODE  
 A A = ADD  
 C C = CHANGE  
 D D = DELETE

PID  
 2. DOCUMENT CODE  
 1

3. COUNTRY/ENTITY  
 HONDURAS

4. DOCUMENT REVISION NUMBER

5. PROJECT NUMBER (7 DIGITS)  
 522-0100

6. BUREAU/OFFICE  
 a. SYMBOL I.A  
 b. CODE 05

7. PROJECT TITLE (MAXIMUM 40 CHARACTERS)  
 HEALTH SECTOR PLANNING

8. PROPOSED NEXT DOCUMENT  
 a.  2 = PRP  
 3 = PP  
 b. DATE  MM  YY  
 12  78

9. ESTIMATED FY OF AUTHORIZATION/OBLIGATION  
 a. INITIAL FY  78  79  
 b. FINAL FY  78  79

10. ESTIMATED COSTS (\$1000 OR EQUIVALENT, \$1 = )  
 FUNDING SOURCE

A. AID APPROPRIATED	175
B. OTHER	
C. HOST COUNTRY	100
D. OTHER DONOR(S)	
TOTAL	275

11. PROPOSED BUDGET AID APPROPRIATED FUNDS (\$1000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. FIRST FY 78		LIFE OF PROJECT	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	H. GRANT	I. LOAN
(1) II	5800	520		175		175	
(2)							
(3)							
(4)							
TOTAL				175		175	

12. SECONDARY TECHNICAL CODES (maximum six codes of three positions each)  
 5300

13. SPECIAL CONCERNS CODES (MAXIMUM SIX CODES OF FOUR POSITIONS EACH)  
 14. SECONDARY PURPOSE CODE

15. PROJECT GOAL (MAXIMUM 250 CHARACTERS)  
 To improve the health status of the Honduran populace

16. PROJECT PURPOSE (MAXIMUM 480 CHARACTERS)  
 To strengthen the analytical capacities in health planning and management of the Ministry of Health.

BEST AVAILABLE COPY

17. PLANNING RESOURCE REQUIREMENTS (staff/funds)

1. Scope of Work Team, 4000 WH, \$30,000	TOTAL: \$210,000
2. Baseline Studies and PP preparation, 24 WH, \$144,000	
3. Training, 54,000	

18. ORIGINATING OFFICE CLEARANCE

Signature: *[Signature]*

Title: J. R. Robinson, Director DEAI/DII

Date Signed:  MM  DD  YY  
 01  01  77

19. DATE DOCUMENT RECEIVED BY AID/W, or FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION  
 MM  DD  YY

<b>AGENCY FOR INTERNATIONAL DEVELOPMENT</b> <b>PROJECT AUTHORIZATION AND REQUEST</b> <b>FOR ALLOTMENT OF FUNDS PART I</b>		<b>1. TRANSACTION CODE</b> <input checked="" type="checkbox"/> A - ADD <input type="checkbox"/> C - CHANGE <input type="checkbox"/> D - DELETE	<b>PAF</b> <b>2. DOCUMENT CODE</b> 5
<b>3. COUNTRY/ENTITY</b> HONDURAS		<b>4. DOCUMENT REVISION NUMBER</b> <input type="checkbox"/>	
<b>5. PROJECT NUMBER (7 digits)</b> <input type="text" value="522-0119"/>	<b>6. BUREAU OFFICE</b> <input type="checkbox"/> A. SYDUL <input type="checkbox"/> B. COUL	<b>7. PROJECT TITLE (Maximum 40 characters)</b> <input type="text" value="HEALTH SECTOR PLANNING"/>	
<b>8. PROJECT APPROVAL DECISION</b> <input type="checkbox"/> A - APPROVED <input type="checkbox"/> D - DISAPPROVED <input type="checkbox"/> DE - DEAUTHORIZED		<b>9. EST. PERIOD OF IMPLEMENTATION</b> YRS. <input type="text" value="0"/> <input type="text" value="2"/> QTRS. <input type="text" value="1"/>	

13. APPROVED BUDGET AID APPROPRIATED FUNDS (\$000)									
A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		C. 1ST FY 79		H. 2ND FY		K. 3RD FY	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	I. GRANT	J. LOAN	L. GRANT	M. LOAN
(1)	580	520		475					
(2)									
(3)									
(4)									
TOTALS				475					

A. APPROPRIATION	N. 4TH FY		O. 5TH FY		LIFE OF PROJECT		11. PROJECT FUNDING AUTHORIZED	
	O. GRANT	P. LOAN	R. GRANT	S. LOAN	T. GRANT	U. LOAN	ENTER APPROPRIATE CODE(S) 1 = LIFE OF PROJECT 2 = INCREMENTAL LIFE OF PROJECT	
(1)					475			
(2)								
(3)								
(4)								
TOTALS					475		C. FY PROJECT FUNDING AUTHORIZED THRU <input type="text" value="8"/> <input type="text" value="1"/>	

12. INITIAL PROJECT FUNDING ALLOTMENT REQUESTED (\$000)			13. FUNDS RESERVED FOR ALLOTMENT		
A. APPROPRIATION	B. ALLOTMENT REQUEST NO.		TYPED NAME (Chief, SERVICEMEN) _____  SIGNATURE _____  DATE _____		
	C. GRANT	D. LOAN			
(1)	475				
(2)					
(3)					
TOTALS		475			

14. SOURCE/ORIGIN OF GOODS AND SERVICES  000  541  LOCAL  OTHER \_\_\_\_\_

15. FOR AMENDMENTS, NATURE OF CHANGE PROPOSED

BEST AVAILABLE COPY

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

PROJECT AUTHORIZATION AND REQUEST FOR ALLOTMENT OF FUNDS

Name of Country: Honduras

Name of Project: Health Sector Planning  
Number of Project: 522-0148

Pursuant to Part I, Chapter I, Section 106 of the Foreign Assistance Act of 1961, as amended, I hereby authorize a Grant to the Republic of Honduras the "Cooperating Country" of not to exceed four hundred and seventy five thousand United States Dollars (US\$475,000) to help in financing certain foreign exchange and local costs of goods and services required for the Project as described in the following paragraph.

The Project, which will be implemented by the Ministry of Public Health, seeks to strengthen the analytical capacities of the Government of Honduras in health planning and management so as to increase the effectiveness of their allocation of health resources and their sector strategies for future investments.

Sub-sector analyses, a summary sector assessment, and in-depth special studies for specific improvements will be completed; GOH staff will be trained in basic analytical concepts, quantitative techniques, professional standards, and specific technical subjects; and certain program improvements will be designed, tested and evaluated. A.I.D. funds will be used to provide technical assistance in environmental sanitation, communicable disease control and epidemiology, human resources development, materials management, and finance and budgeting; participant training in epidemiology, environmental sanitation, health planning and health administration; invitational travel; and to finance commodities and other costs for Project support.

I hereby authorize the initiation of negotiation of the Project Agreement by the officer to whom I have redelegated such authority 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 of Origin of Goods and Services

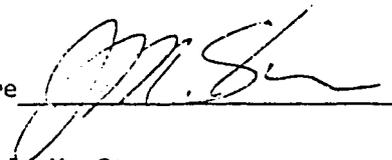
Goods and services, including ocean shipping, financed by A.I.D. under the Project shall have their source and origin in the Central American Common Market or in the United States, except as A.I.D. may otherwise agree in writing.

(b) Nationality Waivers for Technical Services

The following waiver to A.I.D. regulations is hereby approved:

Procurement of services, other than transportation, from countries included in A.I.D. Geographic Code 241, when the cost of said services does not exceed \$50,000 (exclusive of transportation costs). This waiver shall be interpreted in accordance with applicable A.I.D. Handbooks.

Signature



J. M. Stone

Typed name of Authorizing Officer

Acting Mission Director

Official Symbol

PROJECT PAPERHEALTH PLANNING

Contents:	Page No.
PP Face Sheet	i
PID Face Sheet	ii
Contents	iii
Tables	v
Acronyms	vi
I. Narrative Summary	1
II. Project Description	2
A. Background	2
1. The Problems, Responses, and Constraints	2
2. Relation to A.I.D. Sector Objectives	8
3. History of Project Development	9
4. Relation of Project to Future Sector Activity	10
B. Detailed Description	10
1. Sector and Project Goals	10
2. Project Purpose	11
3. Project Outputs	12
4. Project Inputs	15
5. Strategy and Methodology	16
6. Beneficiaries	21
III. Project Specific Analyses	22
A. Economic Analysis	22
B. Social Analysis	23
1. Management Methodologies	23
2. Benefit Flows	25
C. Technical Analysis	26
1. Availability of Information	26
2. Availability of Technical Assistance and Honduran Technical Counterparts	27

	Page No.
3. Alternatives for Project Phasing	28
4. Alternative Sources of Training	29
5. Alternatives to Focusing on Regional Management	29
6. Alternatives to Focusing on Planning and Decision-Making	30
D. Administrative Analysis	31
1. General Administration	31
2. Contracting and Procurement	33
3. MOH Training in A.I.D. Procedures	35
4. Determination of Feasibility	35
E. Population Concerns	35
F. Environmental Considerations	35
G. Impact on the Status and Participation of Women	36
IV. Financial Plan and Analysis	
A. Project Financial Requirements and Timing of Expenditures	36
B. Financial Impact of Project on the MOH	37
V. Implementation Plan	41
VI. Review and Evaluation Plan	46
VII. Conditions, Covenants, and Negotiation Status	47
A. Negotiation Status	47
B. Covenants and Conditions	47
C. Third Country Technical Assistance and Waivers	47

## ANNEXES

- A. Financial Data
- B. PID Approval Cable
- C. Logical Framework
- D. Statutory Check List
- E. Project Authorization and Request for Allotment of Funds
- F. Environmental Threshold Decision
- G. GOH request for Project
- H. MOH Proyecto de Planificación y Desarrollo Administrativo.

TABLES

	Page No.
Comparative Health Status Indicators	3
Illustrative Content of Training Outputs	14
GOH/MOH Budget Analysis	37
Summary Cost Estimate and Financial Plan	38
Costing of Project Outputs/Inputs	39
Projection of Expenditures by Fiscal Year	40
Administrative Schedule	41
Analytical Schedule	42
Training Schedule	43
Management Methodologies Schedule	44
Review and Evaluation Activity Schedule	45
Illustrative Budget Administrative Activity	A1
Illustrative Budget Analytical Activity	A2
Illustrative Budget Training Activity	A3
Illustrative Budget Management Methodology Activity	A4
Illustrative Allocation of Trainees	A5
Detailed Commodities List	A6
Logical Framework	C1-2

ACRONYMS

A.I.D.	United States Agency for International Development
AID/W	A.I.D. Washington Offices
CARE	Cooperative for American Relief Everywhere, Inc.
CESAR	Rural Health Center (Centro de Salud Rural)
CDC	Communicable Disease Control
CONSUPLANE	Consejo Superior de Planificación Económica (National Economic Planning Council)
DGS	Directorate General of Health (Dirección General de Salud)
EEC	European Economic Community
FX	Foreign Exchange Costs
FY	Fiscal Year
GDP	Gross Domestic Product
GOH	Government of Honduras
GSA	General Services Administration
HRD	A.I.D./Honduras Office of Human Resource Development
IDB	Inter-American Development Bank
IHSS	Honduran Social Security Institute (Instituto Hondureño de Seguridad Social)
IQC	Indefinite Quantity Contract
LAC/DR	A.I.D. Bureau for Latin America and the Caribbean/ Development Resources.
LASPAU	Latin American Scholarship Program of American Universities
LC	Local Currency Costs
LDC	Less Developed Country
MCH	Maternal Child Health
MOF	Ministry of Finance (Ministerio de Hacienda y Crédito Público)
MOH	Ministry of Health (Ministerio de Salud Pública y Asistencia Social)
OIH/DHEW	Office of International Health/Department of Health, Education, and Welfare
PAHO	Pan American Health Organization
PANI	The National Lottery (Patronato Nacional de la Infancia)
PIO/C	Project Implementation Order for Commodities
PIO/P	Project Implementation Order for Participants
PIO/T	Project Implementation Order for Technical Services
PM	Person-months

PRO AG	Project Agreement
PROSABA	Basic Sanitation Program (Programa de Saneamiento Básico)
PW	Person-weeks
PY	Person-years
Rev	Revision
RSSA	Resources/Services Support Agreement
SANAA	National Water Board (Servicio Autónomo Nacional de Acueductos y Alcantarillados)
SOH	Secretariat of Health (Secretaría de Salud Pública)
TA	Technical Assistance
TCC	Technical Coordination Committee
UNAH	National University (Universidad Nacional Autónoma de Honduras)
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Emergency Fund
US	United States of America

## I. NARRATIVE SUMMARY

This is a 27 month Project totaling \$ 687,000 including an A.I.D. grant in the amount of \$ 475,000 to the Ministry of Health (MOH) of the Government of Honduras (GOH). The purpose of the project is to improve decision-making at all levels in planning and implementing health sector resource allocations for both the short and the long term.

This purpose will have been achieved when: (1) sector management is acting on the basis of analytical results in budgeting, planning, and programming; (2) interventions have been selected and designed for health sector resource allocations over the next two to five years (based on analytical results), and designs have been integrated into sector plans and budgets; (3) key management methodologies have been implemented in at least one region; and (4) personnel trained have been placed in key decision-making and/or implementing positions.

The outputs needed to realize the project purpose are: (1) analytical studies; (2) training; and (3) management methodologies designed and tested.

A.I.D. will finance inputs of \$ 262,000 in technical assistance for project coordination, analyses and studies, in-country training, and development of management methodologies. In addition \$ 50,000 will be provided for short and long term participant training. Commodities, including office equipment, vehicles, books, training materials, and supplies and equipment will be provided at a cost of \$ 41,000. Other costs of \$ 122,000 for secretarial support, translation services, invitational travel (professional exchanges), per diem for host country personnel, and honorarium and salary for selected Honduran counterparts will round out A.I.D.'s \$ 475,000 contribution.

The total GOH counterpart contribution, i.e. salaries, supplies and equipment, vehicle support, documents, per diems, and in-country transportation, is approximately \$ 212,000.

The Project begins a process through which over 1.1 million largely rural people will eventually receive better services as a result of improved MOH (and related agency) administrative and operational efficiency. The target group for public health sector programs is the Honduran lower class, be it urban or rural. This is the group served by the MOH. Thus the target group for investment is the Congressionally mandated A.I.D. target group, with little likelihood that it will change in the next generation.

## II. BACKGROUND AND DETAILED PROJECT DESCRIPTION

### A. Background

#### 1. The Problems, Responses and Constraints

##### a. Major Health Problems

Hondurans suffer from the classic health conditions prevalent in poor, developing countries: high fertility and mortality; infections as the leading causes of death and illness; endemic undernutrition; worse health conditions in the rural areas; greatest morbidity/mortality in the mother and child groups. (see Table 1).

The same un-hygienic environmental and harsh economic conditions that affect the majority of the world's poor countries also affect Honduras. Acute and chronic gastro-intestinal infections are the frequent result of contamination of food and water with human excreta, and of poor housing. Active transmission of many communicable diseases persists despite the existence of preventive measures such as vaccination programs and vector control. Curable conditions become chronic and manageable conditions become complicated due to lack of information, limited access to medical care, unfavorable home environment, and lack of the knowledge or economic means needed to improve them.

While the processes which produce poor health in Honduras are the same which operate in most other less developed countries (LDCs), of the 26 Latin American countries, only Bolivia and Haiti have significantly higher mortality combined with lower life expectancy. Solutions are often frustrated by the dispersion of the largely rural population and the severity of its poverty.

##### b. Responses to the Problem

Varied attempts to confront the problem described earlier include efforts oriented toward distinct target groups which are designed to provide different packages of services. These efforts are discussed below in three general categories of (1) Government of Honduras (GOH) (including semi-autonomous), (2) private (Honduran) and (3) international.

##### i. Government of Honduras Response

A broad range of government services (water supply for the rural areas, communicable disease control and medical care) are only beginning to be provided through the Ministry of Health which is responsible for providing one or more of these services to 85% of the population. Other agencies provide limited services. These agencies include: Servicio Autónomo Nacional de Acueductos y Alcantarillados (SANAA), the National Water Service, which

TABLE 1  
COMPARATIVE HEALTH STATUS INDICATORS

		<u>Honduras</u>	<u>El Salvador</u>	<u>Nicaragua</u>	<u>United States</u>
Crude Birth Rate	Births/1000 population <sup>1</sup>	47	40	47	15
Crude Death Rate	Deaths/1000 population <sup>1</sup>	13	8	13	9
Natural Increase	Percent increase/year <sup>1</sup>	3.4%	3.3%	3.4%	.6
Infant Mortality Rate	Infant deaths/1000 live births <sup>1</sup>	103	55	110	15
Level of malnutrition	% population 0-5 years classified as malnourished <sup>2</sup>	73%	74%	56%	< 5%
Level of infection related mortality	Deaths from other infective (non enteritis) and parasitic disease rate/100,000 population <sup>3a</sup>	60.2	37.2	49.1	6.5
General	Deaths from enteritis and other diarrheal disease Crude rate/100,000 <sup>3b</sup>	99.6	104.7	108.7	.9
	Physical quality of life index (scale 0-100) <sup>4</sup>	50	67	53	96

1. Population Reference Bureau 1978

2. Nutritional Evaluation of Central America and Panama - data for 1966

3. Health Conditions in the Americas 1973-1975 - a. Year of all data 1975

b. Year of data Honduras 1975, El Salvador 1974, Nicaragua 1973,  
 United States 1975

4. Pan American Health Organization Magazine  
 Vol. 9, No.3, 1977.

provides water systems for population concentrations greater than 500\*; Patronato Nacional de la Infancia, (PANI), financed by the National Lottery, provides maternal-child health services and production of medicines; the Armed Forces, which only provide services for military personnel; and the Instituto Hondureño de Seguridad Social (IHSS), Social Security, which provides medical services for five per-cent of the population.

