

NONCAPITAL PROJECT PAPER (PROP)

I. PROJECT TITLE

.. PROJECT IDENTIFICATION

Development and Evaluation of Integrated Delivery Systems
(Core Contract)

APPENDIX ATTACHED

YES NO 77p

2. PROJECT NO. (M.O. 1095.2)
931-11-580-9/1

3. RECIPIENT (specify)

COUNTRY _____

REGIONAL _____ INTERREGIONAL _____

4. LIFE OF PROJECT

BEGINS FY 72

ENDS FY 78

5. SUBMISSION

ORIGINAL

REV. NO. 2-78E DATE

CONTR./PASA NO. _____

II. FUNDING (\$000) AND MAN MONTHS (MM) REQUIREMENTS

A. FUNDING BY FISCAL YEAR	D. TOTAL \$	C. PERSONNEL		D. PARTICIPANTS		E. COMMODITIES \$	F. OTHER COSTS \$	G. PASA/CONTR.		H. LOCAL EXCHANGE CURRENCY RATE: \$ US (U.S. OWNED)		
		(1) \$	(2) MM	(1) \$	(2) MM			(1) \$	(2) MM	(1) U.S. GRANT LOAN	(2) COOP COUNTRY	
											(A) JOINT	(B) BUDGET
1. PRIOR THRU ACTUAL FY												
2. OPRN FY 76	1,115	381	96				733					
3. BUDGET FY 77	1,148	394	96				754					
4. BUDGET +1 FY	1,108	395	96				713					
5. BUDGET +2 FY												
6. BUDGET +3 FY												
7. ALL SUBQ. FY												
8. GRAND TOTAL	3,371	1,170	288				2,200					

9. OTHER DONOR CONTRIBUTIONS

(A) NAME OF DONOR	(B) KIND OF GOODS/SERVICES	(C) AMOUNT

III. ORIGINATING OFFICE CLEARANCE

1. DRAFTER Merrill M. Shutt, M.D.	TITLE Chief, Health Delivery Systems	DATE 3-5-75
2. CLEARANCE OFFICER Lee M. Howard, M.D.	TITLE Director, Office of Health	DATE 3-5-75

IV. PROJECT AUTHORIZATION

1. CONDITIONS OF APPROVAL

will change p.14 to support the DEIS approved. 2/24/76

2. CLEARANCES

BUR/OFF.	SIGNATURE	DATE	BUR/OFF	SIGNATURE	DATE
TA/PPU	Lovha Wakefield		LA		
TA/PPU	John Gunning		NENA		
PHA/POP	Wm. Boynton		PPC		
TA/N	Marty Forman				
AFR					
ASIA					

3. APPROVAL AAs OR OFFICE DIRECTORS

SIGNATURE	DATE

4. APPROVAL A/AID (See M.O. 1025.1 VI C)

SIGNATURE	DATE

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Part I Summary and Recommendation

B. Recommendation

Grant		Health	Population
FY 76	\$1.115	(743.3)	(371.7)
FY 77	1.148	(765.3)	(382.7)
FY 78	1.108	(738,7)	(369.3)
Total	\$3.371	(2.247)	(1.124)

C. Description of the Project

This project is a continuation of the original Development and Evaluation of Integrated Delivery Systems Project (DEIDS) approved 12-6-71 for a 10 year life of project. Obligations for the core contract through February, 1976 have totalled \$2,688,000. This includes core costs of managing the Thailand sub-project, but not the costs of the field elements.*

Prior to the 1973 Foreign Assistance Act (FAA) which specifically authorized the Agency to help LDCs provide health services for the majority, the DEIDS project constituted the Agency's first efforts to define patterns for delivery of integrated health, population and nutrition services to a population in the location in which the majority live, and at a cost within the capacity of national budgets to maintain without external subsidy. Preceding project efforts by the Regional Bureaus to implement the 1973 FAA, the original DEIDS project served as an interregional focus for initiating, exploring, and evaluating a new direction in Agency health policy.

*The Thailand sub-project field elements are funded separately. A five year approval for the sub-project was given in 1974, with funding of \$1,117,000 for the first two years of operation.

The project originally planned to support interregional demonstration programs in the form of four country sub-projects. Of two administratively approved projects (Thailand and Ecuador), only the Thailand project has been implemented. The Ecuador project will not be implemented, and approved funds have been deobligated. With the rapid growth since 1973 of Regional Bureau projects which have incorporated basic principles of the DEIDS concept, it is no longer essential that the TAB DEIDS Project support more than the one on-going sub-project in Thailand.

This project will continue activities begun earlier, including:

1. Intermediate management of the demonstration project in Thailand designed to test the hypothesis that delivery of basic health services to the majority of target populations (women of child bearing age and children under five) can be achieved within resources available to the host nation.
2. Provision of technical assistance to Regional Bureaus, Missions and LDCs for determining project feasibility (Phase I), and for planning and designing (Phase II) operational and evaluation components of low cost integrated delivery system project prior to actual implementation. Following project implementation (Phase III) by any contractor, periodic technical consultation will be available upon request for any aspect of program operation or evaluation. Evaluation functions (number 3 below) and information exchange (number 5 below) will require periodic consultation or visitation of selected operational programs in order to provide the Agency with at least one central focus for technical monitorship and on-going assessment of the global effort.
3. Development of guidelines for evaluation of health delivery systems. Alternative approaches to evaluation, developed from an analysis of tech-

niques used in a variety of on-going programs, will be incorporated in the guidelines. Evaluation methodology will be required for measurements such as the determination of percentage of access to and service utilization by target populations, deficiencies and efficiencies in providing specific services, unit costs of services provided, changes in health status (specific morbidity, mortality, and fertility rates), behavioral or attitudinal changes with respect to weaning and dietary practices, breast feeding, acceptance and use of potable water, utilization of contraceptives and prenatal care.

4. Completion of a State of the Art Survey of integrated health delivery systems.
5. Development of an information management and exchange system for integrated health delivery systems and their components. An increasing volume of information regarding successes and failures in health delivery systems experience is being developed by project managers, government health agencies, donor agencies, universities, private and voluntary agencies and others. Only a fraction of this information is published in recognized journals with international circulation. The MEDLARS and MEDLINE system of the National Library of Congress provides access to such published information to governments and universities, but most of such information lacks timeliness as it is published years after it is produced. Newsletters of the Christian Medical Commission, which has wide access to voluntary organization experience, bibliographies produced by the International Research and Development Center, (IRDC), and other agencies provide some descriptive information to a limited audience. With the increasing worldwide momentum to expand health coverage to population majorities, a need exists to provide AID Missions and developing countries timely access to current information, including analysis of worldwide developments, progress and innovative techniques in integrated delivery systems.

In the absence of operational alternatives, this project will establish an information management system which will actively collect pertinent information from planned and on-going project and programs, donor and international agencies, universities and private and voluntary agencies and other sources, collect and analyze information, (primarily to assess potential for applicability to the majority), and distribute it to AID Missions, developing countries and other interested recipients in the form of special and periodic reports. The system will also respond to requests for specific information.

6. Promotion and coordination of the integrated health delivery development efforts with bilateral and international donors, developing nations, resource institutions, and the private and voluntary sectors.

This project will be managed by the Technical Assistance Bureau, Office of Health. In order to have an institution accountable for gathering global information, the American Public Health Association (APHA) through contract will continue to develop and administer project activities as described above, using full time staff, short term consultants and subcontracts. Provision of technical assistance to the demonstration project in Thailand is being carried out by an APHA subcontract with the University of Hawaii.

Project intent is to provide a continuing agency capability to respond rapidly to the Congressional mandate to provide health and family planning services through low cost integrated delivery systems. As a central program of support to Regional Bureaus and collaborating institutions, the project purposes address Agency goals which extend beyond the immediate 3 year funding time frame. Within this 3 year time frame, successful completion of the project objectives will 1) demonstrate what is possible, within the resource limitations of Lampang Province, Thailand, to provide health, family planning and nutrition services to the majority of a defined target population;

2) provide AID Missions and developing countries continuing access to professional expertise for determination of project feasibility, design and evaluation of health systems and their components; 3) provide program designers and managers improved evaluation techniques for project management and will permit some commonality of evaluation objectives and subsequent comparative analyses of results obtained; 4) provide the Agency a capability to collect, analyze and exchange information pertaining to integrated health delivery systems, with rapid dissemination for use by interested AID Missions, developing countries, and other organizations; 5) provide concepts and experience in integrated health delivery systems to other donors, resource institutions and the private sector, and 6) coordinate AID's inputs with the support activities of developing countries and donor organizations.