In 1973 the Ministry of Health initiated implementation of a policy of extension of coverage of health care and sanitation programs into the rural areas. The resulting program is based on a regionalized system of graduated levels of care provided by community volunteers, auxiliary nurse dispensaries, regional hospitals and, finally, national hospitals. The overall policy of extension of coverage is based on the model of using integrated rural health services to reach the poor majority.

While the increase in GOH health care coverage has been encouraging, the attainment has been considerably less than complete. Only 45% of the population for which the MOH recognizes responsibility has access to basic health services and, unfortunately, the quality of the services is often inadequate. The consultation rate of 260/1000 population in 1972 increased to 970 in 1977 (visits to physicians, auxiliary nurses, and village volunteers are included). This is well below the commonly accepted norm of 2000 physicians visits/1000 people established as a goal by the 1972 conference of Latin American Ministers of Health at Punta del Este. Vaccination coverage during this period increased from 8-15% to 50-60% for measles, polio, diphtheria, pertussis and tetanus. However, there has been essentially no increase in the past two years. Epidemics of these diseases are still occurring; 80% coverage would be required to prevent such occurrences. Coverage by the environmental sanitation program is increasing; however, in 1977 only 26% of the rural population were considered "covered" by water services and only 20% had adequate means of human waste disposal. These estimates of coverage are unrealistically high, as they have been observed to include non-functioning service units.

Between 1974 and 1978 the GOH invested 11 to 14% of its central government budget in health sector programs. This is a substantial investment which represents about 2.5% of the Gross Domestic Product (GDP). Moreover, this expenditure has been increasing at an annual rate of 22% over the last five years, much of which is attributable to construction of new facilities. This investment is significant when viewed in terms of Honduras' economic capabilities. However in terms of per capita expenditures, the investment is miniscule in comparison with that of developed countries.

---

\* The MOH Program for Environmental Sanitation, PROSABA, has responsibility for providing water services for rural concentrations of less than 500.

In recent years GOH attempts to improve the quality and coverage of services have left the MOH over-extended, lacking resources for basic supplies, supervision, transportation, and many other necessary elements. This situation will be aggravated in the next few years as hospital and clinic construction programs are finished and these facilities begin to compete for scarce operational resources. It is not expected that the health budget can continue to increase as rapidly as it has in the last five years.

ii. Honduran Private Sector

Private sector health services and expenditures are substantial, even though their extent has not been determined. Private hospitals, laboratories, physicians, nurses, and dentists are concentrated in Tegucigalpa and San Pedro Sula where they serve about 9% of the population (the economically advantaged). Such services are oriented almost exclusively toward diagnosis and treatment of disease, (rather than prevention) and are available basically in urban areas for those who can pay. As such they contribute almost nothing to improving the health status of poor Hondurans.

Pharmacists, druggists, and midwives are distributed much more widely and serve (albeit poorly) a large portion of the urban and rural poor. Midwives, for example, attend about 80% of Honduran births.

iii. International Donors

Honduran health policies and programs have been significantly assisted and supported by non-Honduran agencies.

(a) The Pan American Health Organization (PAHO) has been providing general and specific technical assistance and some training opportunities for many years. PAHO's program has been oriented toward studying and developing recommendations for overcoming specific technical problems but without providing substantial implementational resources to assure that recommended improvements actually take place. The failure to provide implementational resources and to focus on broader management issues has dampened the effectiveness of this assistance.

(b) The Inter-American Development Bank (IDB) provided \$4.7 million in loan funds for construction of the national teaching hospital (1975-1978). The IDB is presently providing loan funds in three areas: (1) \$14 million to the MOH to improve existing health care facilities and to build 10 new hospitals and 235 rural health posts (1976-81); (2) \$12 million to SANAA for urban water systems in El Progreso, La Ceiba, and Puerto Cortés (1978-81); and (3) \$4.5 million to SANAA for urban water systems in Tegucigalpa (1978-81). At the present time the IDB and the SANAA are negotiating another loan of \$4.5 million to \$6 million for rural aqueducts for 150-190 rural towns in the size range of 200 to 2000 persons each, for execution in 1980-1983.

(c) The Cooperative for American Relief Everywhere, Inc. (CARE) is making health and nutrition its priority program area in Honduras. In 1979 CARE donated \$200,000 for rural water programs with SANAA. Their projected input to SANAA for 1980-82 is \$1.2 million. CARE also distributes PL 480 Title II food supplements, provides visiting medical staff, and promotes improved sanitary conditions through housing programs.

(d) Various international agencies including the Swiss Government, Foster Parents Plan and the United Nations International Childrens Emergency Fund (UNICEF) (total about \$1.0 million in grants) are financing extension of small rural water systems through the Programa Sanitario Básico (PROSABA) of the Ministry of Health. (1977-1980).

(e) The United Nations Development Program (UNDP) has recently developed a project to assist demographic efforts, census and vital records. Funds from this project (\$1.0 million) through the United Nations Fund for Population Activities (UNFPA) are being used to support and extend Maternal Child services of the MOH (1979-81).

(f) The European Economic Community (EEC) is negotiating a grant of \$4.0 million with the MOH for latrines, wells, and water systems to cover 90% of the population of Olancho (Health Region 7) during the period 1980-82.

(g) A.I.D.'s own input in the last 5 years includes a \$1.5 million loan component (part of Nutrition Project 522-0129) for extension of rural water systems (1976-80) and a \$1.2 million grant for extension of integrated rural health services (construction of training facilities and training of auxiliary nurses and village volunteers during 1976-81).

#### c. Health Sector Constraints

Since this is the first attempt at systematic analysis of the entire health sector in Honduras, a comprehensive description of the sector's constraints and practical solutions does not yet exist. Therefore, this summary reflects a best judgement of A.I.D.'s health personnel and short-term consultants at this time. The primary objective of this Project is to refine and amplify our understanding of these issues.

The most obvious constraint and one frequently mentioned by GOH representatives is an overall lack of both human and physical resources. This constraint exists in spite of the fact that 12% of the national central budget is devoted to the principal health sector agencies and that this budget has been growing by 22% annually since 1973.

A more serious problem hidden behind the quantitative resource constraint is inefficiency and imbalance in the allocation of resources. Health establishments frequently lack either the medicines, equipment, or personnel needed to function in spite of their existence somewhere else in the

system. Sanitation workers often lack materials, even those for which funds are available. These imbalances imply a short-term need to resolve obvious problems and imbalances now with available resources and a long-term need for improved analysis, planning, budgeting, and management to avoid such costly imperfections in the future.

A rapid turnover in health personnel (due to attrition from the sector and movement within the sector) limits efforts to improve efficiency and improve quality of care. Health sector salaries are low. For example, a graduate nurse with the equivalent of a B.S. degree receives half of what other university graduates receive. Staff instability is especially high in rural areas where the combination of financial and other incentives are not adequate to retain personnel.

The MOH also recognizes its serious human resource constraints in both numbers and capability of personnel. The number of health technicians is inadequate to cover the needs of Honduras. But, more importantly, most of the health technicians are in jobs beyond their level of competence or are performing tasks extraneous to their areas of specialty. This is especially true when one moves outside the area of direct patient contact into supply and management. People trained as accounting clerks often fill the role of managers, for example.

Improved planning and management in the health sector would help reduce problems of resource allocation and development as would an adequately trained staff who can carefully analyze problems, make appropriate decisions, and implement well-designed interventions. This is especially true at the regional level, and at the central level in matters of supply, maintenance, transportation, communication, supervision, and patient referral.

With inadequately trained personnel (who are poorly distributed, financed, supervised, and supplied) there exists a wide gap between the health policy, which is properly designed for Honduran conditions and aimed at full coverage of the economically disadvantaged population, and implementation, which remains tied largely to in-patient hospital facilities and is curative, rather than preventive.

The following list further defines observed areas of existing needs and constraints:

i. Human Resources

Well trained traditional practitioners (midwives, druggists, etc.)

Trained village volunteers

Auxiliary nurses

Nurses and physicians (with knowledge of management, epidemiology, sanitation, general public health, and preventive medicine )

Managers (with knowledge of public health)

Technicians (laboratory, applied research, medical assistants,  
and equipment operators )

ii. Management and Administration

Management and Administrative procedures

Information systems

Supervision and program evaluation

Referral Systems

Surveillance

Budgetary procedures and controls

Program development and planning

Policy development

Selection of appropriate technology

Communications

iii. Materials Management

Equipment and Maintenance

Supplies (especially medicines), inventory control and logistical  
systems

Transportation

Honduras will not be able to eliminate these constraints and provide for basic health care (outpatient services including prenatal, postnatal and delivery care for normal pregnancies, simple treatments for common problems, child development services and health education) for the majority of its population by the year 2000 without substantial external financing to implement them. In spite of the fact that the government has adopted a solid program of developing and employing traditional and para-professional level personnel to complement the more expensive nurses and doctors, the demand is too great for the country's resources.

2. Relation of Project Strategy to A.I.D. Objectives

The GOH has already adopted a health program strategy which matches A.I.D.'s mandate in the sector. This strategy includes the following key elements:

- low-cost primary health care and prevention;
- extension of coverage to the poor (predominantly rural) majority;
- integrated, regionalized health services, and
- para-professional, volunteer, and traditional personnel to complement physicians and nurses within a referral system.

Substantial investments are being made and planned in the purely agricultural sector with the purpose of increasing employment, productivity and income. This effort will require human talents and energies which, at present, are severely constrained by poor education, health, and nutrition. Without improvement in these factors, the benefits of heavy investment in productive activities will not be fully realized. Moreover, without immediate attention to these basic requirements for human resource development, Honduras will face the 21st century in the same relative position it now occupies, near the bottom of the scale of development. And it may well be worse off in real terms.

This sector analytical undertaking and the training opportunities proposed in this Project are intended to improve the basis for GOH planning and to rationalize the application of GOH and external resources as well as to provide the analytical basis for increased A.I.D. support of GOH health sector programs. This Project will complement the technical assistance of PAHO and other donors in areas where assistance is being provided, e.g. water systems, maternal-child health (MCH), nutrition, and health care facility construction.

### 3. History of Project Development

Over the past 10 years in the general area of health, GOH-A.I.D. collaboration has been limited to the development of maternal-child health and family planning services and, more recently, training of auxiliary nurses and rural health care workers and efforts to create systems to improve nutritional status. Though the GOH has been receiving assistance from some foreign organizations it has become apparent that considerably more support for the health sector would be required before the entire Honduran population could have reasonable access to appropriate health services.

Detailed discussions of the health planning project began in August 1978. Health planners were contracted to develop specific analytical approaches for the project. Staff from LAC/DR/Health and OIH/HEW helped to develop strategy and select project elements. A local firm is currently identifying, collecting, and cataloging existing documents which constitute the present basis for health planning in Honduras.

#### 4. Relation of Project to Future Sector Activity

A review of the health document inventory reveals that neither A.I.D. nor any other international organization has ever been involved in comprehensive health sector programs in Honduras. Thus knowledge of the health sector, and the analytical base for planning large scale sector programs are limited. The Mission has used PD and S funds in the last year to assemble descriptive information about the health sector and to identify priority program areas. The current Project will further these efforts by providing the analyses, studies, and plans necessary to determine the appropriateness, size, and scope of possible future A.I.D. involvement in the health sector and to assist the GOH in reaching its decisions as to national and other donor resources allocations.

Moreover, through its emphasis on training and management development the present Project will begin to lay the basis for improved efficiency and efficacy of GOH health sector programs. This will help to assure that future A.I.D. supported GOH health sector programs reach their goal of improving the health status of the Honduran population.

It appears likely that additional A.I.D.-GOH collaborative efforts will grow out of this Project if current rough estimates of the need for resources prove accurate and GOH absorptive capacity can be developed. This Project will help identify in more detail the important constraints and will provide needed training. The follow-on program may provide means to overcome many, if not most, of these constraints, and could provide additional resources to further expand analytic capabilities and vital programs.

#### B. Detailed Description

##### 1. Sector and Project Goals

Ultimately, this Project is designed to support attainment of the Mission's health sector goal, i.e. to improve the health of the majority of Hondurans, and especially the poor majority who are still largely without even basic health care, through achievement of the project goal of more effective and efficient use of health sector resources. A.I.D.'s sector goal is identical to the GOH goal of extension of coverage expressed in the two most recent five-year plans. No measurements of the achievements of the sector goal are applicable to this Project; goal attainment depends on future project implementation which will be affected both by the results of the analytical process and the training conducted under this project. More effective use of health sector resources will be attained through application of the most appropriate medical and public health technologies for the situation which will be selected through an analytical process. More efficient use will be attained through elimination of bottlenecks.

The indicator of progress toward the project goal of more efficient and effective use of funds is improved cost-effectiveness and expanded coverage of basic service units (i.e. cost per hospital admission, clinic visits,

paramedical services including simple medicines, access to water supply, vaccination series delivered). Achievement of both of these goals depends on sustained development in productive and other social sectors over the next 10 to 20 years.

## 2. Project Purpose

The purpose of this Project is to improve decision making at all levels in planning and implementing health sector resource allocations for both the short and long term. The phrase "all levels" includes the central policy making level of the government, the regional (management) level, and the local (delivery) level. Planning and implementing health sector resource allocations include the budgetary process, systems for control of expenditures, and the management of human and physical resources procured through those expenditures in support of appropriate medical/health technology. Both the short term (1-4 years) and the long term (5-20 years) are of importance.

End of Project conditions indicating achievement of Project purpose include: 1) sector management acting on the basis of analytical results in budgeting, planning, and programming; 2) interventions selected and designed for health sector resource allocations over the next two to five years (based on analytical results), and designs integrated into sector plans and budgets; 3) key management methodologies have been implemented in at least one region; and 4) personnel trained have been placed in key decision-making and/or implementing positions.

Over the long term the training conducted and methodologies established should continue to influence the nature of health sector allocations. This will be especially likely if the proposed follow-on health sector program actually materializes.

Several assumptions relate to the achievement of the Project purpose. First, it is assumed the GOH will continue to give priority to the Project purpose and motivate staff to conform to new procedures. Since the GOH has sometimes failed to implement new management methodologies, in spite of potential benefits, this project will support actual implementation of selected methodologies to encourage institutionalization. Secondly, it is expected that GOH laws and regulations will permit implementation of recommendations or can be changed to do so. For example, civil service laws may limit GOH ability to hire adequate managers in rural areas. These limits and alternative solutions will be dealt with as part of the analytical process. Third, it is assumed that trainees will return to work in the Government health sector. This implies both that they return to Honduras and that the GOH continues to employ them. Stipulations to this effect will be included in PIO/Ps and it is likely that the GOH will continue to follow the practice of obligating trainees to return for a specified period of public service.

### 3. Project Outputs

#### a. Analytical Studies

This component of the Project is designed to provide an analytical basis for allocating health sector resources. Because of the urgent need to develop an initial comprehensive assessment, this activity will be carried out in two phases. The first phase will quickly provide an initial assessment. Follow-on analytical work will fill in gaps identified by the initial work.

During the first phase seven subsector studies will be carried out in the following areas:

- i. Environmental Sanitation Program 1/
- ii. Communicable Disease Control (CDC) and Epidemiology Programs 1/
- iii. Human Resources 2/
- iv. Management 2/
- v. Materials 2/
- vi. Finance and Budgetary Processes 3/
- vii. Regional Management 3/

These studies will be focussed on answering questions of strategy and implementation methodology needed to program the proposed Health Sector I Project. Timing of this step is critical to allow development of that project.

One consultant specialist will coordinate work in each of the above areas. Two preliminary outputs (a study outline with preliminary recommendations, and a full draft report) will be prepared and discussed with Mission and GOH personnel to assure that the final report fulfills its scope of work.

---

1/ Covers human resources, management, materials, and appropriate technology for program areas. In the case of (ii), includes appropriate technology for medical care as well.

2/ Covers program areas of medical care, CDC, and environmental sanitation with emphasis on the first.

3/ Covers key program areas and constraints, within topic defined and in relation to existing policy.

The written product will deal with the following broad questions:

- i. What are problems within the area?
- ii. What are existing responses?
- iii. What are constraints to dealing with problems?
- iv. What are the relationships between these problems and constraints and those of other areas?
- v. Recommended alternative courses of action.

As a result of this process a recommended implementation plan will be included along with brief descriptions of alternatives considered and rejected.

While these sub-sector studies are being produced, work will proceed on integrating their results into an initial comprehensive health sector assessment. The initial outlines and draft reports, as well as final reports from each of the subsector studies will guide preparation of the summary assessment document. This document will provide an excellent analytical basis for development of the Project Paper for the proposed Health Sector Project.

During the second phase of this project, after an initial analytical basis has been established, various special studies to be identified in Phase 1 will be carried out. These studies will either expand the analytical basis or develop detailed program methodologies needed in health sub-sectors.

#### b. Training

Training in the areas of epidemiology, sanitation, communicable disease control, human resource development, planning, administration, and health education will be provided to 40-50 health sector policy makers, managers, and administrative/technical personnel, and for four to five trainees who will be able to extend needed analytical skills to other health sector personnel.

Long term academic training will be used when extensive training for single individuals is indicated. Special in-country seminars will be used where a group of persons need similar short term training. In cases where studies indicate that various people need a variety of technical inputs, conferences, observational visits, and short-term academic training will be used. Table 2 illustrates the kind of training mix anticipated.

TABLE 2

ILLUSTRATIVE CONTENT OF TRAINING OUTPUTS

	Seminars in Honduras PM*	Long Term Academic PM	Short Term Academic PM	Observational Visits PM	Conferences PM	TOTALS
Communicable Diseases Epidemiology			4	3	1.25	8.25
Sanitation			4	3	1.25	8.25
Human Resource				2	.75	2.75
Planning		12			1.50	13.50
Administration	30	12		1	.75	43.75
Health Education				1	.50	1.50
TOTALS	30	24	8	10	6	78 PM

\* PM = Person months

c. Management Methodologies

Specific management methodologies will be designed, implemented, and tested in selected areas. Based on preliminary discussions it is expected that these will include methodologies for dealing with human resource, administrative, and material constraints at the regional level. If so, the methodologies would be tested in one region. Emphasis would be on effective use of existing human resources, improved regional determination of future resource needs and allocation of existing resources, and development of improved supply, delivery, or supervision systems among other possibilities.

An alternative may be to work in a single management area (i.e. logistics or supply) for the whole country. In any case the implementation of these methodologies will directly support increased program efficiency, and can be expected to begin to increase the ability to provide health sector services efficiently during the life of this Project.

Assumptions for achieving project outputs are: first, that needed information will be available (this issue is discussed in the section on technical feasibility); second, that practical and economical managerial solutions to program constraints can be found (there is obviously a limit to the extent that managerial changes will improve the system but it appears that management can have significant impact in Honduras at this time); and third, that appropriate trainees can be found who can be temporarily absent for training. (The GOH has shown some reluctance to allow off-the-job training, so the illustrative plan emphasizes various short term options.)

4. Project Inputs

a. AID Inputs:

i. Technical Assistance

\$262,000 will be provided for 92 person months of technical assistance for project coordination, analyses and studies, in-country training, and development of management methodologies.

ii. Participant Training

\$50,000 will be provided for per diem, tuition and fees, insurance, books, and supplies for participants for 32 PM of participant training.

iii. Commodities

\$41,000 will be provided for office equipment, vehicles, books, training materials, supplies, and equipment. The vehicles will be used for consultant field visits and for support of the regional management methodologies activity.

iv. Other Costs

\$122,000 will be provided for secretarial support, translation services, invitational travel, per diem for host country personnel, and honorariums and salaries for Honduran counterparts.

b. GOH Inputs:

i. Technical Assistance

\$100,000 will be provided for counterparts' salaries.

ii. Participants

\$26,000 will be provided for participants' salaries and international travel.

iii. Commodities

\$27,000 will be provided for supplies and equipment, vehicles, (maintenance, parts, and fuel) and documents.

iv. Other Costs

\$69,000 will be provided for salaries for secretaries, chauffeurs, regional and delivery level personnel, per diems; invitational travelers' salaries; and in-country transportation.

5. Strategy and Methodology

The Health Planning Project is designed to facilitate implementation of established health sector policies rather than to promote new policies. Programs have expanded rapidly in the last five years, and a period of consolidation and stabilization is needed to achieve substantial gains. The methodology employed is largely managerial with emphasis on analysis, planning, and institutional mechanisms to achieve policy objectives in the context of limited resources and is also intended to be a means of developing plans for future health investments.

Analyses and studies will be carried out by Hondurans working closely with contract consultants who will provide on-the-job experience to increase the analytical skills of the Honduran counterparts. These analyses will be based largely on existing documents in the health sector which are now being collected and abstracted under AID grant 522-10-78, as well as other available sources. The studies will be related to the GOH's decision making processes. Institutionalization will be facilitated by relating analytical techniques directly to health sector decision-makers and processes. Participant training, seminars and observational travel to increase the experience and skills of managerial personnel will further improve management and planning capability. Finally, the development and testing of selected managerial systems will be employed to improve the efficiency and efficacy of selected GOH health sector activities.

a) Alternative Project Strategies

The health problems of rural and urban poor have been described briefly in the background section of this Project Paper. As an introduction to this analysis, it is useful to consider alternative strategies for addressing the massive health problems identified. These strategies are based on two broad courses of action: funding of health services and analysis of problems in the delivery of health services.

A logical strategic choice is a non-action alternative, providing neither analytical help nor funding. The Honduran public health sector could be left to continue to provide services with internal resources only. While the health budget has increased significantly in the past few years to provide services for the urban and rural poor it must continue to have a substantial growth if it is to (1) overcome existing inflation, (2) overcome the high population growth rate, and (3) make a solid contribution to the provision of coverage of the 55% of the population without access to basic health services. There is a very real possibility that the present momentum can not be maintained and that a quantitative and qualitative deterioration of services could occur. This choice, while logically possible, is morally and politically questionable, as it could result in a deterioration of the quality of life of the AID target group and increasing dissatisfaction with government services in a sector that affects all the population.

Another logical strategic choice is to provide further funding of health services with no overall analysis of the health sector. It can be argued that health problems are sufficiently well-known to justify relatively large infusions of capital into critical areas, e.g. provision of inputs into training of primary health-care personnel and environmental sanitation. However, a one-time projectized infusion of A.I.D. financing would represent only a small percentage of total available resources and would not improve the efficiency and efficacy of the far greater GOH resources. It would not resolve, for example, the problem of medicine stocks for rural health care centers (CESAR's). A.I.D. could finance the purchase of medicines, but could not assure the delivery in the quantities and at the times desired without studying and overhauling the logistical system and, in essence, dealing with related management problems in the health delivery system.

A third choice is to carry out the analytical activities proposed in this Project without further funding, thus providing the MOH with a prescription for its ills but leaving it completely to the GOH to finance the prescribed systemic changes. GOH health expenditures have risen dramatically in real terms since 1973 but cannot be expected to continue to do so in the near future. Only small gains have been achieved by this means, because of inertia and inefficiencies. Substantial gains in health delivery and health status could be produced by applying the analytical results of this project without additional external financing. The reality is, however, that given scarce national resources, improvements will not be undertaken in the near future if the GOH must shoulder the entire incremental cost.

Impact on the target group would be minimal. Other donors have shown no interest in, and are unlikely to provide, appropriate financing for institutional development.

A fourth choice, adopted in this Project, is to carry out the proposed analysis as a basis for possible future AID financing and as a basis for enabling the GOH to make more effective use of its own and other external resources. The problems identified will be addressed in part by A.I.D. providing an appreciable portion of the funds necessary for potential solutions through future collaborative programs. This has neither of the disadvantages of the previous two choices--spending money without knowing how or not investing while knowing how. This strategy will assist the MOH to diagnose its management problems, to identify practical solutions and to increase the level of services delivered through its management system. It is logically consistent, leading from analysis to action, and philosophically correct in terms of the USAID's mandate to improve the quality of life of the country's poor. This analysis is based on the assumption that both steps in the strategy (analysis and funding) will be followed, as the flow of benefits to the needy population is contingent upon both.

b) Project Management

The Project analytical, managerial, and training activities will be managed by a technical coordination committee (TCC) composed of the Chief of the Office of Planning of the MOH (who will be Project Coordinator), the Chief of the Health Sector Planning Office of the National Planning Council (CONSUPLANE), a full time Assistant Coordinator, and Administrative Assistant and a member of the USAID Health Division. The Assistant Coordinator and Administrative Assistant will be financed by this A.I.D. grant.

The TCC will meet as necessary, and on a regular basis, to manage implementation of the Project. These meetings will be chaired by the Chief of Office of Planning of the MOH (the Project Coordinator). The functions of the TCC and its members are discussed in Section III. D, below, "Administrative Analysis".

As the various analyses and methodologies to be prepared under the Project are completed, the TCC will convene selected review committees to consider the value of the results. Seminars may be convened to unite these committees and to discuss and modify recommendations. Participants should include those health sector managers whose actions should be influenced by the analyses and methodologies. The Assistant Coordinator will prepare written reports of the results of these committee activities and/or seminars. The GOH authority to make major implementation decisions and to approve contracts and other implementation documents will rest with the Secretariat of Health (which includes the Minister and Vice Minister). Documents and information will be passed from the Project Coordinator to the Directorate General of Health (which includes the Director General and Sub-Director General) for transmission to the Secretariat. Initial informal A.I.D. concurrence will be obtained through A.I.D. representation

on the TCC. Formal A.I.D. approval will be obtained in response to written requests from the authorized GOH representative(s). The USAID Assistant Director for Human Resource Development and/or his designee will maintain contact with MOH Secretariat and CONSUPLANE decision making levels to assure A.I.D./GOH policy level attention is given to Project results.

c) Analytical and Management Development Strategy

The Project will concentrate the majority of its analytical and managerial effort initially on utilization of existing data and information. This strategy is appropriate because there are large amounts of information in the health sector which could be used if increased analytical capacity were made available. Information gaps will be identified and filled as necessary. The Project will add to the ability of health sector personnel to analyze and use information to make appropriate decisions and select actions needed to improve health sector programs. An important step in this process will be the clear identification of decisions which need to be made. These decisions will provide the focus for project sponsored activities.

The extent to which the editing or extension of existing data is needed will be considered during the first phase of this Project, (see below) and such activities may be undertaken subject to the availability of funds for this purpose.

Long-term (over 3 months) technical assistance will be utilized in this project in order to allow consultants enough time to obtain knowledge on Honduras, and to develop a solid working relationship with Honduran counterparts. However, the consultancy will often not be carried out in one visit to Honduras, but will be staggered over the life of the project to make best use of consultant time and expertise. Working closely with counterparts will be an essential component of the consultant's task. The avoidance of short term consultancies implies that, overall, fewer than 10 consultants will be used (in the main for periods of 3-12 months.)

d) Training Strategy

On-the-job training will be an explicit component of the technical assistance provided under the Project. Basic analytical concepts, quantitative techniques, and professional standards will be taught and demonstrated along with specific technical information. Consultants working on studies and developing improved management procedures will work daily with MOH personnel to perform this training function and to adapt their knowledge to Honduran needs.

Observational visits will be used to allow GOH technicians to observe well-functioning programs and alternate technical approaches in other countries. Where possible, opportunities will be provided to allow the traveler to actually work in the visited program sufficiently to develop

an adequate appreciation of the program's strengths and weaknesses, and the transferability of program components to Honduras;

Seminars given in Honduras will be used for limited, concrete training needs for groups. This will serve to transfer information directly, and to provide means by which central GOH technicians can exchange information with regional management and delivery levels.

Although not explicitly an output of this project, the National Autonomous University (UNAH) will be encouraged to increase attention to public health content in its courses for physicians and nurses, and to develop instruction in the area of public health and public health administration within its management curriculum. Latin American Scholarship Program with American Universities (LASPAU) and other A.I.D. resources may be applied in this regard.

Academic training will also be used in the project. Short term training of two to four months will be used where specific technical information is needed. Longer term training of up to one year will be used when general professional development is required. Both U.S. training and third-country training in Latin America may be employed.

As necessary, training in English will be financed to facilitate formal training in the U.S. A combination of instruction in Honduras followed by a maximum of eight weeks intensive training in the U.S. may be provided as necessary.

e) Implementation Strategy

The technical assistance component of the project will be carried out in two phases (see implementation plan.) The first phase (requiring about 60% of the planned technical assistance) will focus on consolidation of existing information and the development of specific action recommendations needed to improve efficiency and efficacy of health sector programs. This work will be carried out in the first six to nine months of project implementation and is to be completed by March 1980 in order to provide the analytical basis and initial programming for future projects.

The second phase of the technical assistance component (9 to 24 months) will include the development of detailed implementation and management methodologies. These special activities will be selected during the first phase and designed to provide information needed to guide the operation of MOH programs and preparation for the loan and grant project.

GOH counterparts will take increasing responsibility for analytical activities in phase II.

Specific training activities for this and the planned sector program will be identified during phase I, as one of the analytical activities. The sector assessment will include a comprehensive review of training needs and recommendations for the use of project training.

## 6. Beneficiaries

The target group for current public health sector programs is the Honduran lower class, be it urban or rural. It is composed of 75% women and children. In the stratification of health care in Honduran society, the upper and middle classes are served by the private health care system, which has relatively good clinics and physicians. Some of the professional middle class and the lower middle class (blue-collar workers) are served by the social security system, whose services are not equal to the private system but are an improvement over the public hospitals. The lower class, both urban and rural, is served by the public health system and by traditional curative systems. Therefore, it can be stated unequivocally at the outset that the target group for investment is the Congressionally-mandated A.I.D. target group, with little likelihood that this will change in the next generation.

### a. Ultimate Beneficiaries

#### 1) The Rural Poor

This target group has been profiled in the Agriculture Sector Assessment for Honduras. It is composed of small individual farmers, agrarian reform farmers, and landless laborers. Of the estimated 385,000 families in the rural areas, approximately 90% are in the target group. Three separate measures were used to arrive at the above determination of the percentage of rural dwellers who are poor. The first was to use a straight per-capita income measure, taking the figure of \$150 established by A.I.D. in 1969 and inflating it to 1977 dollars. The second was to establish a nutritionally-at-risk population figure; the third came from nutritional status surveys.<sup>2/</sup> A remarkable consistency is noted in all three measures, leading to the conclusion that the 90% figure merits a high degree of confidence.

The population subgroup at highest risk in the rural area are infants of less than one year of age. A 1972 survey found infant mortality was 117/1000 live births nation-wide and the rural infant mortality was 127/1000 live births, placing Honduras among the Latin American countries with the highest rate for this age group. Undernutrition and infection are the most pervasive health problems contributing to this situation, both for infants and for older children. Access to services to prevent and treat such conditions either does not exist or is severely limited.

#### 2) The Urban Poor

Approximately 60% of the urban population, or 119,000 families, are classified as poor by the nutritionally-at-risk measure. By income measurements 80% of the urban population are classified as poor. Knowledge

<sup>2/</sup> Source: Annexes K and Q of the Agriculture Sector Assessment; and the Nutrition Sector Assessment.

of this target group is not as complete because of Mission program emphasis in agriculture. Some of the variance between different measurements may be caused by data skewed toward upper income groups.

Nevertheless, recent surveys provide the following picture of this group. The principal contributing factor to existing endemic health problems is environmental sanitation conditions. Only 26% have running water (of dubious quality) in the home; 30% have acceptable indoor means of human waste disposal while at least 22% have no access to either public or private sanitary facilities, contributing to outdoor refuse problems that provide fertile ground for disease vectors and agents. Environmental sanitation problems are more acute in the urban than in the rural areas, because of population density.

The urban infant mortality rate (87/1000 live births) while significantly lower than in the rural areas, is still very high and, among poor groups, it probably approaches that of rural areas. Urban health service access is better; but the causes of disease and death, undernutrition and infection, remain the same.

### 3) Women

There is no apparent discrimination against women in the distribution of personal health services in Honduras. In the case of potable water programs women often benefit, since they are freed from their traditional task of carrying water for family consumption. In other programs such as malaria control there is obviously no discrimination. Thus, to the extent to which the project improves services in many health areas, women can be expected to receive a just share of the benefits.

#### b. Immediate Project Beneficiaries

The ultimate Project beneficiaries described above will receive benefits derived from the combined effects of the Health Planning and Health Sector Investment Projects. One proximate target of the Planning Project per-se is a group of 40-50 health sector technicians to be trained with project funds. This training, since it is geared to public health needs, can only be of use to these technicians if they continue to serve in the public sector, thus serving the interests of the target group.

The other immediate target is somewhat amorphous, as it is constituted by the health delivery systems--including personnel, procedures, practices, and all other aspects of system management. Since this is the principal entity to be acted on by this Project, the bulk of the social analysis is addressed to it.

### III. PROJECT SPECIFIC ANALYSIS

#### A. Economic Analysis

This Project does not lend itself to quantitative or econometric measurements. Data comparing various direct interventions to not exist

and would not be applicable to this Project in any case, since its direct outputs and purposes are confined to improving decision-making, planning and management capability, and professional qualifications among health sector personnel. As a consequence, it is expected that this Project will improve the efficiency of health sector resource allocations in pursuit of a preventive-oriented, village-based patient care and referral system, which is the system believed, with good and sufficient reason, to be the most cost-effective, and thus most appropriate, for Honduran conditions.

This planning process (calling for an annual expenditure equivalent to just over one-half percent of the total 1979 GOH outlay for health) is a first step toward rationalizing health sector investments to achieve stated policy goals. Analysis of sub-sectors in relation to priorities by a combination of Honduran professionals and contracted technical specialists combined with training in specific areas of health planning and public health are believed to afford the most cost-effective, and probably the only, means to achieve clearly desirable outcomes. Therefore, the project is economically sound.

## B. Social Analysis

The central questions are: (1) to what extent is it feasible to assume that management improvements can be carried out; and (2) to what extent is it reasonable to assume that benefits from improved management will flow to the ultimate target group, given the probability of increased inputs under a future project. The first requires an analysis of socio-cultural aspects of improved management methodologies within the environment of the existing health care delivery systems.<sup>3/</sup> The second requires an analysis of the existing links between users and deliverers of health care. This analysis will be more prescriptive than analytic. That is, one cannot analyze as yet undesigned management methodologies, but one can point out socio-cultural aspects of management that will be taken into account in development of said methodologies.

### 1. Management Methodologies

Efficient management systems often have certain characteristics that are not currently to be found in MOH management systems and are not highly valued in the socio-cultural milieu of the Honduran professional. These characteristics include accountability and delegation of authority and are examined below as socio-cultural phenomena as examples of factors to be considered in developing management systems. On the other hand, there

---

<sup>3/</sup> Neither the analytical studies nor the trained personnel outputs require a feasibility analysis, the one because there are sufficient experiences with analytical processes requiring GOH collaboration with technicians to warrant the conclusion that analytical studies are feasible, the other because there are no major feasibility problems with past and current training efforts for mid-and high-level professionals.

already exist certain desirable features of Honduran health management which will be considered as well.

a) Delegation of Authority

In the culture of Honduran bureaucracy, decentralization of decision-making and delegation of authority are not highly prized values. They run counter to cultural values and long-standing bureaucratic practices. Some decentralization of the MOH has been achieved by regionalizing the health delivery system. However, the limits of decision-making at the regional level are constrained by the procurement and budget procedures of the Ministry of Finance (MOF), and by the lack of administrative capacity to utilize the budgetary and decision-making authority that has been delegated.