At the end of this phase of the project it is expected that there will be a continuing need for AID to promote and support integrated health delivery systems through the provision of technical assistance, evaluation guidance, and dissemination of information, possibly by contribution to an international information and problem solving network.

D. Summary Findings

Technically, this project supports the design, development and evaluation of health, population and nutrition delivery systems which transfer existing health technology and/or information through organization patterns which permit such technology and information to reach the majority in locations where they live and at costs countries can afford without external subsidy. While it is not the major intent of this project to transfer new medical technology in the narrow sense, such transfer will be encouraged when it is supportive of the overall sector goals of improving the health status and thus

the quality of life in the population of developing nations.

The severe resource constraints facing the poor nations imply the need for delivery systems which, in the poorest countries, may be limited in cost and target population. As an initial hypothesis, the most vulnerable among the poor, i.e., women of reproductive age and children under five years of age, should have access at least to information on contraception, infant feeding, weaning, maternal care and elementary sanitation. It is assumed further than the system, in order to operate at costs affordable by the developing nations, will require maximal mobilization of existing practitioners and volunteers whose participation does not require significant supplementation from the public sector.

The impact upon the physical environment will be beneficial to the extent that the delivery system is successful in disseminating information which is beneficial in improving environmental sanitation.

Funding for the project is in accordance with experience of the past three years and upon demand projections by the Regional Bureaus for technical assistance.

The intended beneficiaries of the project are women of child bearing age and children under five years of age. Health services to be provided by the project are socially desirable and acceptable. Based on experience, there should be no significant resistance to the intention of the project, although there may be initial resistance to methods for implementation of majority coverage on the part of small but often politically important vested interest groups of medical and health providers who may view volunteers and mid-level health personnel as competitors. Experience has shown this resistance can be minimized and channeled into supportive activities. The enhanced role of women, both as a beneficiary and as a provider of services, is a major feature

of this program.

From an economic standpoint, the project is designed to assist developing nations deliver better health, family planning and nutrition services at a lower per unit cost, thus enabling existing resources to cover a larger portion of the poor populations.

E. Project Issues

The DEIDS Project was reviewed on August 14, 1975. The PAR Committee recommended that the supervision and monitoring elements of the Thailand sub-project be split out from this project and be incorporated in a separate project paper. The interregional nature of the project, staff limitations of USOM Thailand, and the phase down of bilateral concessional assistance in Thailand argue against the project being redesigned as a bilateral project. The benefits of a separated Thai project are conjectural. The supervisory and evaluation components of the Thai sub-project are so essentially inter-related to evaluation, promotion and other components under this project that after consideration, TA/H has recommended against making the Thai sub-project a separate, centrally funded project. An additional consideration which mitigates against a change in midstream is the fact that the agreement for the sub-project between the APHA and the Royal Thai Government (including University of Hawaii as an APHA subcontractor), was painstakingly negotiated barely eighteen months ago. A change at this point requiring project renegotiation with a new government in Thailand could do severe, if not fatal, injury to the sub-project.

PART II - Background and Detailed Description

A. Background

In 1970, AID identified the lack of health delivery systems capable of reaching national population majorities as a key constraint to development of the poor countries of the world. Absence of a system precluded reaching majority populations required to achieve national family planning, nutrition and basic health goals. Existing systems in the developing nations are molded on inappropriate western models and failed to provide basic services to more than 10-15 percent of LDC populations on the average.

In 1971, the Agency approved the DEIDS (Development and Evaluation of Integrated Delivery Systems) project for a period of 10 years (to 1981) to test the feasibility of the concept that access to majority populations could be achieved through multi-purpose health delivery systems at a cost acceptable to the country, and without a highly developed fixed infrastructure. This concept was to be tested in a demonstration project in each of AID's four geographic regions.

Because of the small number of AID health personnel and the need to have continuity in a rapidly expanding field, the American Public Health Association (APHA), with access to more than 25,000 members, was contracted to explore with LDCs their interest in developing demonstration projects in populations of 500,000 or more. The project would assist government in finding ways to deliver maternal and child health, family planning and nutrition services to the majority of women of child bearing age and children under five years at a cost acceptable to the country within its own resources. If successful, the pilot project would be nationally replicated, and wide dissemination of experience would be achieved through reports and international conferences for use in other countries.

Phase I of the project constituted a review of past and present experience, a visit to twelve interested countries, and recommendations for selection of four countries for pilot projects.

Phase II of the project involved the selection of up to four subcontractors for development and refinement of field projects in cooperation with LDCs.

Phase III of the project called for implementation of sub-projects by subcontracts.

The conditions of approval of the original PROP stated "The project is approved in principle and Phase I and II are approved for implementation. When detailed planning has been completed for the first pilot field activity, the Administrator's review and approval will be required for implementation of the balance of the project, as described in a revised PROP based upon and supported by the initial pilot proposal. Each subsequent field activity will be subject to review and approval by AA/TA, with the concurrence of the particular Regional Bureau concerned." The life of the project was 10 years, with FY '81 being the terminal year.

PROP revision number 1, dated September, 1973, authorized APHA to provide technical assistance by core or consultant staff to Missions and developing countries in addition to the four sub-projects; to subcontract special studies required for project development; and to undertake direct project implementation, i.e., Phase III DEIDS. No additional funding was provided.

PROP revision number 2, dated June 19, 1974, authorized a 5 year implementation of the Thailand sub-project for a total of \$2,617,000. The PROP additionally specified that "additional sub-projects under this DEIDS project will require the approval of the Deputy Administrator."

PROP revision number 3, dated 9-14-74, authorized a 5 year implementation of the Ecuador sub-project for a total of \$2,652,000.

This PP (Revision number 4) cancels pilot sub-projects other than in Thailand. This cancellation includes the Ecuador project, approved in Revision 3, as negotiations for implementation were not successfully concluded between the AID/Quito Mission and the Government of Ecuador (GOE) by December 31, 1975, a date beyond which AID had informed the GOE it was no longer willing to negotiate. This revision also continues the intermediate APHA management (but not funding) of the Thailand sub-project; continues the provision of technical assistance to the Regional Bureaus and Missions for determining feasibility, designing and evaluating integrated health delivery systems or elements thereof; provides for the completion of a State of the Art Survey; provides for the development of evaluation guidelines for integrated delivery systems; emphasizes information collection, analysis and dissemination through the development of an information management system; and continues to promote the concepts of integrated health delivery systems to other donors, resource institutions, developing countries, and private and voluntary organizations.

Under the terms of a contract implemented March 3, 1972, APHA has provided the technical assistance and guidance specified in the DEIDS project design. The accomplishments of this assistance may be summarized as follows:

1. Literature Search

Through a subcontract with the Biological Sciences Communication Project of George Washington University, a systematic and thorough review was conducted of the existing literature of existing experience with integrated or low cost health delivery. These bibliographies were and are used by APHA as a source of information of conditions in specific countries related to health delivery systems.

2. Phase I Reconnaissance Visits

In response to Regional Bureau, AID Mission and LDC initiative, reconnaissance surveys to determine the feasibility of attempting to develop a DEIDS pilot sub-project were completed in twelve countries: Pakistan, Panama, Ecuador, Nicaragua, Honduras, Paraguay, Thailand, Korea, Philippines, Nigeria, Niger and Zaire.

The typical reconnaissance team was comprised of four team members drawn from APHA staff and consultants with expertise in specific areas related to low cost or integrated health delivery systems. Survey reports contain an overview covering the country's internal geography, political systems, demographic data, economic base, educational level, religious customs and civil/legal traditions. The main focus of each report is an analysis of the existing health delivery systems in terms of its major components. Analysis of these inter-relationships, strengths and weaknesses and their potential contribution led to recommendations for future DEIDS or other low cost health delivery system (LCHDS) projects.