Consider one example that might arise in this Project. One of the principal problems in rural health centers has to do with the logistical system for materials and supplies. Nurses at the health centers send in monthly requests for medicine; however, the system supplies them with inputs not on the basis of their needs but on the basis of existing central supplies. A management analysis would be faced with two choices: Attempt to streamline the existing system or replace it with one in which local health centers procure inputs directly. The analysis might conclude that it is both less efficient and more expensive to continue with a centralized supply system, and recommend that local health centers be provided authority to procure medicines directly from private suppliers at rates established in yearly government-wide bidding and published in catalogs, somewhat akin to GSA catalog and pricing procedures. This system, while perfectly acceptable in Anglo-Saxon bureaucracy, will be unacceptable in the current socio-cultural bureaucratic milieu, where central decision-making in procurement is deemed to be the only means of controlling venality at lower levels.

b) Accountability

There are no effective external accountability measures either in the Honduran public service generally, or in the health sector service particularly. There is no administrative or legal resource for clients of the public health sector. Written authorization of surgical procedures, for example, is not required. Malpractice complaints, either administrative or legal, are unheard of. This leads to widespread abuses in public health services that are common knowledge. For example, births take place from time to time in the waiting room or elevator of the Maternal-Child Hospital because of clerical delays in admitting procedures and/or inefficiency in emergency room procedures. Practitioners, (including nurses, doctors, and administrative personnel) do not generally accept the legitimacy of accountability as a value nor is there any management mechanism for enforcing accountability.

Analytical studies in this Project may demonstrate that medical attention

can be increased substantially simply by instituting accountability measures in all public health centers. Improved management methodologies may be designed around this principle as a consequence of the studies. However, the socio-cultural milieu of the bureaucracy will put up resistance to such measures. Therefore, management studies of this milieu may have to devise strategies that will maximize the possibility of acceptance of such innovations.

c) Others

As noted earlier, some features of the current health management system will enhance the feasibility of improved management methodologies to be designed. Most notably, the acceptance of para-professionals by the system is of critical benefit in making the delivery of rural health care more efficient. The system of treatment of simple ailments by local para-professionals and cost-effective referrals has been widely accepted as appropriate for the current health management system. Furthermore, it is proving acceptable in the rural socio-cultural milieu, as members of the target group have not reached the stage of some LDCs and most developed countries where titled physicians are deemed to be the only acceptable purveyors of health care.

Another feature of the health care system that bodes well for improved management efficiencies is the relative lack of fascination with sophisticated technology. Simple appropriate health technologies that might be recommended in the improved management methodologies have a greater probability of acceptance in the Honduran health care milieu where sophisticated but marginal, or dispensable, technology is not widespread. The problem one finds in US community health systems, where each local hospital invests heavily in technology that is more cost-effective on a regional basis, is not found in the Honduran health care system. A management system designed for referrals already is a positive factor in implementing improved management methodologies that recommend referrals for the sake of cost-efficiency.

2. Benefit Flows

The nature and policy orientation of the current health system as operated by the MOH guarantees that the benefits of systematic improvements will provide an incremental qualitative change in the services received by the target group.

Immediate benefits will accrue to the target group as a result of management and administrative improvements to be implemented under this project. At the outset the benefits, e.g. increased access to more efficacious medical services and appropriate medicines, may be localized if innovations are undertaken in only one region. However, after a trial period demonstrating its value the innovation may be implemented in all regions, under future projects.

The benefits will be to AID's target group and will have direct and secondary impact. The direct impact will be an improvement in individual and family health status resulting from improved and more widespread health care, which is an end in itself. Secondary benefits which will accrue to the rural and urban poor include such factors as increased income resulting from less loss of work days. This secondary benefit cannot be quantified, given the lack of current labor/health statistics and the as yet unknown quantity of Project derived benefits. Therefore, it is sufficient to point out that these benefits will occur and that they will impact on the appropriate target group.

C. Technical Analysis

1. Availability of Information

The major questions regarding this area are: (1) is there sufficient data and information to carry out the required analysis and planning; and (2) is the quality of the data and information sufficient for it to be useful.

There is no known comprehensive analysis of data and information generated in the health sector or through sources related to it. Review of studies and specific program planning documents indicate that both the quantity and quality of data varies widely. However, in most cases, it is only just adequate and usually refers only to a small section of the country, a portion of the population, or a limited topic.

The analytical efforts conducted under this Project will obtain data and information from the following sources:

- a) GOH information systems (Census, Vital Statistics, MOH Statistical Department),
- b) health sector documents (plans, budgets, proposals, evaluations, progress reports, special studies),
- c) consultant's direct observation of program operation at various levels, and
- d) accounts of program operations obtained from GOH personnel.

These sources are now uncoordinated and seriously underutilized, but their potential for providing adequate information for improved decision making is considerable.

Incomplete collection of data, poor presentation of it, incomplete and limited analysis, coupled with managers and decision makers unaccustomed to analytical decision-making procedures frequently result in failure to make appropriate use of the existing information. While it is apparent that the data base is not strong in its present condition, the current

activity of systematic collection, organization, and summary evaluation of existing documents will permit identification and description of sector constraints and solutions in a significant number of sub-systems and, at the same time, more clearly delineate the weakness of the existing data and information gaps. Clear delineation of these strengths and weaknesses will form a firm foundation for judging the cost of collecting additional data and generating better information against its potential contribution. Decisions to develop additional data will thus be postponed until the existing information has been better analyzed and used. It is anticipated that by the time future projects are funded, the use of existing information and knowledge of its quality will have progressed to the point where generation of new information will be needed.

2. Availability of Technical Assistance and Honduran Technical Counterparts.

Technical assistance will be required in the seven areas defined in the detailed description under output 1 (sanitation, communicable disease control, human resources, general management, materials, finance, and regional management.)

Additional technicians may subsequently be required for special studies. It is anticipated that one medium to long term contractor (firm or individual) will be obtained for each area. Some technicians have been identified tentatively for several of the areas. However, Spanish speaking contractors who can work within the tight project schedule are expected to be difficult to obtain. Nevertheless this is essential if follow-on projects are to be begun in FY 80.

Both the Office of Health LAC/DR and the Office of International Health (OIH/DHEW) are assisting the Mission to identify suitable candidates. Mission personnel are also making contacts through universities, the Pan American Health Organization, professional societies, and other sources. It is expected that suitable consultants can be found.

Each consultant will work with at least one Honduran technical counterpart. The combination of experienced consultants (who have a thorough knowledge of analytic methodology), with Hondurans (who have a greater knowledge of local policies, customs, and information sources in their respective areas) is required for a quality result and will allow exchange of information in their respective areas. Honduras does not have great depth in individuals who can serve as counterparts and who do not already have at least one full time position. Therefore, individuals have been identified in the Ministry, University, and other health agencies who can maintain at least part time association with the consultant while he/she is in country and can continue to work on a part time basis between consultants' visits. This association of consultants with Honduran technicians is considered to be an important means of improving Honduran analytical capabilities.

Payment of an honorarium to the Honduran technicians for work completed will be an incentive for working in the Project. Honorarium will be provided to Honduran technicians designated by the TCC and A.I.D. to produce special reports, analysis, training and/or other special products which call for services over and above their regular work for the GOH which are not covered by GOH technician salaries provided as counterpart. These payments will not be made on a time worked basis, but rather in return for a specified product.

### 3. Alternatives for Project Phasing

The majority of the analytical activity financed under this Project will be conducted during Phase I, i.e. during the first nine months. During this period, the studies will focus on decisions which need to be made in order to program additional activities in FY 80. The time frame for this activity is extremely short, and any unforeseen delay will make achievement of this aim less likely. During Phase II, or the remaining 18 months of the project, special studies will be conducted to check and extend the results of Phase I and to provide conceptual and implementational underpinnings for future health initiatives.

Factors which could interfere with the schedule include the following:

- a) delays in contracting,
- b) lack of counterpart time, and
- c) failure of contractors to develop focused and detailed recommendations.

Some delays may be inevitable, particularly in Phase I which affects future programming. However, with the advanced identification of consultants and counterparts, appropriate steps have been taken to assure meeting the schedule within reasonable limits.

Alternatives to this scheduling might be:

1. Drop any plans to initiate other activities in FY 80. While this would remove the tension of a deadline in the near future, the need to meet a deadline is expected to provide incentives to develop and implement the project rapidly so as to initiate a well-planned program of comprehensive improvement which the GOH wishes to institutionalize as soon as possible.
2. AID could carry out the entire analysis with periodic consultation with the GOH. The control of almost the entire planning project would be in AID's hands and would reduce or eliminate the delays of contractor selection, contracting, and counterpart technician contributions, but would eliminate

the vital benefits which informal training of Honduran counterparts would receive through working in collaboration with outside technicians. It would also reduce the quality of outputs and the degree to which Hondurans would be committed to change through the analytical process. These would be unacceptable losses. However the Mission must be prepared, in the project as planned, to accept somewhat more than half of the responsibility for implementation.

#### 4. Alternative Sources of Training

A variety of training sources will be used to accommodate project-related needs and availability of personnel for training. Constraints with regard to availabilities have led to selection of predominately short term methods including international conferences, observational visits, seminars in Honduras and short term academic training. Training in project related disciplines is widely available from a variety of sources.

The cost per student month for these training alternatives has been estimated as follows:

- 1) \$3,200/mo for International Conferences (including travel)
- 2) \$2,500/mo for Short Term Academic Training
- 3) \$2,000/mo for Observational Visits (including travel)
- 4) \$1,200/mo for Long Term Academic Training
- 5) \$1,000/mo for In-country Seminars

Where it is determined that approximately the same benefit would accrue from two different training alternatives the cheaper method will be selected.

#### 5. Alternatives to Focusing on Regional Management

Management within the health sector (in particular the MOH), ideally occurs at three levels:

- a) Central (norm setting) level
- b) Regional (Management/Coordination) level, and
- c) Delivery (Facility/Work Team) level.

While all levels of management are important and will be given attention under this Project, the regional level is especially important because regional level management combines a high degree of coordinating

responsibility with a practical operational focus. The regions interpret policy direction and norms of the central level and implement practical services at the local level. The management staff at this level has recently been expanded, and there is significant potential to improve efficiency by effectively orienting this expanded management capability. Therefore, the Project will develop and test specific methodologies for use at the regional level.

A possible alternative to improvement of all management functions at a single region (pilot project) is to improve a single management area i.e. logistics or supply for the entire country. While this is a viable alternative, the regional management functions are very interdependent and to work only in one area ignores the relationships and influences of the other areas.

The possibility of focusing on central level management improvements seem ill advised since (1) the central level has few direct linkages to the target group; and (2) PAHO advisors are already assisting in many important areas at the central level. Nevertheless, because of its policy making, normative and support functions the central level may necessarily be the subject of analysis and action in specified management areas.

#### 6. Alternatives to Focusing on Planning and Decision-Making

This project will focus on planning and decision-making within the health sector by developing action recommendations for key decisions of policy and implementation through orderly analytical processes. This will require consultants, counterparts, and project coordinators to consider carefully which decisions or alternatives are important and to assign priorities among them.

An alternative to this focus on planning and decision-making would be to accept management practices and programs as they now exist and to program funds for expansion of the same. This would not require analysis of program constraints but only a description of problems and programs to determine how much to expand them. Such a product is easier to produce, but is clearly less useful. It would be a more valid approach where analytical capabilities and decision-making mechanisms are fully developed. In Honduras the official health sector policy is acceptable but it is by no means certain that decisions and resource allocations conform to policy. A descriptive assessment would by-pass these implementational or managerial concerns and the programs designed by such means would tend to perpetuate fundamental inefficiencies, thereby frustrating attainment of policy objectives in the long run.

It should be emphasized that this Project seeks to establish, through analysis, the institutionalization of orderly resource allocation and decision-making in conformity with established policy objectives, not only as a basis for the integrity of future project investments in the health sector but also as a means of assuring rational allocation of Honduran

health resources in general. To the extent that these objectives are appropriate, each successive level of analysis should be less descriptive and more prescriptive, with less foreign, and more domestic influence.

D. Administrative Analysis

1. General Administration

Implementation of this Project depends primarily on the cooperation and interaction of two GOH units, the Planning Office of the MOH and the Health Sector Planning Unit of CONSUPLANE, the central planning agency. The occasional participation of specific personnel of PANI, SANAA, and IHSS along with individuals from other entities such as Division Chiefs and Heads of Regional Offices of the MOH, will also be necessary.

The principal management unit will be a Technical Coordinating Committee (TCC) chaired by the MOH Chief of Planning (who is also Project Coordinator) and will include a Health Sector Official from CONSUPLANE, the Assistant Coordinator, the Administrative Assistant, and an AID Representative as permanent members of the committee. The functions of the TCC will be to:

- 1) establish modes of communication and direction in support of the Project;
- 2) identify the sources of technical assistance needed;
- 3) direct a contractor under a Basic Ordering Agreement to secure services for contracts of under one year's duration;
- 4) identify and arrange for Honduran counterparts to participate in the studies;
- 5) approve and assure submission to the USAID for reimbursement, claims from contractors and host-country counterparts;
- 6) review the findings and recommendations of the studies produced;
- 7) transmit findings and recommendations to management for decision and action;
- 8) direct the design of detailed analyses, and identify training needs and management innovations for immediate application in the field, and
- 9) select host-country personnel for training.

The Project Coordinator will oversee the operation of the project on a week-to-week basis, devoting approximately 20% of his/her time to this task. The Coordinator will 1) chair meetings of the TCC, 2) review scopes of work, findings, and recommendations, 3) serve as a liaison between the TCC and the entire MOH, and 4) supervise the work of the

assistant coordinator, administrative assistant, and consultants or assure that this task is appropriately delegated and carried out. In the absence of the coordinator from Tegucigalpa for over 3 consecutive work-days, the assistant coordinator (or other person designated in writing by the DGS) will take over tasks 1) and 2); and the Director General of Health (or his designee) tasks 3) and 4).

The CONSUPLANE Representative will establish modes of communication in support of the project between the TCC and health sector agencies outside of the MOH. This will require approximately 15% of his/her time. The CONSUPLANE representative will: 1) participate in meetings of the TCC; 2) arrange for counterparts as appropriate (outside the MOH); 3) review scopes of work, findings, and recommendations; 4) assure that GOH health sector personnel outside the MOH are considered for training; and 5) transmit findings and recommendations to management outside the MOH for decision and action. The CONSUPLANE representative will name a substitute representative in case of absence from Tegucigalpa.

The full time Project Assistant Coordinator will manage operations of the project on a day-to-day basis, and as such will serve as the executive officer of the project. The Assistant Coordinator will: 1) call meetings of the TCC as necessary; 2) establish the agenda in consultation with the members; 3) keep the TCC informed of project expenditures, reservations of funds, current management activities, problems, and project results; 4) monitor and coordinate the activities of consultants and counterparts; 5) assure that adequate logistical support is provided and manage commodity procurement; 6) review scopes of work, findings, and recommendations; 7) prepare quarterly and comprehensive report reviews; and 8) assist both the coordinator and CONSUPLANE representative with their tasks as requested.

The full time Administrative Assistant will work under the Assistant Coordinator, and will manage project resources and logistical support (such as supplies and equipment, office space, secretarial support, and in-country transportation and per diem). In particular, the Administrative Assistant will assure that implementation documents and contracts are processed on a timely basis and that they fulfill both GOH and A.I.D. technical standards and legal requirements. The Administrative Assistant will also accept technical functions of the Assistant Coordinator which may be delegated and will review findings and recommendations.

The principal management burdens of the TCC for the above functions will be carried by the Assistant Coordinator and Administrative Assistant contracted from Project funds for those specific purposes and to serve as liaison with AID to identify and resolve implementation problems as they arise.

A critical task of the TCC will be that of communicating with policy makers, informing them of progress and referring policy matters upward for discussion and resolution when disputes or questions arise. This will mean arranging for periodic presentations of findings and recommendations to the Minister, Vice-Minister, Director General and Sub-Director General of Health and comparable levels in CONSUPLANE and other

sector agencies coincident with the completion of individual analytical efforts. This has been identified by the MOH as the most appropriate means of keeping decision makers informed of progress, findings and recommendations under the Project and is incorporated specifically into the Project design.

The Director General of Health, as the immediate supervisor of the Chief of the Planning Office, has taken a direct interest in this planning effort and will provide the link to the Ministerial level of the MOH. Day-to-day communications with the policy levels of CONSUPLANE will be through its Chief of Health Planning.

Given CONSUPLANE's continued strong backing of this Project and the interest at MOH's policy level, it is believed that the established communications linkages will ensure effective Project implementation particularly with respect to policy decisions. The USAID staff is, of course, available to facilitate matters in this regard.

The permanent A.I.D. Mission staff includes a qualified public health physician and an experienced health planner who will devote nearly full time to assist the TCC to implement the Project, particularly in securing appropriately qualified technical assistance in the basic areas of study heretofore identified, as well as in facilitating training activities both in and out of country. Based on the findings and recommendations of short-term technical advisors and Honduran counterparts, this team, along with the Mission's public health nurse and nutrition advisor will, at the end of phase one, formulate the Mission's Health Sector Assessment for discussion with Honduran health professionals and decision-makers and presentation to A.I.D./W.

The GOH is in the final stages of approval of its 1979-83 Five Year Plan, the formulation of which delayed this Project by approximately one year because of the heavy institutional resources it commanded. Enthusiasm for yet another planning exercise is based on the likelihood that it will lead to bankable programs for the future. This aspect of the Project is most appealing to the GOH and the decision has been made at the MOH and CONSUPLANE to support this Project effort.

A critical element leading to successful completion is the addition of the Assistant Coordinator and Administrative Assistant to the Technical Coordinating Committee. Without them it is doubtful that the planning units of the MOH (one professional and five generalists) and the CONSUPLANE health planners (4 economists) would have the time to support the Project.