3. Phase II In-depth Planning and Surveys for DEIDS Sub-projects

Phase II planning proceeded in those countries considered to offer the best possibility of success for project field work: Pakistan, Ecuador, Thailand and Panama. Subsequently, the Pakistan and Panama programs were reoriented toward altered programs emphasizing specialized aspects of health delivery and were not selected for DEIDS sub-projects. Detailed plans were developed for projects in Thailand and Ecuador, and the Agency approved implementation of prototype projects in both countries. The Thailand project was initiated in November, 1974. Negotiations between USAID/Ecuador and the Ecuadorean Government did not result in implementation, and that project was cancelled.

4. Phase III, Implementation of Field Test Projects

The Thailand sub-project was formally initiated in late 1974. The 200 page plan is largely a Thai product, designed under technical guidance of the University of Hawaii, subcontractor to the APHA. Details were formulated by a Working Group and Steering Committee in the Ministry of Public Health with the participation of working groups from Lampang Province where the pilot demonstration and field testing are now occurring.

Integrated services will utilize the health and family planning infrastructure which is, in part, already in place. In Lampang Province the DEIDS project will continue to further family planning activities so that the momentum and the pace of existing programs will not diminish. One innovation has been to train in every village a Health Post Volunteer who can serve as a local source of contraceptive resupply, the first time that local resupply has been legally available from non-professionals outside the government health system. These efforts will be supplemented as the project proceeds so that nutritional and family planning will receive prominent attention. In addition the Health Post Volunteers (HPV) have been trained in basic first aid, and in the treatment of simple symptoms. He/she provides safe, simple medications at slightly above the government-subsidized price. They are trained in simple sanitation measures. The HPV are supervised by junior health workers and auxiliary midwives from the Ministry of Public Health, and they in turn supervise communicators. The latter are two-way communication links between the community (one communicator to approximately ten households) and the official health system. They deliver health, family planning, nutrition and referral advice, and are not financially compensated.

The Ministry of Public Health provides services through its hospital-

health center complex which reaches to the level of the villages. The majority of the people, when ill, however, seek help from the private sector which includes resources such as drug stores, traditional doctors, and midwives and monks. Poor utilization of the existing health center complex has been due to fragmented facilities and the scarcity of competent midlevel manpower. To address this situation and the very low doctor/population ratio (1:25,000) the organization of the health and medical services have been streamlined to be more responsive to the needs of the people. The project is geared to create trained, non-physician personnel in addition to lay health promoters and communicators such as monks and village headmen. Programs for extensive training in seven categories of instruction have been designed. These categories and trainee outputs are: cross training for Ministry of Public Health personnel, 616; Medex 85; volunteer health post workers, 540; communicators to provide information between the consumers and providers of health services, 5,400; midwives, 600; and intern training of medical graduates, 30.

The Thailand sub-project design includes considerable attention to program evaluation. A specific Thai task group is identified to inventory and analyze the existing health services, costs, and the utilization of such resources. Information will be gathered in order to assess, evaluate and replan project goal path and strategy, by measuring change in coverage, utilization, service cost, changes in health status, contraceptive usage, birth rates, and nutritional status, from which judgements can be made for replication. Comparisons will be run against conditions in neighboring provinces and districts as controls.

Annual review to assess progress, problems, lessons learned, and systems costs, are held in order to recommend adjustments to the system as may be necessary. The first review was held in November, 1975. The administrative,

service and training components of the project generally were found to be proceeding very well. While the evaluation plan is not fully developed, with changes now being adopted, data will be of sufficient quantity and quality to allow the evaluation component to fulfill project needs.

5. Special Consultation and Other Services

By authority of a PROP amendment approved October 1973, APHA was tasked to provide personnel to AID Missions and Regional Bureaus for both long and short-term assignments on specialized aspects of low-cost health delivery systems or national health planning. APHA work in this area may include such elements as project design and development, evaluation, or the hosting of symposia, conferences or workshops. Under this arrangement, and in addition to the Phase I and II activities listed earlier, personnel have been funded to participate in health sector assessments in Nicaragua, Bolivia and Panama; WHO country health programming exercises in Thailand and Chad; project feasibility studies in the Central African Republic, Indonesia, Zaire, Laos, Cambodia, Egypt, Syria and Korea; project development (often requiring multiple visits) in Korea, Swaziland, Nicaragua, Cameroon, Morocco, Nigeria, Honduras, Dominican Republic, Senegal, Lesotho, Central African Republic, Guatemala, Mali, Bolivia; and evaluation in Liberia, Guatemala, Thailand and Nepal.

In addition to the above centrally funded consultations, a Basic Ordering Agreement which is included as a part of the project offers Missions a channel of access to expertise using Mission funds.

PHA has issued preliminary planning guidelines on maternal and child health, and for evaluation of DEIDS projects. A descriptive report of 48 health delivery projects was issued in March of 1974 for discussion purposes in a State-of-the-Art survey. This survey, now in progress, will identify over a thousand projects worldwide, analyze patterns and trends of several hundred with most innovative features, analyze and publish an in-depth study

of 6-10 of them with lessons learned which most affect replicability elsewhere.

APHA has responded to requests for special reports, such as a MEDLARS search of paramedic training programs and minority group involvement in low cost health delivery.

The project has funded attendance and participation at conferences of the National Council of International Health, the American Public Health Association, the DEIDS Thailand Review and the World Population Conference. APHA has jointly sponsored a well attended Voluntary and Private Sector Strategy Conference on International Health.

Other promotive and coordination activities have been participation in the conference of ministers responsible for health in the English speaking Caribbean, conferences with the World Health Organization and Christian Medical Commission in Geneva, Consultation with the International Development and Research Centre in Canada and the International Bank of Reconstruction and Development, and seminars with students of international health at the University of Illinois, University of Oregon Medical School, and Columbia University.

In evaluation, APHA convened a group of representatives from universities involved in integrated health delivery to review the American Institute of Research report, and participated in a joint APHA-AID task force on the DEIDS Thailand evaluation plan as well as providing technical assistance to Missions mentioned earlier.

APHA has arranged briefings and debriefings with consultants at the request of the Regional Bureaus, and upon request, has contributed to Agency meetings for project development and review.

Since the original DEIDS PROP was signed and the '73 Congressional mandate issued, a number of significant events make it appropriate to review

and revise the project.

- 1) Agency response to the concepts of low cost integrated health delivery has overtaken the original plan of the DEIDS PROP. In 1973 there were about seven AID-assisted projects related to these systems. By FY 75 the number had increased to 16 and by FY 77, approximately 21 are anticipated.* It no longer appears necessary to centrally fund four demonstration projects if experience gained in other health delivery projects can be collected, analyzed and widely disseminated.
- 2) Governments of developing nations have demonstrated interest in the concepts of low cost health systems on an unexpected scale.
- 3) Donor and international agencies are becoming increasingly interested. This is particularly true of WHO. In the May, 1975 World Health Assembly, a resolution was passed which strongly supported the concepts of primary health care (their term equivalent to integrated or low cost delivery which provides majority coverage). Coordination with these groups must be increased if duplications of effort are to be minimized and if implementation of the concepts of low cost delivery is to be accelerated.
- 4) Since there now will be but one DEIDS pilot project, and there are a large number of Regional Bureau projects being developed, it has been suggested that APHA and AID identify Regional Bureau sponsored projects which are most similar in objectives to the DEIDS Thailand sub-project, and analyze the various approaches used to obtain specific results. This would achieve the evaluation intent of the original project, and would

*For a list of projects, see Annex D. .

assist in the development of evaluation guidelines for integrated delivery systems. While the guidelines are being developed, APHA core and contract staff represents a competent resource prepared to respond to Regional Bureau requests for assistance in evaluation design.

B. Detailed Description:

1. Goal Towards Which Project is Addressed

a. Statement of Sector Goal

To improve the health status and thus the quality of human life of the populations of developing nations through assistance in health planning, integrated health delivery services and improvements in the environment.

b. Measurement of Goal Achievement

- 1) Increase in age specific life expectancy.
- 2) Decrease in age specific mortality rates - particularly in children under five.
- 3) Reduction in age/parity specific birth rate verified by WHO and LDC statistics.

c. Basic Assumption

- 1) That LDCs are interested in improving the health status of their populations.
- 2) That assistance in the health sub-sectors listed will be acceptable to the LDCs.
- 3) That assistance in the health sector will improve health status.

2. Sub-sector Goal

a. Statement of the Sub-sector Goal

To make basic health services, particularly those related to MCH, nutrition and family planning available and accessible to the majority of LDC populations at affordable costs. The prime target is women of child bearing age and children under five.

b. Measures of Sub-sector Goal Achievement

- 1) A majority of target populations in assisted LDCs are aware of and utilize the developed health system. Verification can be done by surveys, project statistics, project evaluations and facility records.
- 2) The programs developed are affordable to the host country. Verification will be by the LDC evaluation and decision to retain, modify, or discard the system developed. Nationwide replication of major elements of the project would verify.

c. Basic Assumptions

- 1) That assisted LDCs will build into the system evaluation techniques which will be useful in making decisions as to design, implementation or replicability of project components.
- 2) That the target group is the appropriate intervention point.

3) That maternal and child health, family planning and nutrition services are the appropriate primary interventions to affect health status.

d. That countries will replicate AID assisted pilot projects in other regions of the country.

3. Project Purpose

a. Statement of Purpose

To support the Agency's capability to respond rapidly to requests for information, feasibility assessment, project design assistance and evaluation of systems to deliver combined health, population, and nutrition services to a national majority within the limits of national resources and to manage the testing of one means of delivering such services in an LDC.

b. Conditions Expected at the End of Project

By the end of three years, when this phase of the project is completed, the demonstration project in Thailand will have been implemented as described in the Thai subproject PROP or its amendments. Ongoing evaluation will have resulted in some elements of the model being replicated in other provinces in the country. Experience there will be in the process of analysis and wide distribution.

Technical assistance for promotion, planning, project design, operation and evaluation will have been provided to

the Agency, as desired, for planning, implementation, evaluation or improvement of up to 24-30 field projects, 21 of which will be in planning or in process by FY 77.

Guidelines for evaluation of health delivery systems derived in part from an analysis of evaluation elements in the Thailand and other AID assisted projects will assist LDCs in incorporating evaluation components in the planning state of project design. Development of common guidelines for evaluation will permit some degree of comparability of results of alternative approaches to similar objectives, and dissemination of lessons learned.

The Agency will have ^{established} a central point for collection and analysis of information pertaining to health delivery systems which will be supplied rapidly to requesting AID Missions, developing countries, donors, and other inquirers.

The concepts of integrated health delivery will be widely understood throughout the AID assisted countries, and support from donors, international agencies, resource institutions and private and voluntary organizations will be complementary and coordinated for the benefit of the recipient countries.

c. Basic Assumptions

- 1) The World Health Assembly resolution (May 1975) reflects a growing demand by developing countries for low cost

health delivery systems to provide basic health services to the majority of their populations.

- 2) U.S. legislative emphasis as expressed in the Foreign Assistance Act, and AID policy support will continue. The U.N. will continue to support expanded efforts in this field as expressed by the Secretary of State at the 7th Special Session of the U.S. General Assembly.
- 3) That evaluation guidelines can be developed which are sufficiently comprehensive to be useful in a wide variety of project situations.
- 4) That universities, LDCs, private and voluntary organizations, and other donors are willing to share their experiences (negative as well as positive).

4. Project Outputs

- a) As a result of the management of the Thailand sub project, and the results obtained, the hypothesis will continue being tested that majority population coverage for services in maternal child health, family planning and nutrition can be provided through an integrated health delivery system, at costs within the resources of developing countries.
- b) Assessment of project feasibility, project design, evaluation design and other improvements in health delivery systems provided to AID assisted countries. Technical assistance will be provided by APHA core staff, consultants and subcontractors.

- c) Guidelines for evaluation of local and national integrated delivery systems formulated and disseminated.

A publication, "Guidelines for Health Delivery System Evaluation" will be developed by members of the contractor staff and consultants selected to constitute an Evaluation Task Force. They will be based on review of both published and unpublished materials, consultant reports, and observation and assessment of ongoing evaluations. They will include discussion of benchmarks useful for determining the need for an integrated health delivery system and of alternative methodologies for evaluation of the delivery system. An illustrative "ideal" evaluation scheme for a theoretical integrated delivery system will be presented.

1) Proposed Users

The guidelines would be designed for the use of host country, AID, other donor and implementing agency officials at ministry and field levels in assessing need for programs from a health standpoint and for evaluating on-going programs for coverage, cost, impact and replicability.

2) Guideline Components

Guidelines would focus first on benchmarks that could be used to assess the needs for an integrated health delivery system and to assess program effectiveness in terms of population coverage, cost, impact and replicability. The

guidelines would stress the (1) identification of valid benchmarks or evaluation indicators, (2) cost factors of their use in terms of time, staffing and funding, (3) validity or sensitivity of the benchmark or indicator, and (4) the mechanisms by which evaluation data can be used for management purposes. Results in terms of usefulness, accuracy and problems associated with actual employment of various benchmarks or indicators will be incorporated in the discussion of each.

The emphasis throughout will be placed on developing measurements of percentage of population coverage, including utilization of services; deficiencies and efficiencies in management, supervision, and manpower use of the various approaches to provide specific health services; unit and per capita costs of services provided; and changes in health status resulting. The guidelines would include the methodology for measurement of changes in life expectancy, age specific morbidity and mortality rates, population growth rates and fertility rates over a period of years. Guidelines will also be provided for the measurement of short and intermediate indicators of health improvement reflecting behavior or attitudinal changes that can be expected eventually to result in improved health status. Such indicators include changes in quantitative and qualitative dietary intake, use of potable water, acceptance and prolongation of breast feeding, introduction of supplemental foods to infants at an earlier age,

utilization of contraceptives, spacing of children, prevalence of induced immunity, etc.

Another section of the guidelines will describe alternative techniques for evaluation of similar objectives. To develop this portion of the guidelines, the contractor will be given access to evaluation plans and methodologies of three to four AID supported projects which have as their end of project objective the same general objective as the DEIDS Thailand project, i.e., development of a health delivery system which provides integrated health, family planning and nutrition services to a majority of a targeted population at costs affordable by the host nation, and which can be replicated without external assistance. Evaluation techniques from these will be jointly analyzed by the contractor and the project representatives, and the strength and advantages of the evaluation aspects of each project presented for possible use elsewhere.

As a final part of the guidelines, an ideal evaluation schema for a theoretical integrated health delivery system will be developed to demonstrate:

- a) Appropriate use of single indicators and combinations of indicators to assess program effectiveness.
- b) Proper sequencing of actions to achieve the most useful and cost-effective evaluation.
- c) Methods of rapid feedback of evaluation data for management purposes.

3) Format

An outline of important benchmarks or indicators to be studied in the guidelines and considerations to be discussed with reference to their use follows, but final format of the guidelines will be determined by the Evaluation Task Force and presented for AID approval within three months of contract signature. During this same 3-month interval, AID and the contractor will jointly identify projects and mechanisms for contractor access to evaluation methodologies. The entire study, culminating in publication of the guidelines, is expected to require approximately three years, but an initial report will be submitted to AID one year after the study format is approved. The initial report will cover aspects of the study listed on the attached format and will include a visual presentation of appropriate indicators and considerations affecting their use for evaluation of specified objectives. The final publication will include further refinement of the guidelines, including presentation of the comparative methodologies and the "ideal" schema.

4) Technical Assistance in Evaluation

Under other parts of the contract, the contractor will continue to provide AID and host countries an evaluation capability and technical assistance in developing such capability when requested to do so. Results deriving from this assistance will be incorporated into the guidelines as will be information on evaluation garnered from the State-of-the-Art activity and the proposed health systems information exchange.

DRAFT GUIDELINE FORMAT

I. Assessment of Needs

Indicator/Benchmark	Sources of Data/ Method of Collection	Value	Costs
Age-Specific Mortality Rates			
Cause Specific Mortality Rates			
Age-Specific Morbidity Rates			
Infant Mortality Rates			
Fertility Status			
Nutritional Status in Children			
	Workers		
	Reproductive Age Women		

II. Assessment of Program Effectiveness on the Basis of Stated Program Objectives

A. Health Status

Objective	Indicator/Source of Data	Method of Collection	Cost	Indicator of Change	Adv./ Disadv.	Use to Mgt.
	Intermed. Indicator	Source of Data/ Method of Col- lection (base- line/follow-up)	Cost		Adv./ Disadv.	Link to primary objective

B. Program Coverage (including accessibility and acceptability)

Objective	Definition	Method of Verification of Baseline Status/of Change	Costs	Problems	Use by Mgt.
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C. Program Cost

Objective	Method of Assessing Baseline Status Method of Assessing Change	Feedback mechanism to management
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D. Replicability

Definition of criteria	Method of verification
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Considerations listed will be discussed with reference to a number of objectives and indicators.