## 2. Contracting and Procurement Arrangements

### a. Contracting of Technical Assistance

Scopes of work will be developed by the TCC with Mission assistance and concurrence. Mission personnel will help the TCC to identify sources

of technical assistance, and determine availabilities. Candidates will be selected using commonly accepted practices. Contracts and contractors will be approved in writing by the Mission.

Contracts for the Assistant Coordinator, the Administrative Assistant, a secretary and all long-term technical assistance of over one year will be executed by A.I.D. directly.

For desired technical assistance that is available through RSSA and/or AID Indefinite Quantity Contracts (IQC's), the Mission will issue PIO/Ts and AID/W will, in most cases, be requested to act as the authorized agent.

Candidates for positions of less than one year will be contracted by a local firm specialized in acquiring and administering these services. A Basic Ordering Agreement will be used since the MOH does not have the administrative capacity and experience with A.I.D. regulations to allow it to contract directly on a continuing basis in the short time available. A Basic Ordering Agreement between the MOH or the USAID and a local firm or firms is expected to provide this service. The TCC with Mission assistance and written concurrence will negotiate a Basic Ordering Agreement with a local firm, spelling out any special instructions on items such as tax exemption, source and origin, and AID reimbursement procedures. The TCC will issue task orders specifying the name of the consultant to be contracted, the scope of work, salary recommendation and any other particulars. These task orders will be reviewed by the MOH and A.I.D., before execution. The local firm will execute the task orders and serve as the financial agent for these consultants.

The TCC will monitor compliance with signed contracts, and the Mission will act as financial agent for services not covered under the basic ordering agreement.

b. Procurement of Commodities

Goods identified as necessary for Project support to be procured with A.I.D. funds will be procured by the Mission directly based on requests from the MOH. PIO/C's will be issued under the signatures of the MOH and AID Representatives, with detailed equipment lists, specifications, and estimated prices, and will be executed by the Mission.

c. Training

The TCC will identify and recommend to the Secretariat the candidates for training and the Secretariat will notify AID in writing of the names of those selected. On the basis of such requests (including written approval from the trainee's agency, if other than the MOH) A.I.D. will issue PIO/Ps for participant training and Invitational Travel Orders for those attending conferences and making special observational visits.

### 3. MOH Training in A.I.D. Procurement and Contracting Procedures

In order to prepare the MOH for an expanded role in the administration of possible future projects, participation in an A.I.D. contracting course is planned for certain of its staff during the first phase of the Project. In addition, the Mission Management Office will provide assistance to the MOH's Administration Office on A.I.D. contracting and procurement procedures.

### 4. Determination of Feasibility

Given the limited scope of this Project, the plan for additional support personnel for the GOH, the anticipated special contracting arrangement, and the fact that the Mission is adequately staffed to manage this Project, it is considered administratively feasible.

### E. Population Concerns (104d)

The ultimate goal of this Project is to contribute to the improvement of health of the Honduran people through more effective use of resources. Basic to this effort is a knowledge of the country's demographic characteristics. Through non-project sources this information will be collected and made available for the use of the individuals who are engaged in various project planning activities. The technicians will be requested to develop their analyses and recommendations within the framework of the various demographic factors. This will increase their appreciation of how high fertility in Honduras will influence the health sector as well as other sectors. It is expected that their conclusions will reflect this influence in the analytical documents and have the potential of influencing programmatic and funding decisions.

The Planning Project will deal directly with factors which influence child mortality, communicable disease control, water, and rural sanitation programs. It is anticipated that better planning in these areas will allow greater coverage with decreased child mortality. There is evidence that decreased child mortality contributes significantly to fertility reduction by reassuring parents of the survival of offspring.

This Project will not have any direct effect on fertility as it is not a service project. Indirectly it will address the issue through generally improving project planning, training, management, logistics, supervision, reporting and decision making. These are important elements in family planning programs and improvements in these areas should be reflected in improved family planning program service delivery. In as much as the Government of Honduras has a policy of integrating health, nutrition and family planning in the Ministry of Health, no attempt will be made to single out family planning programs for special attention within the Planning Project.

### F. Environmental Considerations

The proposed Project is not an action which will have a significant

effect on the human environment and therefore the USAID/Honduras has recommended a negative determination with which AA/LAC has concurred.<sup>1/</sup>

G. Impact on the Status and Participation of Women

Women's participation in decision-making in the Honduran health sector is minimal at present. Women participate primarily in nursing and clerical roles. In these roles they have little status and do not readily climb what slim career ladder does exist. Positions of authority within the MOH are held almost exclusively by physicians, and most physicians in Honduras are male. There are only five women in health sector decision-making positions within the MOH and CONSUPLANE outside of the nursing area.

For this Project it is expected that one member of the TCC, at least one of the principal counterparts and possibly some of the trainees and/or consultants will be female. It is beyond the capability of this Project, however, to substantially alter the role and participation of women in the health sector. Nevertheless the Project will study possible solutions for increasing meaningful female participation in all levels of the sector. The scope of work for each analytical study to be conducted under the Project contains a component for analyzing the potential for women's participation and recommending actions to increase their status and involvement.

Over the long term, the Project holds significant potential for improving the status of women, as the auxiliary nurses and midwives, who are almost exclusively women, adapt to their role as the cornerstone of the MOH extension of coverage strategy. To the extent that this Project encourages better training and better logistical support for these paraprofessionals, in carrying out their tasks, the Project will contribute to increasing their potential for leadership and service, and to increasing status and participation of women in the national economy.

IV. FINANCIAL PLAN AND ANALYSIS

A. Project Financial Requirements and Timing of Expenditures

It is expected that A.I.D. Grant and GOH counterpart financing will be allocated to this Project and will be expended approximately as summarized in Tables 4 through 6.

It has been determined, on the basis of GOH and A.I.D. estimates, previous experience, and the implementation plan, that twenty-six months is a reasonable period in which to implement a project of this complexity and magnitude. The Project is to be executed from approximately August of FY 1979 to September of FY 1981.

---

<sup>1/</sup> See Annex F for IEE

B. Financial Impact of the Project on the MOH

1. The Fiscal Capability of the GOH/MOH to Bear the Cost of the Project

The projected total MOH counterpart contribution of approximately \$212,000 is primarily in the form of budget for existing MOH personnel, who will be contributing their time to the Project, and operational costs as well as some supplies, materials, and equipment. Counterpart requirements are not considered excessive in view of the fact that no new hiring is envisioned and the \$25,000 in new costs due to the Project are minimal.

The size of the current MOH budget and its steady growth in time series comparison with the GOH budget are illustrated in Table 3 below.

TABLE 3. GOH/MOH BUDGET ANALYSIS  
(Lempira Millions)

<u>YEAR</u>	<u>GOH BUDGET</u>	<u>MOH BUDGET</u>	<u>TRANSFERS TO SANAA</u>	<u>MOH BUDGET NET OF TRANSFER</u>	<u>NET MOH BUDGET AS % OF TOTAL GOH BUDGET</u>
1974	329.2	28.1	2.9	25.2	7.6
1975	394.8	49.6	16.9	32.7	8.3
1976	516.0	52.2	8.9	43.3	8.4
1977	625.8	67.4	12.7	54.7	8.7
1978	832.0	84.5	22.4	62.1	7.5 <sup>a/</sup>
1979	1004.4	109.5	22.3	87.2	8.8

SOURCE: Ministry of Finance, Presupuesto por Programas

Given the current rate of growth in the MOH budget, it appears reasonable to conclude that the MOH will have the resources necessary to provide the personnel and operations support as well as the \$25,000 in new costs during the life of the Project.

2. Fiscal Capability of the GOH/MOH to Bear the Recurrent Costs of this Project

No recurrent costs are anticipated as a result of the Project. On the contrary, the purpose of the Project is to make current MOH efforts in the health sector more efficient and effective. Consequently, the MOH should achieve greater results per unit of expenditure at the end of the Project than at present.

<sup>a/</sup> Decline is due to extraordinarily large transfer to SANAA in this year for the Aqueduct Construction Project being carried out with IDB assistance.

TABLE 4: SUMMARY COST ESTIMATE AND FINANCIAL PLAN  
( US \$ 000 )

Source	A.I.D.		Host Country		TOTALS
	FX	LC	FX	LC	
Administration	21	40	0	35	96
Analyses	180	20	0	66	266
Training	100	20	0	46	166
Mgmt. Methodologies	55	39	0	65	159
TOTALS	356	119	0	212	687

TABLE 5: COSTING OF PROJECT OUTPUTS/INPUTS  
( US \$ 000 )

   x New  
   Rev #   

Project No. 522-0148 Title Health Sector Planning

Project Inputs	Project Outputs			TOTAL
	# 1	# 2	# 3	
A.I.D. Appropriated	(229)	(138)	(108)	(475)
TA	195	20	47	262
Participants	0	50	0	50
Commodities	10	11	20	41
"Other Costs"	24	57	41	122
Host Country	( 79)	( 55)	( 78)	(212)
TA	65.5	4	30.5	100
Participants	0	26	0	26
Commodities	11	7	9	27
"Other Costs"	2.5	18	38.5	59
Total	308	193	186	687

No. 1 Studies and Analyses (See Annex A Table 2.1)

No. 2 Training (See Annex A Table 2.2)

No. 3 Management Methodologies (See Annex A Table 2.3)

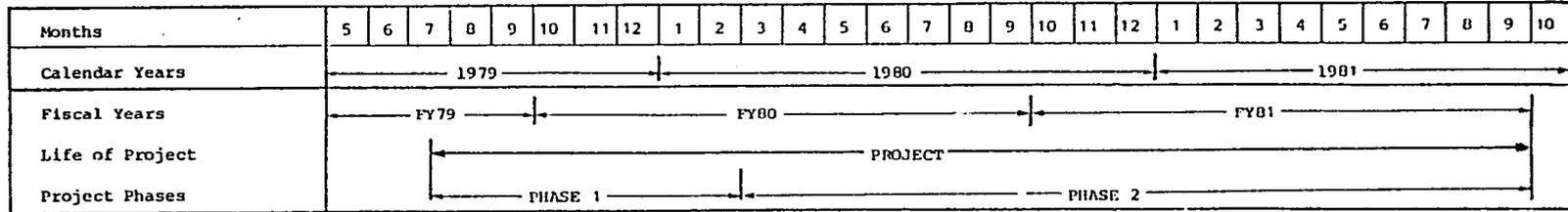
TABLE 6: PROJECTION OF EXPENDITURES BY FISCAL YEAR  
( US \$ 000 )

Fiscal Year	A.I.D.	Host Country	Total
1979	9	4	13
1980	289	123	412
1981	177	85	262
Total	475	212	687

V IMPLEMENTATION PLAN

EXHIBIT 1.1: Administrative Activity Schedule

BASIC PROJECT TIME SCALES



Administrative Activities

Months	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10
Project Paper approved <u>1/</u>		X																												
Project Agreement approved <u>3/</u>		X																												
PIO/Is approved <u>3/</u>		X																												
Basic Ordering Agreement <u>3,5/</u>			X																											
Assistant Coordinator <u>4,5/</u>			X																											
Administrative Assistant <u>4,5/</u>				X																										
Final Project Report <u>3/</u>					X																									
Consultants contracted <u>4/</u>			X																											
Purchasing of commodities <u>1/</u>			X															X												
Health Sector I																														
Project Paper <u>1/</u>									X				X																	
Project Agreement <u>3/</u>										X		X		X																

1. AID
2. GOB
3. AID/GOB
4. AID/GOB/Ordering Agreement
5. Refers to period of agreement, or contract.

V IMPLEMENTATION PLAN

EXHIBIT 1.2 : Analytical Activity Schedule

BASIC PROJECT TIME SCALES

Months	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10
Calendar Years	1979												1980												1981					
Fiscal Years	FY79						FY80												FY81											
Life of Project	PROJECT																													
Project Phases	PHASE 1												PHASE 2																	

Analytical Activities

Months	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	
Consultant's work periods																															
Sanitation <u>1/</u> Communicable Disease																															
Human Resources Management																															
Materials																															
Finance																															
Reports:																															
Sub-sector <u>3/</u> studies																															
Outlines																															
First Draft																															
Final																															
Summary <u>4/</u> Assessment																															
Outline																															
First Draft																															
Final																															
Special <u>3,5/</u> Studies																															

1. 12 PM financed outside project.
2. See related work in Exhibit 1.4
3. Consultants responsible with counterpart.
4. AID/GOH responsible.
5. Numbers refer to number of studies completed.



V IMPLEMENTATION PLAN

EXHIBIT 1.4 : Management Methodologies Activity Schedule

BASIC PROJECT TIME SCALES

Months	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10
Calendar Years	1979												1980												1981					
Fiscal Years	FY79						FY80												FY81											
Life of Project	PROJECT																													
Project Phases	PHASE 1												PHASE 2																	

Management Methodology Activities

Months	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	
Technical Assistance																															
Activity Phases																															
Design																															
Testing																															
Use of Honduran Manager in design and testing																															
Use of Honorarium for counterparts																															
Reports <sup>1/</sup>																															
Design																															
Test Summary																															

<sup>1/</sup> Technical Assistants and counterparts responsible

V IMPLEMENTATION PLAN

EXHIBIT 1.5 : Review and Evaluation Activity Schedule

BASIC PROJECT TIME SCALES

Months	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10
Calendar Years	1979										1980										1981									
Fiscal Years	FY79					FY80										FY81														
Life of Project	PROJECT																													
Project Phases	PHASE 1															PHASE 2														

Review and Evaluation Activities

Months	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	
Reviews																															
Quarterly <sup>1/</sup>					X	X			X	X				X	X			X	X			X	X			X	X			X	X
Comprehensive <sup>1/</sup>											X	X									X	X									
Evaluation <sup>2/</sup>																													X	X	

<sup>1/</sup> Technical Coordinator responsible

<sup>2/</sup> AID responsihte

## VI. REVIEW AND EVALUATION PLAN

Project reviews will be conducted by the TCC and other A.I.D. Mission personnel as appropriate. Quarterly reviews will provide periodic appraisals (during implementation) of Project achievements and processes. The project staff will use this information to adjust project management and improve performance.

The budget for coordination and support includes staff time for Project reviews and evaluation. As no external assistance is contemplated, no specific budget is included.

The reviews will systematically consider progress toward attainment of outputs, purpose and goals and attempt to identify the factors in the project processes which are potentially or actually affecting progress toward reaching desired outcomes.

Each of the studies produced by the Project is being designed to identify action recommendations, a preferred implementation plan and alternatives for consideration by the decision makers. The reviews will pay special attention to assessing the quality and practicality of these elements and assessing the extent to which they support health sector policy and rationalize resource allocations.

Documents on existing health sector policy and resource allocation are now being collected and arranged through a document collection activity funded in PRO AG 522-10-78, as a source of baseline data. Further data on the general population, health service beneficiaries and sector financial allocation will be developed early in the project by consultant and counterparts. This information will be used by the technical coordination committee and A.I.D. to assist in evaluating recommendations of the various subsector analyses and to strengthen or adjust them as is required.

At the quarterly review meetings training requirements and candidate selection procedures will be reviewed and modified as necessary to achieve Project outputs and purposes. All training activities will be reviewed to assure that training is geared to areas vital to attainment of project purposes.

Reviews will be prepared during the last 22 days of each quarter. The project coordinator will be responsible for assuring that evaluation is carefully discussed and for preparing written evaluation reports. The 4th and 8th reports will be comprehensive reviews of the entire life of the project up to that time.

After the end of the project, a project evaluation will be prepared by the A.I.D. Project monitor.

VII. CONDITIONS, COVENANTS, AND NEGOTIATION STATUS

A. Negotiating Status

The Project has been developed jointly with the Chief of the MOH Planning Office and has been discussed in detail with the Ministry of Public Health and in more general terms with CONSUPLANE.

The MOH Planning Office was instrumental in identifying the focus of the Project, the types and amounts of technical assistance and training required to institutionalize the activities of the Project. Accordingly no difficulty is anticipated in signing the Project Agreement before the end of FY 1979.

B. Covenants and Conditions

There are no special Conditions Precedent or Covenants for this Project.

C. Third Country Technical Assistance and Waivers

This Project anticipates use of U.S. National, Central American and third country national contract consultants selected on an individual basis to address the specific needs of the Project. The TCC, with USAID participation, will prepare the scopes of work and both will be directly involved in identifying and selecting the firms or individual technicians. Selections and contracts will be approved in writing by USAID/H.

The current contracting authorization delegated to the Honduras Mission Director is for personal services contracts of up to \$100,000. There are no nationality restrictions provided such contractors are free world nationals.<sup>1/</sup>

---

1/ Reftel State 121267 Dated May 28, 1978 subject Third Country National Contracting.

TABLE

Illustrative Budget for  
 Administrative Activity

AID CONTRIBUTION	\$ 000s				TOTALS
	TA	Parti- cips	Com- modi- ties	Other Costs	
1. Assistant Coordinator 18 PM ea. \$1000	18				
2. Administrative Assistant 18 PM ea. \$ 750	14				
3. Secretary 18 PM ea. \$ 300				5.4	
4. Translation 520pp. ea. \$5				2.6	
5. Office Equipment			11		
6. Vehicle			10		
AID TOTALS:	32	0	21	8	61

GOH Contribution

1. Supplies			3		
2. Vehicle maintenance, parts, fuel			5		
3. Office and classroom space			5		
4. Technical Coordinators' salaries	15				
5. Chauffer (Salary)				2.4	
6. Secretarial (Salaries)				4.6	
GOH TOTALS:	15	0	13	7	35

GRAND TOTALS:

47	0	34	15	96
----	---	----	----	----

TABLE 2.1  
 Illustrative Budget for  
 Analytical Activity

AID CONTRIBUTION	\$ 000s				TOTALS
	TA	Parti- cipants	Com- modi- ties	Other Costs	
Non-administrative cost items:					
1. 1 person x 1 year x \$45,000 (in environmental sanitation)	45				
2. 1 person x 5 mo. x \$2,000 (in communicable disease control)	10				
3. 5 persons x 5 mo. x \$5000 (in other areas)	125				
4. Honorarium for counterparts				20	
Non-administrative cost sub-totals:	180	0	0	20	200
Administrative costs (from table 1):	15	0	10	4	29
<b>AID TOTALS:</b>	<b>195</b>	<b>0</b>	<b>10</b>	<b>24</b>	<b>229</b>

GOH CONTRIBUTION

Non-administrative cost items:					
1. Documents			3		
2. Supplies			3		
3. Counterpart Salaries	60				
Non-administrative cost sub-totals:	60	0	6	0	66
Administrative costs (from table 1):	5.5	0	5	2.5	13
<b>GOH TOTALS:</b>	<b>65.5</b>	<b>0</b>	<b>11</b>	<b>2.5</b>	<b>79</b>

GRAND TOTALS:

260.5	0	21	26.5	308
-------	---	----	------	-----

TABLE 2.2  
Illustrative Budget for  
Training Activity

AID CONTRIBUTION	\$ 000s				TOTALS
	TA	Parti- cipants	Com- modi- ties	Other Costs	
Non-administrative cost items:					
1. Conferences 25 PW ea. \$800				20	
2. Observation 10 PW ea. \$2000				20	
3. In-country 30 PM ea \$1000	10		5	15*	
4. Short Academic 8 PM ea. \$2500		20			
5. Long Academic 2 PY ea. \$15000		30			
Non-administrative cost sub-totals:	10	50	5	55	120
Administrative costs (from table 1):	10	0	6	2	18
AID TOTALS:	20	50	11	57	138

GOH CONTRIBUTION					
Non-administrative cost items:					
1. Trainee salaries		24		15	
2. Supplies and Equipment			4		
3. Transportation		2			
Non-administrative cost sub-totals:	0	26	4	16	46
Administrative costs (from table 1):	4	0	3	2	9
GOH TOTALS:	4	26	7	18	55

GRAND TOTALS:	24	76	18	75	193
---------------	----	----	----	----	-----

TABLE 2.3  
 Illustrative Budget for

Management Methodology Activity

	\$ 000s				TOTALS
	TA	Parti- cants	Com- modi- ties	Other Costs	
<b>AID CONTRIBUTION</b>					
Non-administrative cost items:					
1. Advisor 1 PY ea. \$40,000	40				
2. Honorarium				10	
3. Equipment and Supplies			15		
4. Per Diem				15	
5. Salary (Manager)				14	
Non-administrative cost sub-totals:	40	0	15	39	94
Administrative costs (from table 1):	7	0	5	2	14
<b>AID TOTALS:</b>	<b>47</b>	<b>0</b>	<b>20</b>	<b>41</b>	<b>108</b>

**GOH CONTRIBUTION**

Non-administrative cost items:					
1. Central level advisors' salaries	25				
2. Regional level salaries				25	
3. Transportation				4	
4. Per Diem				7	
5. Supplies and Equipment			4		
Non-administrative cost sub-totals:	25	0	4	36	65
Administrative costs (from table 1):	5.5	0	5	2.5	13
<b>GOH TOTALS:</b>	<b>30.5</b>	<b>0</b>	<b>9</b>	<b>38.5</b>	<b>78</b>

**GRAND TOTALS:**

77.5	0	29	79.5	186
------	---	----	------	-----

TABLE 3:

ILLUSTRATIVE ALLOCATION OF TRAINEES

	Epidemiology	Environmental Sanitation	Health Planning	Administra- tion	Human Resources	Health Education	Total
<u>A. Invitational Travel</u>							
1. International Conferences person/weeks	5	5	6	3	3	2	24
2. Observational Visits person/months	3	3	-	1	2	1	10
<u>B. Per Diem</u>							
1. In-country Seminars person/months	-	-	-	30	-	-	30
<u>Participant</u>							
A. Short term 4 months	1	1	-	-	-	-	2
B. Long term 12 months	-	-	1	1	-	-	2

Detailed Commodities List <sup>1/</sup>

2 electric typewriters		
1 IBM selectric self-correcting or equivalent	\$	900
1 micro-line feed, long carriage		1,100
1 Fotocopier		5,300
3 Office desks ea. \$500		1,500
5 Electric calculators ea. \$300		1,500
4 Filing cabinets ea. \$175		700
1 vehicle (four wheel drive Wagoneer or equivalent)		\$10,000
		<u>\$21,000</u>

---

<sup>1/</sup> Excludes \$15,000 in commodities to be identified later in the Project for the Management Methodology Activity, and \$5,000 for materials for the Training Activity.



CLASSIFICATION

## -----(B) HEALTH SECTOR PROGRAMS:

(1) THE HEALTH SECTOR PLANNING PROJECT PID WAS APPROVED AND IT WAS ALSO ADVANCED TO FY 1978. A PP SHOULD BE SUBMITTED IN THE FIRST QUARTER OF FY 78 FOR THE ENTIRE PLANNING EFFORT, I. E., FOR BOTH THE PLANNED TECH. SUPPORT FUNDED PROJECT DEVELOPMENT ACTIVITIES AND THE HEALTH SECTOR PLANNING ACTIVITIES PROPOSED IN THE PID; SUGGEST YOU INCLUDE FAMILY PLANNING COMPONENT IN SECTOR ASSESSMENT.

(2) A DOLS 15 MILLION HEALTH SECTOR LOAN PROJECT WAS BUDGETED FOR FY 1979, ALONG WITH A COMPANION GRANT OF DOLS 539 THOUSAND. THE MISSION SHOULD SUBMIT A PID FOR THE FY 1979 LOAN/GRANT PROJECT AS SOON AS POSSIBLE. AN INTERIM REPORT WILL PROBABLY BE NEEDED. THE NEED FOR AND CONTENT OF THE REPORT WILL BE DETERMINED FOLLOWING RECEIPT OF THE PID FOR FY 1979 LOAN/GRANT PROGRAM.

-----(C) CPY'S TO BE SELECTED HAVE BEEN INCLUDED IN THE BUDGET REQUEST AND WILL REQUIRE PID EQUIVALENTS.

4. PLEASE ADVISE YOUR PROPOSED SCHEDULE FOR SUBMISSION OF SECTOR ASSESSMENTS, INTERIM REPORTS, AND DAP. CHRISTOPHER  
BT  
#3319

BEST AVAILABLE COPY

ANNEX C  
Logical Framework

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

(INSTRUCTION: THIS IS AN OPTIONAL FORM WHICH CAN BE USED AS AN AID TO ORGANIZING DATA FOR THE PAR REPORT. IT NEED NOT BE RETAINED OR SUBMITTED.)

Life of Project:  
From FY 79 to FY 81  
Total U. S. Funding \$475,000  
Date Prepared: May 7, 1979  
Prepared by HRD- PAGE 1

Project Title & Number: HEALTH SECTOR PLANNING 0148

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p><u>Sector Goal:</u> Improve the health of the Honduran people.</p> <p><u>Project Goal:</u> More effective and efficient use of health sector resources.</p>	<p>Measures of Goal Achievement:</p> <p>Reduced general morbidity and mortality and infant mortality, increased life expectancy at birth.</p> <p>GOH will improve cost-effectiveness of basic service units.</p>	<p>Vital Statistics and Census data over the next 10-20 years.</p> <p>GOH health sector cost information systems, and joint GOH/AID evaluations.</p>	<p>Assumptions for achieving goal targets:</p> <p>Sustained Development in other productive and social sectors for 10-20 years.</p>
<p><u>Project Purpose:</u></p> <p>Improve decision-making at all levels in planning and implementing health sector resource allocations for both the short and long term.</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <p>Sector management acting on basis of analytical results in budgeting, planning and programming.</p> <p>Intervention selected and designed for possible future health investments, and designs integrated into sector plans and budgets.</p> <p>Key management methodology implemented in at least one region.</p> <p>Personnel trained in key decision-making and/or implementation positions.</p>	<p>GOH planning documents, progress reports, and joint GOH/AID evaluations.</p> <p>Same as above.</p> <p>Same as above.</p> <p>Project progress reports.</p>	<p>Assumptions for achieving purpose:</p> <p>GOH will continue to give priority to policy development and improvement of program efficiency and efficacy.</p> <p>GOH will motivate staff to conform to new procedures.</p> <p>GOH laws and regulations will permit implementation of recommendations or can be changed to do so.</p> <p>Trainees return to work in government health sector.</p>

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Outputs:</p> <p>A. Analytical Studies.</p> <p>B. Trained personnel.</p> <p>C. Improved management methodologies designed, developed, and tested.</p>	<p>Magnitude of Outputs:</p> <p>A. Seven sub-sector analyses, one summary assessment document, and 7-14 special studies recommending practical and economical solutions to identified sector constraints.</p> <p>B. Training provided to 40-50 GOH health sector management/technical personnel, and to 4-5 trainers in epidemiology and communicable disease control, sanitation, human resources development, planning, administration, and health education.</p> <p>C. 1-2 reports describing the design and results of improvements.</p>	<p>The reports themselves</p> <p>GOH reports and project records.</p> <p>The reports themselves.</p>	<p>Assumptions for achieving outputs:</p> <p>Needed information is available and/or can be obtained.</p> <p>Practical and economical solutions can be developed.</p> <p>Trainees can be found who are capable of benefitting from training and who can take time from their job for training.</p> <p>Well defined areas can be agreed upon, and GOH will give priority to this activity.</p>
<p>Inputs:</p> <p>AID Inputs</p> <p>Technical Assistance</p> <p>Participant Training</p> <p>Commodities</p> <p>Other Costs</p> <p>GOH Inputs</p> <p>Technical Assistance</p> <p>Participant Training</p> <p>Commodities</p> <p>Other Costs</p>	<p>Implementation Target (Type and Quantity)</p> <p>\$ 262,000 for 92 PM</p> <p>\$ 50,000 for 32 PM</p> <p>\$ 41,000 for office equipment, vehicles, books, training materials, and supplies and equipment.</p> <p>\$ 122,000 for secretarial support, invitational travel, per diem for host country personnel, honorarium, salary for Honduran counterparts, and translation services.</p> <p>\$ 100,000 for counterpart salaries,</p> <p>\$ 26,000 for participants' salaries.</p> <p>\$ 27,000 for supplies, vehicle maintenance, books, and documents.</p> <p>\$ 59,000 for secretaries', chauffeurs', regional and delivery level personnel's, and invitational travelers' salaries, per diem; in-country transportation, and project offices.</p>	<p>Project progress reports.</p> <p>Project progress reports.</p> <p>Project progress reports.</p> <p>Project progress reports.</p> <p>Project progress reports</p> <p>Project progress reports</p> <p>Project progress reports</p> <p>Project progress reports</p>	<p>Assumptions for providing inputs:</p> <p>AID can supply quality and quantity of resources needed on a timely basis.</p> <p>GOH personnel will have time and skills needed to participate.</p>

COUNTRY CHECKLIST

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. 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 a consistent pattern of gross violations of internationally recognized human rights?
  1. The Project Paper demonstrates that the assistance will benefit the needy.
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?
  2. No such determination has been made.
3. 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?
  3. The Secretary of State has determined that Honduras is not controlled by the international Communist movement
4. FAA Sec. 620(c). If assistance is to a 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?
  4. A.I.D. knows of no such cases.
5. 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?
  - 5
6. FAA Sec. 620(a), 620(f); FY 79 App. Act Sec. 103, 114 and 606. Is recipient country a Communist country? Will assistance be provided to the Socialist Republic of Vietnam, Cambodia, Laos, Cuba, Uganda, Mozambique, or Angola?
  6. Honduras is not a Communist country. Assistance will not be provided to any of the countries indicated.
7. FAA Sec. 620(i). Is recipient country in any way involved in (a) subversion of, or military aggression against, the United States or any country receiving U.S. assistance, or (b) the planning of such subversion or aggression?
  7. A.I.D. has no evidence of any subversion or aggression or of plans for such action.

BEST AVAILABLE COPY

8. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction, by mob action, of U.S. property?
9. FAA Sec. 620(l). 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?
10. FAA Sec. 620(o); Fishermen's Protective Act of 1967, as amended, Sec. 5. If country has seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters,
- a. has any deduction required by the Fishermen's Protective Act been made?
- b. has complete denial of assistance been considered by AID Administrator?
11. FAA Sec. 620; FY 79 App. Act Sec. 603. (a) Is the government of the recipient country in default for more than six months 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?
12. FAA Sec. 620(s). If contemplated assistance is development loan or from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget which is for military expenditures, the amount of foreign exchange spent on military equipment and the amount spent for the purchase of sophisticated weapons systems? (An affirmative answer may refer to the record of the annual "Taking Into Consideration" memo: "yes, as reported in annual report on implementation of Sec. 620(s)." This report is prepared at time of approval by the Administrator of the Operational Year Budget and can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)
13. 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?
14. 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?
8. In the past there have been incidents where the GOH has been unsuccessful in containing demonstrations aimed at the U.S. Embassy. This has not been the case during recent years.
9. The OPC Investment Guaranty Program is in operation in Honduras.
10. Honduras has not seized or imposed any penalties or sanctions against U.S. vessels because of their activities in international waters during recent years.
11. (a) No  
11. (b) No
12. Yes.
13. Yes.
14. Honduras is not in arrears to the extent described in Article 19 of the U.N. Charter.

BEST AVAILABLE COPY

15. FAA Sec. 620A, FY 79 App. Act, Sec. 607. Has the country granted sanctuary from prosecution to any individual or group which has committed an act of international terrorism?

15. No.

16. 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?

16. No.

17. FAA Sec. 669, 670. Has the country, after August 3, 1977, delivered or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards? Has it detonated a nuclear device after August 3, 1977, although not a "nuclear-weapon State" under the nonproliferation treaty?

17. No.

B. FUNDING CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria.

a. FAA Sec. 102(b) (4). Have criteria been established and taken into account to assess commitment progress of country in effectively involving the poor in development, on such indexes as: (1) increase in agricultural productivity through small-farm labor intensive agriculture, (2) reduced infant mortality, (3) control of population growth, (4) equality of income distribution, (5) reduction of unemployment, and (6) increased literacy.

1.a. Criteria for assessing progress in involving the poor in development have been set through sector and sub-sector assessments in agriculture, education, and nutrition, and will be set through urban-regional and health sector assessments planned in the near future.

b. FAA Sec. 104(d)(1). If appropriate, is this development (including Sahel) activity designed to build motivation for smaller families through modification of economic and social conditions supportive of the desire for large families in programs such as education in and out of school, nutrition, disease control, maternal and child health services, agricultural production, rural development, and assistance to urban poor?

1.b. Over the long term, improved economic conditions for rural poor, promoted by development assistance programs such as this one, are expected to impact positively on reductions in family size.

2. Economic Support Fund Country Criteria.

a. FAA Sec. 502B. Has the country engaged in a consistent pattern of gross violations of internationally recognized human rights?

2.a. No.

b. FAA Sec. 533(b). Will assistance under the Southern Africa program be provided to Mozambique, Angola, Tanzania, or Zambia? If so, has President determined (and reported to the Congress) that such assistance will further U.S. foreign policy interests?

2.b. Not applicable.

c. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have

2.c. Not applicable.

Special Account (counterpart)  
arrangements been made?

- d. FY 79 App. Act Sec. 113. Will assistance be provided for the purpose of aiding directly the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?
- e. FAA Sec. 620B. Will security supporting assistance be furnished to Argentina after September 30, 1978?

2.d. No

2.e. Not applicable

PROJECT CHECKLIST

A. GENERAL CRITERIA FOR PROJECT.

1. FY 1979 App. Act Unnumbered; FAA Sec. 653(b); Sec. 634A

(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).

The Project was included in the FY 1979 Congressional Presentation at a lower dollar level. A Congressional Notification has been made for the additional allocation 1979 and the required 15 day waiting period has passed without Congressional objection.
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?

The required plans have been contemplated and a reasonably firm estimate of the cost to the U.S. of the activity to be financed has been obtained.
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 action will be required within recipient country.
4. FAA Sec. 611(b); FY 79 App. Act Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per the Principles and Standards for Planning Water and Related Land Resources dated October 25, 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 and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?

Not applicable.
6. FAA Sec. 209. Is project susceptible of execution as part of regional or multi-lateral project? if so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.

The project is not suitable for execution as part of a regional project nor will it necessarily encourage regional development programs.
7. FAA Sec. 601(a). 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).

The equipment to be purchased under the Project is expected to be of US origin and participant training will be at US universities whenever possible.

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.

Honduras is contributing 100 percent of counterpart of incremental Project costs in local currency.

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

The US does not own such excess foreign currency.

11. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

12. FY 79 App. Act Sec. 603. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

**B FUNDING CRITERIA FOR PROJECT**

**1. Development Assistance Project Criteria**

a. FAA Sec. 102(b); 111; 113; 281a. Extent to which activity will (a) effectively involve the poor development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (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; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

The Project will support the Ministry of Health's Program for Extension of Health Coverage to the rural poor by strengthening the analytical and delivery capabilities of the Ministry so as to increase its effectiveness and efficiency in allocating health resources in its program for extension of coverage into rural areas. The majority of target and direct beneficiaries of this program are women in keeping with the heavy maternal-child focus of the Ministry.

b. FAA Sec. 103, 103A, 104, 105, 106, 107 Is assistance being made available: (include only applicable paragraph 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;
- (2) [104] for population planning under Sec. 104(b) or health under Sec. 104(c); if so, extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems and other modes of community research.
- (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;
- (4) [106] for technical assistance, energy, research, reconstruction, and selected development problems; if so, extent activity is:
  - (i) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;
  - (ii) to help alleviate energy problems;
  - (iii) research into, and evaluation of, economic development processes and techniques;
  - (iv) reconstruction after natural or manmade disaster;
  - (v) for special development problem, and to enable proper utilization of earlier U.S. infrastructure, etc., assistance;
  - (vi) 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.