- d) A State-of-the-Art analysis involving identification of the most significant and innovative LCHDS or elements of health delivery systems in operation, with a published analysis of patterns or trends in low cost health delivery. Data from the State-of-the-Art will be compiled, analyzed and stored in a manner permitting ready retrievability for the use of interested LDCs, USAIDs and other agencies.

Cross-project comparisons will be made for designated elements of project such as the use of physician assistants, techniques of logistic support, supervision techniques and means and effectiveness of community support.

- e) An information management system established which provides for the Agency and assisted countries a central point for collection, analysis and dissemination of information useful for planning, managing, evaluating or improving integrated health delivery systems or the components thereof.

The development of categorical programs for the control of specific diseases, improvement of human nutrition and modification of fertility patterns has resulted in large numbers of specialty publications, including a variety of newsletters, monographs, journals, and related publications. Thus far, relatively little has been done to disseminate the rapidly accumulating experiences in the delivery of more comprehensive and diversified health services, including planning, budgeting, approaches to community involvement, health manpower training and utilization, the incorporation of the private sector in health delivery systems, research

and evaluation, and techniques for delivery of traditional and new health services to specified populations. As a result, successes and failures go unreported and the development process is inhibited. The few publications which are available are usually highly technical, research oriented, or deal with policy issues which are of little practical use to field workers. Furthermore, the sophisticated topics and levels of writing make it extremely difficult for health education or media units in developing countries to translate and disseminate information to field workers who need to be kept informed of current developments in the delivery of health services. This activity will support AID in the publication of monographs and quarterly issues of an 8-page newsletter, which might be entitled, "The Interchange - An International Health Systems Information Exchange."

The newsletter publication would be distributed to approximately 5,000 addresses with a total of 7,000 copies of an English edition, 2,000 copies of a Spanish edition and 1,000 copies of a French edition being printed for each issue. Approximately 50% of each printing will be sent to field-level health workers, with the remainder to be distributed to individuals and institutions as listed below.

- 1) The nature of the products to be produced will be:
 - a. A digest of worldwide activities relating to the delivery of low-cost health services in less developed countries. Each issue of the newsletter will contain (1) brief reviews of important project-related developments; (2) a feature article on a project of special interest; (3) a feature article reviewing activities in selected

topical areas such as health manpower utilization or evaluation;
(4) descriptions of important publications or coming events,
and a question and answer section. Photographic coverage of
activities will be included.

- b. Monographs which will respond to needs for more detailed information on topics identified by AID and field inquiries from recipients of the newsletter. Topics selected will be approved by AID.

2) The sources of information will include:

- a. Information from AID supported field projects, including shared projects reports, communications with Missions, debriefings and other available information.
- b. Information collected during the State-of-the-Art survey, communications with other donors, international organizations, private and voluntary organizations, project managers, consultant reports.
- c. Published data related to integrated delivery, available through TA/PPU/EUI, TA/N, PHA/POP, National Library of Medicine, WHO, IDRC and other sources.

3) The analysis of the above data will include:

- a. Brief summaries of pertinent literature and reports;
- b. Comprehensive reviews of selected project reports and evaluations;
- c. Synthesis of information on topical issues and activities and the development of feature articles:

- d. Collection and publication of photographic and other illustrated materials;
 - e. Computerized sortage of coded information covering selected variables to permit rapid location of more detailed information, i.e., projects with important manpower utilization components.
- 4) The audiences for whom this periodical is intended are:
- a. AID Missions and LDC personnel working in the field on projects designed to bring low-cost primary health services to low-income populations;
 - b. Public health officials from governmental and non-official agencies in LDCs who are interested or involved in the support of the delivery of integrated health services to majority populations;
 - c. Representatives of bilateral and multi-lateral agencies which support the above-mentioned activities;
 - d. Major training institutions in LDCs which are responsible for the training of field workers;
 - e. Selected health training institutions and health data centers in the U.S.

It is intended that the publication be of the greatest practical use of field workers rather than be aimed primarily towards high policy-level officials, researchers or academicians.

It is the intent of this project to establish the value of the newsletter, and to attract other support for its continuation. The format will be such that it will not be viewed as serving AID or the contractor's purposes primarily, but in fact as responding to the needs of all countries and organizations with interests in low cost integrated delivery. During this phase of the project, external sponsorship of the newsletter will be explored. Possibilities for exploration include regional public health associations, the World Health Organization, and the World Federation of Public Health Associations. The latter organization headquartered in Geneva, currently represents 24 country public health associations, and enjoys Non-Governmental-Organization (NGO) status with WHO. The Executive Secretary of the organization is an APHA member from the United States.

Based on our present knowledge of the number of projects, agencies, institutions and related potential recipients, the following distribution pattern is envisioned:

<u>Type of Recipient</u>	<u>Number of Recipients</u>	<u>No. Copies</u>
1. Field workers	2,500	5,000
2. Supportive levels in LDCs	1,000	2,000
3. Selected agency representatives	500	1,000
4. Training institutions	500	1,000
5. Others	<u>500</u>	<u>1,000</u>
	5,000	10,000

Lists of appropriate recipients will come from records developed over the years and in the conduct of the State-of-the-Art Study, AID lists maintained by TA/PPU/EUI, TA/N and the Office of Population, as well as such recent publications of EDRC, WED and the bibliography of "The Training of Auxiliaries in Health Care" published by Intermediate Technology Publications in London. George Washington University maintains a coded list of some 35,000 addresses of individuals and institutions interested in family planning. A number of these addresses would be incorporated into the "Interchange" mailing list.

- f. Active promotion of the concepts of integrated health delivery by conferences, seminars, workshops, and direct communication will result in donor agencies, resource institutions and private voluntary organizations increasing and coordinating their support to integrated health delivery activities in developing nations.

This will require frequent meetings and communication with appropriate groups, and convening conferences, workshops and seminars, regional or international in scope, related to integrated health delivery.

Additionally, participation from LDC nations in conferences, seminars and workshops, such as at WHO meetings, annual meetings of the National Council of International Health, appropriate APHA and other international meetings will be supported.

These outputs will be verified by reports of USAIDs and LDCs which reflect the quality of services provided by the contractor, by evaluations of projects, by project documentations, and reports by contractor, subcontractors, consultants, and by conference reports.

5. Magnitude of Outputs

- a. 27 man months of core and consultant manpower for management of the Thai sub project. This includes negotiations with the RTG and the subcontractor, supervision of field activities, project modifications as appropriate as a result of evaluation, completion of the evaluation plan, and joint conduct of annual reviews.
- b. Technical assistance to AID missions and developing countries 195 mm.
- c. Guidelines for evaluation. Three to four Regional Bureau or Mission sponsored projects which are most likely to contribute useful information and comparability with the DEIDS Thailand project identified, with evaluation components shared with the contractor and a descriptive analysis incorporated into guidelines for the evaluation of local and national delivery systems which are published and distributed to all AID Missions, AID assisted countries and requesting organizations. 300 copies.

d. State-of-the-Art survey.

From a survey of worldwide experience, correspondence and personal communications, a completed inventory of 1,000 systems or components thereof with a summary report which analyzes and describes patterns of delivery systems prepared three months after project begins, including successful and unsuccessful innovations. Detailed files of 100-200 projects or systems which attempt particularly innovative features, with minimal computerization of major characteristics. A descriptive report will be made of 30 such systems, and the accumulated information will permit special analysis on request of LDCs, USAIDs or other interested organizations.

In depth case studies on 6-10 of the above published within 24 months after start of project.

e. Information management system.

Newsletter on integrated health delivery systems and components produced and distributed within three months of project implementation, and quarterly thereafter. Two monographs annually.

Information exchange channels regarding interest in and contributions to integrated health delivery established with at least ten international donors, ten universities, ten private and voluntary organizations (including corporate interests) and to LDCs. Accomplished six months after start of project.