The purpose of this Project is to increase the effectiveness and efficiency of the Ministry of Public Health to plan and manage a low-cost, integrated delivery system and the extension of coverage into rural areas using paramedical and auxiliary medical personnel, clinics and health posts.

c. [107] is appropriate effort placed on use of appropriate technology?

Not applicable.

d. FAA Sec. 110(a) Will the recipient country provide at least 25% of the costs

The Grant Agreement will commit the GOH

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)?

to 31% of Project costs. Past experience indicates that this commitment will be honored. The Project Agreement will formally establish this commitment.

e. 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, or is the recipient country "relatively least-developed"?

The grant funds will be disbursed in less than three years.

f. FAA Sec. 381(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 civil education and training in skills required for effective participation in governmental and political processes essential to self-government.

The Project has been designed to develop the country's intellectual resources so as to improve health planning and management systems in the Ministry of Public Health and the National Planning Council.

g. FAA Sec. 122(b). 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?

2. Development Assistance Project Criteria (Loans Only)

Not applicable

a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan, including reasonableness of repayment prospects.

b. 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 Economic Support Fund

Not applicable

a. FAA Sec. 531(a). Will this assistance support promote economic or political stability? To the extent possible, does it reflect the policy directions of section 102?

b. FAA Sec. 533. Will assistance under this chapter be used for military, or paramilitary activities?

AGENCY FOR INTERNATIONAL DEVELOPMENT <b>PROJECT AUTHORIZATION AND REQUEST          FOR ALLOTMENT OF FUNDS PART I</b>		1. TRANSACTION CODE <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> D	PAF 2. DOCUMENT CODE 5
3. COUNTRY/ENTITY HONDURAS		4. DOCUMENT REVISION NUMBER <input type="checkbox"/>	
3. PROJECT NUMBER (7 digits) <input type="text" value="522-0119"/>		5. BUREAU/OFFICE A. SYMBOL <input type="text"/> B. CODE <input type="text"/>	
6. PROJECT APPROVAL DECISION <input type="checkbox"/> A - APPROVED <input type="checkbox"/> D - DISAPPROVED <input type="checkbox"/> DE - DEAUTHORIZED		7. PROJECT TITLE (Maximum 40 characters) <input type="text" value="HEALTH SECTOR PLANNING"/>	
8. ACTION TAKEN		9. EST. PERIOD OF IMPLEMENTATION YRS. <input type="text" value="6"/> <input type="text" value="2"/> QTRS. <input type="text" value="1"/>	

10. APPROVED BUDGET AID APPROPRIATED FUNDS (\$000)									
A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. 1ST FY <u>79</u>		H. 2ND FY		K. 3RD FY	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	I. GRANT	J. LOAN	L. GRANT	M. LOAN
(1)	580	520		475					
(2)									
(3)									
(4)									
TOTALS				475					

A. APPROPRIATION	N. 4TH FY		Q. 5TH FY		LIFE OF PROJECT		11. PROJECT FUNDING AUTHORIZED	
	O. GRANT	P. LOAN	R. GRANT	S. LOAN	T. GRANT	U. LOAN	1. ENTER APPROPRIATE CODE(S) 1 = LIFE OF PROJECT 2 = INCREMENTAL LIFE OF PROJECT	2. GRANT
(1)					475			
(2)								
(3)								
(4)								
TOTALS					475			C. FY PROJECT FUNDING AUTHORIZED THRU <input type="text" value="8"/> <input type="text" value="1"/>

12. INITIAL PROJECT FUNDING ALLOTMENT REQUESTED (\$000)				13. FUNDS RESERVED FOR ALLOTMENT				
A. APPROPRIATION	D. ALLOTMENT REQUEST NO. _____			TYPED NAME (Chief, SER/EM/ESD) SIGNATURE _____ DATE _____				
	C. GRANT	D. LOAN						
(1)	475							
(2)								
(3)								
(4)								
TOTALS		475						

14. SOURCE/ORIGIN OF GOODS AND SERVICES  
 000  941  LOCAL  OTHER \_\_\_\_\_

15. FOR AMENDMENTS, NATURE OF CHANGE PROPOSED

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

PROJECT AUTHORIZATION AND REQUEST FOR ALLOTMENT OF FUNDS

Name of Country: Honduras      Name of Project: Health Sector Planning  
Number of Project: 522-0148

Pursuant to Part I, Chapter I, Section 106 of the Foreign Assistance Act of 1961, as amended, I hereby authorize a Grant to the Republic of Honduras the "Cooperating Country" of not to exceed four hundred and seventy five thousand United States Dollars (US\$475,000) to help in financing certain foreign exchange and local costs of goods and services required for the Project as described in the following paragraph.

The Project, which will be implemented by the Ministry of Public Health, seeks to strengthen the analytical capacities of the Government of Honduras in health planning and management so as to increase the effectiveness of their allocation of health resources and their sector strategies for future investments.

Sub-sector analyses, a summary sector assessment, and in-depth special studies for specific improvements will be completed; GOH staff will be trained in basic analytical concepts, quantitative techniques, professional standards, and specific technical subjects; and certain program improvements will be designed, tested and evaluated. A.I.D. funds will be used to provide technical assistance in environmental sanitation, communicable disease control and epidemiology, human resources development, materials management, and finance and budgeting; participant training in epidemiology, environmental sanitation, health planning and health administration; invitational travel; and to finance commodities and other costs for Project support.

I hereby authorize the initiation of negotiation of the Project Agreement by the officer to whom I have redelegated such authority 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 of Origin of Goods and Services

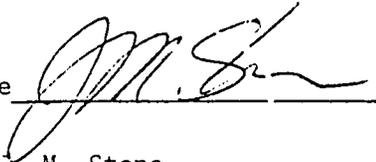
Goods and services, including ocean shipping, financed by A.I.D. under the Project shall have their source and origin in the Central American Common Market or in the United States, except as A.I.D. may otherwise agree in writing.

(b) Nationality Waivers for Technical Services

The following waiver to A.I.D. regulations is hereby approved:

Procurement of services, other than transportation, from countries included in A.I.D. Geographic Code 941, when the cost of said services does not exceed \$50,000 (exclusive of transportation costs). This waiver shall be interpreted in accordance with applicable A.I.D. Handbooks.

Signature



J. M. Stone

Typed name of Authorizing Officer

Acting Mission Director

Official Symbol

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

LAC/DR-IEE-79-38

ASSISTANT  
ADMINISTRATOR

ENVIRONMENTAL THRESHOLD DECISION

Location : Honduras, 522-0148  
Project Title : Health Sector Planning  
Funding : \$475,000 Grant FY 79  
Life of Project: Two Years

Mission Recommendation:

Based on the Initial Environmental Examination, the Mission has concluded that the project will not have a significant effect on the human environment and therefore recommends a Negative Determination.

The Development Assistance Executive Committee of the Bureau for Latin America and the Caribbean has reviewed the Initial Environmental Examination for this project and concurs in the Mission's recommendation for a Negative Determination.

AA/LAC Decision:

Pursuant to the authority vested in the Assistant Administrator for Latin America and the Caribbean under Title 22, Part 216.4a, Environmental Procedures, and based upon the above recommendation, I hereby determine that the 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.

Annex F  
Assistant Administrator for  
Latin America and the Caribbean

June 28, 1979  
Date

Clearances:

LAC/DR:Environmental Advisor:ROtto OTTO  
DAEC Chairman:MBrown [Signature]

INITIAL ENVIRONMENTAL EXAMINATION

PART I

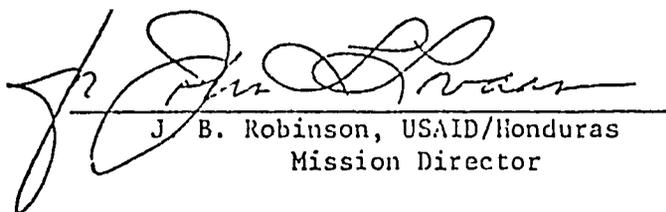
Project Location : Honduras  
Project Title : Health Sector Planning  
522-0148  
Funding : \$475,000 Grant  
(FY79)  
Life of Project : 2 years, 1979-1981  
IEE Prepared by : Andrea Mohn  
Date: May 8, 1979

Threshold Decision

a. Recommendation:

Negative Determination

b. Concurrence:

  
J. B. Robinson, USAID/Honduras  
Mission Director

Date:

5/18/79

c. Assistant Administrator's/Director's

Date:

\_\_\_\_\_

## DESCRIPTION OF THE PROJECT

### PART II

The Project seeks to strengthen the analytical planning and management capability within the Ministry of Health.

Approximately 7 sub-sector analyses, a summary sub-sector assessment, and in-depth special studies for 7-14 specific improvements will be completed; MOH staff will be trained in basic analytical concepts, quantitative techniques, professional standards, and specific technical subjects; and 1 to 2 regional program improvements will be designed, tested, and evaluated. A.I.D. funds will be used to provide technical assistance, participant training, invitational travel, and to finance commodities and other costs for Project support.

## IDENTIFICATION AND EVALUATION OF ENVIRONMENTAL IMPACT

### PART III

The Project is one of those classified in Part 216.2 of A.I.D. Environmental procedures as published in the Federal Register among the "general class of activities that do not normally require the filling of an Environmental Impact Statement or the preparation of an Environmental Assessment: Education or training programs not designed to result in activities directly affecting the environment."

The Impact Identification Form is attached to this IEE as a reference.

## RECOMMENDATION FOR ENVIRONMENTAL ACTION

### PART IV

Since the Health Sector Planning Project does not involve any actions that will have a direct adverse effect on the human environment, a Negative Determination is proposed.

IMPACT IDENTIFICATION AND EVALUATION FORM

Impact Areas and Sub-areas

A. LAND USE

- |  |              |
|--|--------------|
| 1. Changing the character of the land through: |              |
| a. Increasing the population -----             | <u>    N</u> |
| b. Extracting natural resources -----          | <u>    N</u> |
| c. Land clearing -----                         | <u>    N</u> |
| d. Changing soil character -----               | <u>    N</u> |
| 2. Altering natural defenses -----             | <u>    N</u> |
| 3. Foreclosing important uses -----            | <u>    N</u> |
| 4. Jeopardizing man or his work -----          | <u>    N</u> |
| 5. Other factors                               |              |
| _____  | _____        |
| _____  | _____        |

B. WATER QUALITY

- |   |              |
|---|--------------|
| 1. Physical state of water -----        | <u>    N</u> |
| 2. Chemical and biological states ----- | <u>    N</u> |
| 3. Ecological balance -----             | <u>    N</u> |
| 4. Other factors                        |              |
| _____                                   | _____        |
| _____                                   | _____        |

1/ Symbol meanings: N - No environmental impact  
 L - Little environmental impact  
 M - Moderate environmental impact  
 H - High environmental impact  
 U - Unknown environmental impact

IMPACT IDENTIFICATION AND EVALUATION FORM

C. ATMOSPHERIC

1. Air additives -----	<u>N</u>
2. Air pollution -----	<u>N</u>
3. Noise pollution -----	<u>N</u>
4. Other factors	
 <u>Short Term Construction Air Pollution</u>	 <u>N</u>
_____	_____

D. NATURAL RESOURCES

1. Diversion, altered used of water -----	<u>N</u>
2. Irreversible, inefficient commitments -----	<u>N</u>
3. Other factors	
_____	_____
_____	_____

E. CULTURAL

1. Altering physical symbols -----	<u>N</u>
2. Dilution of cultural traditions -----	<u>N</u>
3. Other factors	
_____	_____
_____	_____

F. SOCIO-ECONOMIC

1. Changes in economic/employment patterns--	<u>N</u>
2. Changes in population -----	<u>N</u>
3. Changes in cultural patterns -----	<u>N</u>
4. Other factors	
_____	_____
_____	_____

IMPACT IDENTIFICATION AND EVALUATION FORM

G. HEALTH

- |   |                          |
|---|--------------------------|
| 1. Changing a natural environment -----   | <u>        N        </u> |
| 2. Eliminating an ecosystem element ----- | <u>        N        </u> |
| 3. Other factors                          |                          |
| _____                                     | _____                    |
| _____                                     | _____                    |

H. GENERAL

- |                                 |                          |
|---------------------------------|--------------------------|
| 1. International impacts -----  | <u>        N        </u> |
| 2. Controversial impacts -----  | <u>        N        </u> |
| 3. Larger program impacts ----- | <u>        N        </u> |
| 4. Other factors                |                          |
| _____                           | _____                    |
| _____                           | _____                    |

I. OTHER POSSIBLE IMPACTS (not listed above)

_____	_____
_____	_____
_____	_____



CONSEJO SUPERIOR DE PLANIFICACION ECONOMICA

TEGUCIGALPA, D. C., HONDURAS, C. A.

ANNEX G  
GOH Request for Project  
Page 2 of 2

2

- Capacitar de 40 a 50 empleados administrativos/técnicos del sector salud.
- Desarrollar metodologías de administración a nivel regional.

El costo total del Proyecto y las fuentes de financiamiento se detallan a continuación:

Rubro	Total		Fuente			
	Lps.	US\$	AID	%	Gob.Cent.	%
Personal	424,000.0	212,000.0	\$ 40,000.0	8.4	\$172,000.0	81.5
Materiales y Equipo	88,000.0	44,000.0	22,000.0	4.6	22,000.0	10.4
* Cooperación Técnica	500,000.0	250,000.0	250,000.0	52.5	-	-
Viáticos y Transp.	24,000.0	12,000.0	-	-	12,000.0	5.7
Mantenim.Vehículos	10,000.0	5,000.0	-	-	5,000.0	2.4
* Adiestramiento	220,000.0	110,000.0	110,000.0	23.1	-	-
* Desarrollo Regional	108,000.0	54,000.0	54,000.0	11.4	-	-
	1.374,000.0	687,000.0	476,000.0	100.0	211,000.0	100.0

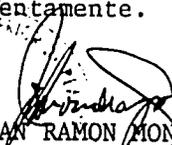
\*/ Los componentes de Adiestramiento y Desarrollo Regional tenían incorporado originalmente un renglón para asesoría por \$10,000.0 y \$40,000.0 respectivamente, los cuales han sido incorporados al renglón de Cooperación Técnica que ha sido incrementado por igual valor.

El Proyecto tendrá una duración de dos años, a partir de la fecha en que se firme el convenio.

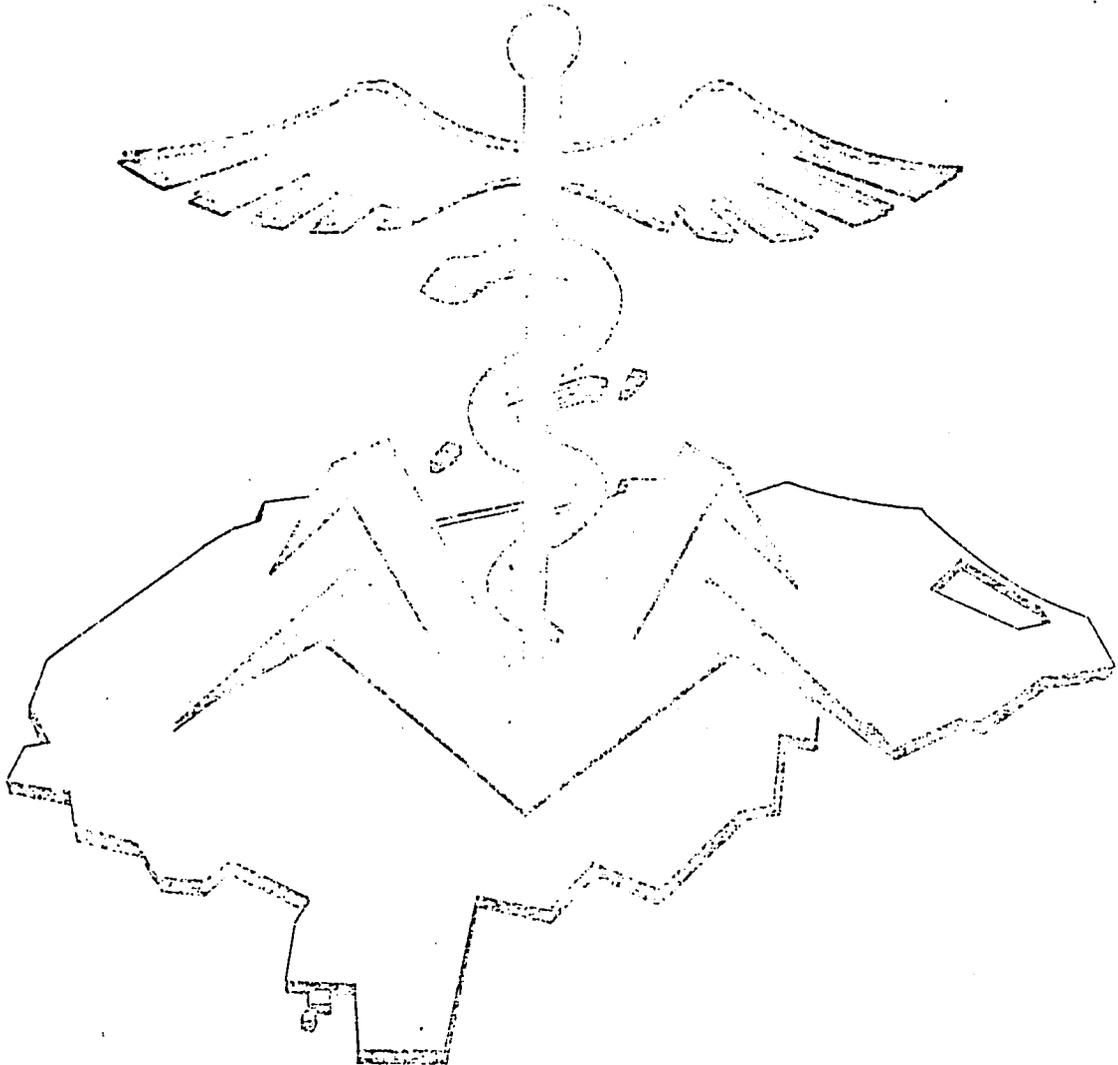
El Ministerio de Salud Pública será la unidad ejecutora, a través de la Dirección General de Salud, y como coordinadora la Unidad de Planificación de Salud. Además se contará con un grupo técnico coordinador integrado por el MSPAS, CONSUPLANE y la AID, a fin de obtener una mejor coordinación y agilidad en la ejecución.