While the above participants will benefit from shared experience and information exchange, as well as receiving the various analyses

prepared by collaborating donors and the information center staff, it is the AID-assisted countries which will be the primary beneficiary of the information exchange. Health planners and policy makers would be regularly provided the published outputs of the centers. Additionally, each can request from the center specific information on any component of low cost health delivery which might have application in its country.

- f. Work plan for conferences prepared within three months of project initiation. Conference for establishment of international information management and exchange network convened within nine months. At least one conference, workshop or seminar convened annually, and LDC participation supported in at least three annual conferences, seminars or workshops related to integrated delivery sponsored by other agencies or donors. Promotion and coordination through channels identified in (e) above.

6. Project Inputs

a. AID:

- 1) Project monitoring - TA/H
- 2) For contract services - \$3,371,000
- 3) Provide access by contractor to AID projects to identify those projects most similar to the Thailand DEIDS subproject for analysis of evaluation methodologies and information exchange system.

b. Contractor:

- 1) **Core staff** - The core staff is an inter-disciplinary group and individual members which will be assigned to a variety of program elements throughout each year.

The core staff should provide geographic expertise in health delivery. For each of AID's geographic regions, one core staff member should be expert in his knowledge of the geographic, economic, political, programmatic and social factors affecting health delivery within that region.

The principal professional core requirements are the following:

- (a) **Director** - Overall technical and administrative responsibility for the program; liaison with other donors, liaison with professional groups and universities, and medical backstopping for the project.
- (b) **Assistant for contract and special operations** - Responsible for contract and budgetary negotiations and management, management of consultants.
- (c) **Health Education and Community Organization Specialist.**
- (d) **Public health nursing and maternal child health specialist** with expertise concerning the role of women in health services delivery.
- (e) **Evaluation specialist** - Development of evaluation guidelines and analyses of evaluations.

- (f) Private and Voluntary Organization Coordinator -
Liaison with and coordination with corporate and voluntary resources interested in health delivery.
 - (g) Information Systems Specialist - Establish information exchange mechanisms; oversee collection, storage and retrievability; conference coordinator.
 - (h) Information Manager - Overall management, analysis and editing of State-of-the-Art and information exchange system.
 - (i) Support staff - for State-of-the-Art, information exchange
 - 1 reports-editorial assistant
 - 2 secretaries
 - for other professional staff
 - 1 admin. assistant
 - 3 secretaries
- 2) Consultants - Subcontracts - The contractor will provide the services of consultants and subcontractors to provide services not met by core staff relating to affordable health delivery systems to AID/W and Missions when requested by the project manager, and will use them as required in the State-of-the-Art and evaluation, and information exchange. See Budget.

Host Countries:

The inputs of Thailand in the demonstration project are included in the Thailand PROP. There are no additional direct host country inputs into this project except as LDCs make information available to the State-of-the-Art survey and the information management system, and share the results of evaluations.

PART III - Project Analysis

A. Technical Analysis, including Environmental Assessment

A premise of this project is that the technologies of the medical aspects of basic health services are widely known to medical practitioners and ministries of health worldwide. Responsible health officials in all developing countries, for instance, are aware that certain diseases are preventable by immunizations and other mechanisms; that many diseases are self limiting and require few if any interventions; that a wide variety of illnesses can be treated with relative safety with a few medications; that a variety of family planning mechanisms are available, that adequate maternal nutrition will result in increased fetal salvage, etc.

While knowledge of existing medical, family planning and nutrition technology is widely available, organizational methodology for translating these into better health for population majorities is not. The physician-oriented, clinically based model for health delivery has been deeply ingrained in the developed nations as well as in the developing nations, and is a costly and inefficient mechanism to provide majority coverage.

This project will attempt to incorporate technologies of planning, management of manpower, finances, and material, supervision and logistics, and delivery of preventive and curative services appropriate to the setting of the individual developing nations in order to reach the majority population. While recognizing that non-health system effects upon health status are considerable, this project concerns itself with modifications in the health systems. In general, it promotes emphasis upon service at the periphery by volunteer and minimally trained personnel,

with a pyramid of increasing medical and health sophistication as one ascends the referral chain.

Specific technologies will vary from country to country; the techniques used in one country to achieve an objective in any of the above areas may vary considerably from that used in another country to achieve the same general result.

While it is not the major intent of this project to encourage the transfer of new medical technology, such transfers will be encouraged when supportive of the overall sector goal of improving the health status and thus the quality of human life in the populations of developing nations.

There is no standard of the level of technology applicable for any specific country; each projected input must be carefully tailored for the environment in which it will be used. An example; whereas it might not be technically feasible to depend on x-ray diagnosis of tuberculosis in Indonesia, health and medical communications and education networks might be technically feasible using earth satellite relays. A country may not be able to absorb the cost of widespread use of disposable syringes and needles, yet could find profitable use for much more highly sophisticated Ped-o-jet injectors for immunization campaigns. Information gathering at the end user point may be by necessity very simple, and may consist of simply completing a limited check-list, yet at the other end of the information chain use of computers may be appropriate.

The effects of the project on employment will be minimal at least and moderate at best. Emphasis in the project is placed on host country's better use of resources available to them. Greater community participation

is encouraged more through the incorporation of volunteers and the private sector into the delivery system than through government employment. There will be in some countries increased numbers of middle and lower level paraprofessionals governmentally employed; therefore the overall expected effects of the project on the job market, while likely marginal, will be for greater employment.

Effects upon the physical environmental resulting from technical assistance in this project will be slight but very largely favorable to the extent that environmental sanitation prevents fecal pollution of soil and water. Construction of facilities where necessary should be simple, with adequate provision of potable water and safe waste disposal. Disease prevention and environmental sanitation measures to be encouraged in generated projects will include those aimed at providing potable water, liquid and solid waste disposal, vector-borne disease control, and garbage disposal and will result in an improvement of the environment rather than a deterioration.

Project design, through demonstration, technical assistance and information generation, analysis and exchange is appropriate to the Agency's needs in the health delivery area. In addition to AID's involvement, the project seeks to identify interest of other donors and to work collaboratively with them.

B. Financial Analysis and Plan

The outputs for which funding is herein provided, are those which have been identified by a PAR review to be desirable by the Agency, and are fully supportive of the intent of AID legislation.

SUMMARY BUDGET

<u>Personnel</u>	<u>Salary</u>	<u>Benefits @ 27%</u>	<u>Year 01 1/</u>	<u>Year 02 1/</u>	<u>Year 03 1/</u>
DEIDS Director	37,500	10,125	47,625	49,054	50,525
Contract & Special Projects	26,903	7,264	34,167	35,192	36,248
Community Health & Health Ed.	33,371	9,010	42,381	43,652	44,962
MCH & PHN (Role of women)	26,903	7,264	37,167	35,192	36,248
Evaluation Specialist	26,903	7,264	37,167	35,192	36,248
PVO Specialist	27,771	7,498	35,269	36,327	37,417
Information Systems Specialist	24,795	6,695	31,490	32,435	33,408
Information Managers	15,366	4,149	19,515	20,100	20,703
Reports/Editorial Assistants	13,095	3,536	16,631	17,130	17,644
Administrative Assistants	14,639	3,953	18,592	19,150	19,725
Secretary	10,311	2,784	13,095	13,488	13,893
Secretary	12,576	3,396	15,972	16,451	16,945
Secretary	9,665	2,610	12,275	12,643	13,022
Secretary	10,634	2,871	13,505	13,910	14,327
Secretary	10,311	2,784	13,095	13,488	13,893
			381,946	393,404	405,208