Agradeciendo de antemano su apoyo a este Proyecto, aprovecho la oportunidad para saludar a usted.

Atentamente.

  
 JUAN RAMON MONDRAGON  
 Secretario Ejecutivo  
 por Ley

MINISTERIO DE SALUD PÚBLICA



PROYECTO  
DE PLANIFICACION Y DESARROLLO  
ADMINISTRATIVO  
1979

PROYECTO  
DE PLANIFICACION Y DESARROLLO  
ADMINISTRATIVO  
1979

I N D I C E

Resumen.....	1
Introducción.....	1
Integralidad del Sistema y sus Restricciones.....	2
Situación Actual y Areas Prioritarias.....	4
El Proyecto.....	5
Ambito Institucional.....	6
Dirección y Ejecución.....	7

C U A D R O S

Fondos de AID	
Personal.....	1
Equipo de Oficina.....	2
Cooperación Técnica.....	3
Adiestramiento y Otros.....	4
Administración Regional.....	5
Resumen.....	6
Desglose de Adiestramientos y otros .....	7
Fondos Gobierno de Honduras.....	8

R E S U M E N

El siguiente documento es un proyecto de Planificación y Desarrollo Administrativo. Consiste en una - propuesta sintética sobre algunas áreas que el Ministerio de Salud Pública y Asistencia Social ha identificado como prioritarias para analizar detalladamente, identificar sus restricciones y formular soluciones - adecuadas a los problemas encontrados. También se destinan fondos para desarrollar adecuadamente algunas - áreas sobre las cuáles hay ya una clara identificación de los factores limitantes que están actuando, enfocando aspectos administrativos, material y equipo, adiestramiento y recursos humanos, procurando la aplicación y mejoramiento de las metodologías operativas vigentes.

El monto total del proyecto es de L.1.374.000.00; la Agencia Internacional para el Desarrollo (AID-EUA) financiará L.952.000.00; y L.422.000.00 como contraparte del Gobierno de Honduras. El tiempo de ejecución se estima en unos dos (2) años.

SOLICITUD DE FINANCIAMIENTO NO REEMBOLSABLE PARA UN  
PROYECTO DE PLANIFICACION Y DESARROLLO ADMINISTRATIVO EN  
SALUD.

Introducción:

La Política General de Salud que ha definido el Ministerio de Salud Pública y Asistencia Social (MSPAS) de extender los servicios de salud a toda la población ha motivado un intenso proceso de planificación y desarrollo administrativo con el fin de mejorar su capacidad operativa y financiera, de manera que le permita en un plazo relativamente corto cumplir con su objetivo de elevar el nivel de salud y hacer accesible los servicios a toda la población.

Resulta claro que el objetivo propuesto es incompatible con la organización tradicional del sistema de salud, y con la mecánica que se ha seguido para hacer entrega de los servicios a la población. Este enfoque, por tanto, implica un cambio en el sistema de trabajo, en la distribución de los recursos, normatización y regulación de los procedimientos administrativos, una política consecuente de recursos humanos y una captación de recursos financieros que pueden dar el soporte necesario a un cambio de política.

A pesar de que esta situación es clara, operativamente existen grandes restricciones para poder llevar a cabo las reformas necesarias, y poder crear una infraestructura de funcionamiento capaz de soportar con el enorme esfuerzo que representa el cubrir una población con altas demandas en salud.

- 2 -

Evidentemente existen restricciones serias de recursos disponibles, lo cuál obliga a desarrollar los elementos fundamentales: (1) aumento de la eficiencia y eficacia de los recursos actuales, (2) captación de nuevos recursos. En un análisis global vemos que el mejoramiento de la eficiencia y eficacia es el factor clave y la restricción fundamental que constriñe el sistema.

#### Integralidad del Sistema y sus Restricciones

El enfoque para desarrollar el sistema, en la medida de lo posible, debe de ser integral. En la mayoría de los casos la integridad absoluta es muy difícil de conseguir, pero es conveniente hacer un esfuerzo notable para identificar todas (o la mayoría) de las variables que pueden influir en el éxito de un proceso. Por lo tanto hay que tener muy claro el espectro de demandas y tipos de necesidades existentes y que surgirán como consecuencia de la aplicación de medidas específicas para poder enfrentarias convenientemente. Un efecto inmediato de esta falta de previsión es la inadecuada distribución de los distintos tipos de recursos: Suficiente personal, pero insuficiente equipo; ó pueden existir ambos en forma adecuada, pero no hay materiales. La consecuencia es una ineficiente e ineficacia para el cumplimiento de objetivos, a pesar de que la inversión y el gasto realizado sea alto.

Es decir, en términos generales la capacidad real operativa va por abajo de la demanda real y las necesidades que surgen como consecuencia de los nuevos enfoques y las nuevas expectativas. Esto es frecuentemente

- 3 -

observable cuando vemos que las funciones y capacidades que el sistema exige están por arriba de la capacidad y preparación del personal encargado de su manejo.

El rendimiento óptimo de los recursos actuales y futuros sólo podrá lograrse en la medida en que mejoremos nuestra capacidad para manejarlos adecuadamente, mejorando nuestra planificación y administración, con todas sus variables allí implícitas de personal (cantidad y calidad), procedimientos, financiamiento, etc...

El segundo factor enunciado es el de los nuevos - recursos, especialmente financieros, que requieren para aumentar nuestra capacidad de operación, los cuáles tienen un doble efecto: Por un lado producen un impulso a los programas de salud, ya que permite la adquisición - de insumos y el mejoramiento de las instalaciones, especialmente los fondos de inversión; pero por otro lado, producen una crisis de operación, acentuando la incapacidad relativa de manejo ya que generalmente la estructura administrativa no tiene la suficiente agilidad para adecuarse a las demandas de operación que los nuevos recursos (a veces substanciales) exigen, evidenciándose esto como una falta de capacidad de gasto, con el consecuente retraso de los proyectos y la disminución de su rendimiento. Aquí surge de nuevo el concepto de la integralidad en las soluciones, abordando todas las variables que pueden influir en el éxito de los programas y proyectos.

### Situación Actual y Areas Prioritarias

Honduras y especialmente el MSPAS, ha sufrido de una u otra forma el proceso antes descrito, y cada vez es más apremiante la necesidad de tener un adecuado control del mismo y generar las acciones pertinentes que nos permiten corregir los desajustes observados. Para poder realizar esto necesitamos hacer un análisis detallado de algunas áreas finales de actividades en salud y de otras que constituyen el apoyo necesario para su funcionamiento. Son de alta prioridad el saneamiento básico, que incluye agua, excretas, basuras y mejoramiento de la vivienda; control de enfermedades transmisibles que incluye las inmunoprevenibles, las transmitidas por vectores y el control de la diarrea. La atención médica organizada en función de la atención primaria de salud, la extensión de cobertura, la promoción de la salud, el control y la atención de enfermedades y la referencia de pacientes.

En el segundo grupo, actividades que constituyen el apoyo para llevar a cabo las acciones específicas de los programas tenemos: los recursos humanos, enfocado tanto a aquéllos que dan atención directa al paciente como los administrativos (comunitario, auxiliar y técnicos, médicos y enfermeras, administradores y directores; Dirección y Administración, referido a todos aquéllos factores que influyan sobre una adecuada conducción de los programas de salud, procedimientos de dirección y administración, planificación y programación, sistema de información, evaluación y manejo y control presupuestario. También, se incluye la dotación y organización adecuada de la comunicación, transporte, equipamiento, mantenimiento y sistema de suministros, Asimismo se considera necesario iniciar el desarrollo de esquemas que nos permitan detectar problemas de tipo tecnológico, tanto en aquéllas tecnologías de objeto como de proceso además

- 5 -

de innovaciones también de tipo tecnológico que sería conveniente difundir o estudiar más de de talladamente con el fin de mejorar su utilización.

#### El Proyecto:

Visto lo anterior, el proyecto de planificación y desarrollo administrativo deberá estar encaminado a ubicar claramente el problema de salud en relación con las acciones o ejercidas como medio de solución, los procedimientos y me todologías usadas, su utilidad y la medida en que sería conveniente incrementar, modificar o - cambiar . Es básico para esto identificar las - restricciones operantes y sus posibles relaciones con el eficacia de las soluciones, dar alter nativas de enfoque y delimitar niveles de respon sabilidad. Es importante investigar el impacto - de las acciones desarrolladas y el grado de uso que la población hace de ellas, identificando - problemas que existan para que la población acce da a los servicios.

En términos concretos se trataría de englobar esa serie de estudios en algunas áreas repre sentativas; (1) Saneamiento Ambiental, (2) Control de Enfermedades Transmisibles, el cuál evidentemente tiene un componente preventivo y de - atención de medicina curativa; (3) Recursos Huma nos; (4) Administración; (5) Suministros; (6) Pre supuestación; (7) Dirección y Administración Regional. Todos estos campos se encuentran concatenados en función de la atención médica y preven tiva de salud, dentro de la política y esquemas - de prestación de salud definida por el MSPAS.

La identificación de lo anterior deberá permitir estimar los elementos que deberán ser apoyados con nuevos recursos ya sea de tipo tecnológico, humano, financiero y equipo, etc.

Dentro del proyecto se apoyarán acciones inmediatas para ayudar a resolver algunos de los problemas identificados, fundamentalmente orientado a manejo de procedimientos, sistematización de la función administrativa, adiestramiento, personal, equipo y materiales; esto con el fin de producir un impacto inmediato en el mejoramiento de la eficiencia administrativa y operativa de los programas.

También se contempla un plan de adiestramiento en áreas seleccionadas, cursos, seminarios y visitas de observación, como parte de la formación y captación de experiencias nuevas en áreas específicas.

#### Ambito Institucional

En la medida que resulte necesario para una mayor efectividad de proyecto y de acuerdo con las resoluciones de política de salud que se definan, el ámbito institucional se referirá a todo el sector (IHSS, PANI) y a instituciones de estrecha vinculación como la UNAH, orientado en el campo operativo y docente. La participación de CONSUPLANE es necesaria como elemento de política general de salud, lo cuál se efectuará a través de su Departamento de salud.

- 7 -

### Dirección del Proyecto

El proyecto será dirigido por la Dirección General de Salud del MSPAS, siendo la unidad - coordinadora la División de Planificación del - MSPAS. Para asuntos de una adecuada comunicación existirá un grupo de discusión que estará integro do por el Jefe de la División de Planificación - del MSPAS, el Jefe del Depto. de Salud de CONSU- PLANE, y un representante de la agencia que con- tribuye al financiamiento (AID). Con fines de a- gilizar el manejo del proyecto, la División de - Planificación del MSPAS, será reforzada con dos (2) Planificadores a tiempo completo que se encar- garían de la operación del mismo. Ellos participa- rán en las discusiones del grupo antes enunciado. Para cualquier decisión de tipo político se segui- rán los canales formales ya establecidos del MSPAS y el Gobierno de Honduras.

### Ejecución:

Para el manejo de los fondos y de los proce- dimientos administrativos que permita la agiliza- ción del gasto, uno de los planificadores tendrá también función administrativa.

Para la operatividad en el desarrollo de las áreas enunciadas como prioritarias, se considera necesario la formación de equipos específicos en cada una de ellas, que contarán con el apoyo de un consultor financiado por medio del proyecto, -- recursos de equipo y logística, adiestramiento, - participación en seminarios y visitas de observa- ción. También se hará un plan de implementación -

- 8 -

regional y de adiestramiento.

La duración del proyecto se ha estimado en  
24 meses.

/ab.

CUADRO No.  
DISTRIBUCION DE FONDOS DE AID

PERSONAL

Tipo de Personal	Tiempo	Costo		
		Mensual	Total	
		Lps.	Lps.	\$ EUA
Planificador	18 meses	2.000.00	36.000.00	18.000.00
Planificador	18 meses	1.500.00	28.000.00	14.000.00
Secretaria	18 meses	600.00	10.800.00	5.400.00
Personal para Traducciones <u>/1</u>			5.200.00	2.600.00
Total.....			80.000.00	40.000.00

/1 Se estima en L. 10.00 ( \$ EUA 5.00) página traducida, total 520 páginas.

CUADRO No. 2  
EQUIPO OFICINA  
FONDOS AID

Rubro	Costo	
	Lps.	\$ EUA
1 Máquina de Escribir Micro Carro Largo	2.200.00	1.000.00
1 Máquina de Escribir Macro Carro Standard	1.800.00	900.00
1 Fotocopiadora	10.000.00	5.000.00
3 Escritorios	3.000.00	1.500.00
6 Calculadoras	3.600.00	1.800.00
4 Archivos	2.000.00	1.000.00
Misceláneas	1.400.00	700.00
Sub Total	24.000.00	12.000.00
<u>Equipo Transporte</u>	Lps	\$ EUA
1 Automóvil	20.000.00	10.000.00
Total.....	44.000.00	22.000.00

CUADRO No. 3  
Cooperación Técnica  
Asesoría Externa  
Fondos AID

Area	Meses/Hombre	COSTO	
		Lps.	\$ EUA
Saneamiento Básico	12	90.000.00	45.000.00
Enf. Transmisibles	5	20.000.00	10.000.00
Recursos Humanos	5	50.000.00	25.000.00
Administración	5	50.000.00	25.000.00
Suministros	5	50.000.00	25.000.00
Presupuesto	5	50.000.00	25.000.00
Desarrollo Regional	5	50.000.00	25.000.00
Sub-Total.....	42	360.000.00	180.000.00

Asesoría de Funcionarios Nacionales

Asesoría para unos 20 trabajos		40.000.00	20.000.00
Total.....		400.000.00	200.000.00

CUADRO No. 6

RESUMEN

FONDOS AID

Rubro	Costo	
	Lps.	\$ EUA
Personal	80.000.00	40.000.00
Equipo	44.000.00	22.000.00
Cooperación Técnica	400.000.00	200.000.00
Adiestramiento	240.000.00	120.000.00
Desarrollo Regional	188.000.00	94,000.00
Total.....	952.000.00	476.000.00

CUADRO No. 4  
ADiestRAMIENTO Y OTROS /1  
FONDOS AID

Rubro	Tiempo/hombre	COSTO	
		Lps.	\$ EUA
Becas Largas	24 meses/hombre <u>/2</u>	60.000.00	30.000.00
Becas Cortas	8 meses/hombre <u>/3</u>	40.000.00	20.000.00
Conferencias internacionales	30 meses/hombre	40.000.00	20.000.00
Visitas de Ob-servación	10 meses/hombre	40.000.00	20.000.00
Cursos Nacionales	30 meses/hombre	40.000.00	20.000.00
Sub-Total		220.000.00	110.000.00
Asesoría		20.000.00	10.000.00
Total.....		240.000.00	120.000.00

- /1 El desglose esta anexo 7  
/2 Becas Largas 12 meses -2  
/3 Becas Cortas 3-4 meses.-2

Cuadro No. 5  
DESARROLLO DE LA ADMINISTRACION REGIONAL  
FONDOS AID

Rubro	Costo	
	Lps.	\$ EUA
Asistencia Técnica	80.000.00	40.000.00
Honorarios	20.000.00	10.000.00
Equipos y Materiales	30.000.00	15.000.00
Viáticos	30.000.00	15.000.00
Salario Administrador	28.000.00	14.000.00
Total .....	188.000.00	94.000.00

CUADRO No. 6

RESUMEN

FONDOS AID

Rubro	Costo	
	Lps.	\$ EUA
Personal	80.000.00	40.000.00
Equipo	44.000.00	22.000.00
Cooperación Técnica	400.000.00	200.000.00
Adiestramiento	240.000.00	120.000.00
Desarrollo Regional	188.000.00	94 <del>0</del> .000.00
Total.....	952.000.00	476.000.00

CUADRO No. 7  
DESGLOSE DE ASIGNACION DE ADIESTRAMIENTOS  
SEGUN AREA DE TRABAJO  
FONDOS AID

Area de Trabajo	<u>Becas</u>		Confe- rencias Interna- cionales	Visitas Observa- ción.	Seminarios Nacionales.
	Largas	Cortas			
Planificación	1	-	6	-	-
Desarrollo Administrativo	1	-	6	1	30
Saneamiento Ambiental	-	1	6	3	-
Epidemiología	-	1	6	3	-
Recursos Humanos	-	-	4	2	-
Educación	-	-	2	1	-
<b>Total</b>	<b>2</b>	<b>2</b>	<b>30</b>	<b>10</b>	<b>30</b>

Cuadro No. 8

Fondos de Contraparte del Gobierno  
de Honduras Ministerio de Salud  
Pública y Asistencia Social  
Fondos AID

Rubros	Monto	
	Lps.	\$ EUA
Material y Equipo	28.000.00	14.000.00
Mantenimiento Vehículo	10.000.00	5.000.00
Equipo de Oficina	10.000.00	5.000.00
Documentos	6.000.00	3.000.00
Transporte	10.000.00	5.000.00
Viáticos	14.000.00	7.000.00
Salarios	344.000.00	172.000.00
<b>Total</b>	<b>422.000.00</b>	<b>211.000.00</b>