SUMMARY BUDGET

	<u>Year</u> <u>01</u>	<u>Year</u> <u>02</u>	<u>Year</u> <u>03</u>
PERSONNEL			
Salary	300,743	309,765	319,059
Benefits	81,203	83,639	86,149
	<hr/>	<hr/>	<hr/>
CONSULTANTS			
1150 days @ \$125/day	143,750	145,000	130,000
	<hr/>	<hr/>	<hr/>
TRAVEL & PER DIEM			
International:			
30 trips @ 1080	32,400		
58 trips @ 1500	8,700		
6 trips @ 1750	10,500		
1 trips @ 2200	2,200		
Per Diem 1325 days			
@ approx. \$40			
	132,000	122,400	114,900
	<hr/>	<hr/>	<hr/>
	53,000	50,200	47,400
	<hr/>	<hr/>	<hr/>
Domestic:			
38 trips @ 350	13,300	12,960	8,540
Per Diem 303 days @ \$35	10,605	10,675	7,700
	<hr/>	<hr/>	<hr/>
OTHER DIRECT COSTS			
Rent 2557. 1 sq. ft. x \$60/mo.	18,500	20,250	22,275
Telephone/Telegraph	8,000	8,100	8,200
Postage	10,000	10,000	10,000
Printing	15,000	12,000	12,000
Supplies	8,700	8,000	7,500
Contract Services (Computer usage)	10,000	10,000	10,000
Magazines/Journals	3,500	3,500	3,500
Special evaluation activities		25,000	
	<hr/>	<hr/>	<hr/>
Overhead	73,700	96,850	73,475
SUB-TOTAL	229,167	236,042	243,124
Continquency/Inflation: 7 1/2%	1,037,568	1,067,531	1,030,347
	72,817	80,065	77,276
	<hr/>	<hr/>	<hr/>
TOTAL	1,115,385	1,146,596	1,107,623

ESTIMATED COSTS OF OUTPUTS - YEAR Q1

Output Elements	Core Staff				Travel				Other		Prorated Total	Percentage			
	Professional Support Group		Support Group		International		Domestic		Direct Costs	Overhead					
	MM	\$	MM	\$	MD	\$	Per diem	Trans.					Per diem	Trans.	Prorated
1. Management of Thailand DEIDS Project															
a. General supervision	6	18,486	3	3909			2,000	5250	875	1700	3672	12,150	48,042	4.66	
b. Annual review	2	6,162	1	1303	30	3750	1,200	1750	175	350	1224	4,050	19,964	1.94	
2. Technical Assistance to AID sponsored programs															
a. Sector analysis and feasibility studies	4	12,324	1	1303	200	25,000	8,000	18,000			2040	6,750	73,417	7.13	
b. Planning questions	8	24,648	2	2606	360	45,000	14,400	30,000			4080	13,500	134,234	13.02	
c. Operations questions	9	27,729	2	2606	100	12,500	4,000	7,500			4488	14,850	73,673	7.15	
d. Evaluation	16	49,296	3	3909	160	20,000	6,400	13,500			7752	25,650	126,507	12.28	
3. Evaluation guidelines															
a. Format/design															
b. Literature search															
c. Analysis and publication	18	55,458	24	31272	60	7,500			2275	3400	17,136	56,700	173,741	16.86	
4. State-of-the-Art															
5. Information exchange															
a. Respond to field requests	3	9,243								350	350	1,224	4,050	15,217	1.48
b. Newsletter and center activities	20	61,603	30	39087	45	5,625	1,800	3,500		1050	1020	20,435	67,624	201,744	19.58
c. Monographs	2	6,162	12	15636	60	7,500				1400	700	5,712	18,900	56,010	5.44
6. Promotion															
a. Conferences	4	12,324	3	3909	25	3,125	8,400	32,400			2,856	9,450	72,464	7.03	
b. Communication links	4	12,324	3	3909			1,200	3,000	1575	1020	2,856	9,450	35,334	3.43	
7. Special Evaluation Activity															
							47,400	114,900	7700	8540					
SUBTOTALS	96	295,759	84	109,449	1040	130,000			178,540		73,675	243,124			
												1,030,347		100%	
												27,276			
												1,107,623			

Contingency/Inflation 7% X
Total

Cost estimates are of varying precision. Funds allocated to the provision of technical services are based on utilization factors of three years' experience and anticipated requirements for future assistance as projected by Regional Bureaus. It is anticipated that as initial requests for feasibility assessment and project design diminish, requests for assistance in evaluation will increase. Changing demand would influence these costs; our best estimate is no more than 15% in either direction.

Costing of the development of evaluation guidelines is ^arough approximation, as are the other estimates. While some elements can be rather carefully costed (i.e., the State-of-the-Art), other elements depend on the degree of participation and/or interest by other professional groups, donor agencies, universities, private and voluntary organizations, and at this point can be costed only approximately.

In summary, the funding to produce the desired outputs, while appearing relatively firm for the first twelve months, will require annual review.

C. Social Analysis

The intent of this project is to improve the health status of target populations of the poor majority particularly of women of childbearing age and children under five, who are the intended beneficiaries of the project, by providing minimal health, family planning and nutrition services to those not now receiving them. This target group represents a major human resource and is the group most vulnerable to preventable morbidity and mortality, unchecked fertility, inadequate food supplies and poor nutrition practices.

The demand for health services varies widely around the world. When asked to express felt needs, people in some primitive societies may not even list the provision of health services as a felt need, yet every society has developed a source for provision of such services, through traditional practitioners, exorcists, shamans, wizards, herbalists or some other intermediary.

People in the developing world increasingly view access to health services based on "scientific" as opposed to "magical" principles as a desirable thing, and in some societies view services as a universal right. To be responsive, health systems must be developed in accord with the sociocultural environment of each society. Acceptance of health practices which developing societies view as innovative occurs rapidly in crisis situations such as cholera epidemics, but at a much slower pace in non-crisis situations. Education and demonstration are the methods used to gain acceptance over time. That values and motivations regarding modern health services are amenable to change is demonstrated by a nearly universal trend of increasing demand for such services where they are available. To our knowledge, there is no country where the trend is contrary; that is, no country with a diminishing demand for modern services where they are freely available. The rate of acceptance of service varies by category; curative services are more readily accepted than preventive, yet there have been remarkable successes even in preventive services - such as in yellow fever, malaria and smallpox programs.

There should be little resistance on any front to the intent of the project. While the social benefit will impact largely on the poor, the

social burden on the more affluent will be minimal. Two widely divergent groups of providers will likely resist the method of implementation on the ground of professionalism, threat of status challenge, and financial self-gain. These groups are the scientific providers (M.D.s, RNs) on the one hand, and the traditional practitioners (midwives, injectionists, shamans) on the other. Experience to date has shown that a combination of education, demonstration and enlightened nationalism with strong political support can blunt this resistance, and indeed channel it into supportive channels.

The role of women as primary beneficiaries of the assistance provided by this project has been described. Her physical, mental and social well being will be enhanced if she is provided better health through maternal and child care, knowledge of and access to family planning opportunities, and improved nutritional status for herself and her children. Improved health status will free her to more actively participate not only in the economic sector, but also will enable her to be better able to participate in the delivery of health services. Village committees and volunteers will largely be drawn from the ranks of mothers who will be freed to more actively participate in community activities. Although women in many societies have been providers of limited health services, the project will encourage delegation of health and medical roles, traditionally performed by male professionals, to paraprofessionals and volunteers, largely women. With increasing participation of women in political, professional and social leadership roles, women will participate more equally with men as providers of care.

A blanket statement concerning the spread effects of this project is not possible to make. Technical assistance provided by this project will encourage project development of innovative health service delivery demonstrations which countries can replicate in whole or at least in part. It is clearly the intent that the innovative features selected for replication will be affordable to countries and will expand coverage to the population majority. Information exchange supported by the project will make innovations learned in one country rapidly available to others.

In summary: The primary beneficiaries of the project are women of childbearing age and children under five years of age. The services to be provided by the project are socially desirable and acceptable. There should be no significant resistance to the intention of the project, although there may be initial resistance to methods of implementation on the part of small but politically important vested interest groups of providers. Experience has shown this resistance can be minimized, and channelled into supportive activities. The role of women, both as a beneficiary and as a provider of services, is enhanced. The project encourages spread effect.

D. Economic Analysis:

When compared to the developed nations, the health status of the population of traditional and transitional societies in the developing nations is characterized by marked deficiencies which adversely affect the development process. Man's inefficiencies in reaching harmony with his environment in the developing countries are reflected by infant mortality rates comparable to those of developed nations a century ago,

by the expectation of living a decade less than his cohort in the developed nation, and by fertility rates which overtax the resources available to support resultant population gains.

The provision of health services* is one approach to improving health status, and is complementary to health status improvement fostered in the long run by increased functional literacy, more effective agricultural practices, increased family incomes and other non health-system factors which contribute to overall development.

Most authorities agree as few as 10% and not more than 30% of the populations in most developing countries, including the AID assisted countries, have regular, convenient access to health, population, or nutrition services based on scientific principles. The provision of such services is vital to improving the quality of human physical and social well being; these in turn are the desired end products of the development process. Increase in labor productivity permitted by improved health status of the labor force itself does not automatically yield such benefits; the fruits of increased productivity must be shared and translated into actionable programs in order to achieve social equity for deprived majorities of the populations of these nations.

Developing nations must consider funding for the provision of health, population and nutrition services in relationship to other aspects of their development, including economic development goals and the amounts of

*The term "health services" refers to those health, population and nutrition activities based upon scientifically derived principles as opposed to those practiced in many parts of the developing world based on magic, animism, the spirit world, etc.

resources, internal and external, available to develop and better manage effective health outreach systems.

The argument has been made that development in the social sectors is a natural and evolutionary result of economic development, and that the health of populations, along with other elements of social equity, will improve as per capita income increases. Over periods of generations this is perhaps true, but the poor majorities of the populations are the last to benefit. Even before the energy crisis accentuated the deficit balance of payments situation in most developing countries, economists, in the IBRD and AID anticipated less than 2% annual increase of per capita income, building from a very low pci base of about \$100 U.S. It is unrealistic to expect economic development in itself to markedly alter the health status of developing nations in the next decade.

The relationship of unchecked population growth to health status cannot be overlooked. Although the nations of the world are becoming increasingly aware of the need to take aggressive action to slow this threat, population programs under the most optimal circumstances will only slow the rate of increase for the next several decades. Although child spacing and lower fertility directly affect the health of the mother and child, the overall results from such programs over the next decade will not significantly alter the health status of the majorities.

When compared to amounts of private and public funds expended by the AID assisted nations, the funds provided by the donor community can have but minimal additive value. In AID assisted nations, for instance, estimated government health expenditures are \$3.5-\$7 billion annually and an additional \$5-10 billion are privately expended. Donor contri-

butions add only marginal augmentation.

It is clear, therefore, few additional significant resources are likely to be available in the next decade to enable the developing nations to markedly expand the costly medical-care based health delivery systems which exist today.

The developing nations must choose between continuing the general pattern of urban based, physician-oriented curative facilities at current or diminishing levels which reach small minorities of the population, or of finding alternative methods for the provision of health services to the majority populations.

This project proposes alternative methods of delivering maternal and child health, family planning and nutrition services to a majority of the population at costs consistent with existing resources. The economic analysis presented in this project paper is a cost effective analysis, i.e., it analyses the efficiency of the proposed program for delivering health services (an intermediate good) but does not attempt to compute the economic value of this intermediate good. One simple assumption is made in the following analysis, i.e., that health services delivered to populations currently not receiving health services have the same social value as those delivered to current recipients.

A. Cost of Low Cost Health Delivery Systems

Existing estimates would place the per capita costs of a low cost health system of the DEIDS type somewhere between \$2.00 and \$6.00. One small scale experiment in Guatemala operated at a per capita cost of

\$2.26¹ using the population served as the denominator.

The PROP for DEIDS Thailand estimated replication costs at \$1,002,267 for 500,000 people.² This yields a per capita cost of almost exactly \$2.00.

The Ecuador non-capita project paper estimated replication costs at \$862,000 for a population the size of Canar Province, 138,000.³ The per capita cost there would be \$6.25.

B. Cost of Existing Delivery System

WHO estimates of official expenditures for medical and health care in developing countries varies between 1-3% of the GNP. Per capita private expenditures in Thailand are estimated at \$7.50 per year.⁴ Total Thai government expenditures on health are placed at \$66 million, or a per capita expenditure of \$1.93. Total per capita costs would then come to \$9.43. The same source, however, also states public facilities serve only 17% of the population. This raises per capita public sector health expenditures to those served to \$11.37. In this case, the annual total cost would be \$18.87. Thailand provides an example of inequitable distribution of limited resources, which is common throughout the developing world.

In ^{the} Ecuador case, the cost per capita served by the current delivery system is probably about \$15.00 assuming that only 1/3 of rural population

1. J.P.Habicht, G. Guzman, J.M. Reyna-Barrios, "Outpatient Curative Medical Care Provided by a Paramedical Staff: Needs, Practicability and Quality Control", (Draft), p. 27.

2. DEIDS (Thailand Subproject) PROP (6/17/74), p. 30.

3. DEIDS Ecuador subproject noncapital project paper, p. A.4.

4. APHA, Proposal for Development & Evaluation of an Integrated Delivery System in Thailand "DEIDS", Washington, D.C. APHA (undated) p.4.

has access to public health system. Ecuador, like Thailand, manifests characteristic inequities of health resources distribution.

C. Quality of Low Cost Delivery System Services

The evidence is fairly strong that low cost health delivery systems can provide fairly high quality care at the costs cited earlier. For instance, the previously mentioned study in Guatemala found that when satisfactory quality was defined in terms of academically accepted modern medical practice, over 95% of the cases seen by the paramedical personnel there were judged as "well-managed."⁵

D. Summary

In the two project examples cited the low cost health delivery systems proposed were expected to deliver health services at a per capita cost of less than 50% of that of the existing system.

The specific savings of efficiencies introduced include:

(1) increasing the appropriate training and utilization of volunteers, auxiliaries and indigenous practitioners in provision of basic health services.

It has been variously estimated that 60-80% of the medical services provided by highly trained physicians and nurses can be provided by paraprofessionals with tremendously less costly training and maintenance costs. In Guatemala it was estimated that it was possible to maintain 70 "promotores" for the same costs required to maintain one physician. This in no way implies that the highly-trained physician and nurses have no place in the delivery system. Their presence will be continually required at the central level in preventive medicine, and in the referral

5. Habicht et al, op. cit, pp 14-27.

cycle for medical care. Of equal importance, the role of the physician and nurse in the lower echelons of the delivery systems must change from the conventional one of providing care to individuals to roles of leadership, supervision and training.

(2) Providing more resources to the development of outreach services instead of a disproportionate allocation of resources to costly hospitals and urban based curative centers.

It is not uncommon in developing countries to find that 75-85% of health budgets are spent in curative facilities located largely in urban areas with health benefits which reach a small percentage (10-30%) of the population. This project, while not expecting the governments to ignore the political demand for urban services, does attempt to assist in determining far more equitable budgetary allocations to achieve greater coverage of majority populations in rural areas. Increasing of national budgetary allocations to health is a more appropriate effort for macro-level national health planning, a parallel and complementary program activity of AID.

In this analyses it is assumed that the services delivered by the low-cost delivery system will be directed at the same target groups and health problems as the extant delivery systems. It is expected that the low-cost delivery system will focus on preventive and other services which change health status more effectively than current delivery technologies. It is very difficult to predict exactly the greater efficiency of low-cost health delivery systems in improving health status. The evaluations of the projects generated by this project will not only evaluate the efficiency of the low-cost health delivery systems in producing health

services, but will also evaluate their efficiency in producing improved health status.

PART IV - Implementation Arrangements

A. Analysis of Recipient and AID Administrative Arrangements

The contractor will continue to be the American Public Health Association. The International Division of the APHA has been the Division responsible for the contract under the DEIDS project since its inception. APHA's more than 25,000 members provide public health expertise and experience unmatched by any organization in the United States. The APHA is recognized nationally and internationally as the authoritative voice of the public health professions in the United States.

The organization has demonstrated its ability to quickly respond to the demands of the Agency, at times fielding teams for overseas assignments on as short as one week's notice.

Administrative arrangements for the obtaining of technical assistance are as follows:

USAID Missions or the Regional Bureaus identify the need for technical assistance and prepare a scope of work including desired length and dates. The request is sent to the AID project manager in TA/H. The project manager authorizes APHA to fund requests which serve to test feasibility, promote, develop or evaluate health delivery systems.

APHA core staff search their roster, identify suitable candidates, determine availability and pass the information obtained to the appropriate Regional Bureau. When a consultant, core staff member, or subcontractor is selected, the APHA arranges travel, briefing and debriefing sessions, and the preparation of reports.

The AID project manager is in the Office of Health, TAB. He has responsibility for monitoring contractor performance. He authorizes utilization of project funds for the use of consultants and is responsible through the Regional Bureaus for obtaining mission clearance for travel. He authorizes preparation of final consultant reports and distributes the reports as appropriate.

In all activities, the contract manager is responsible for keeping the Regional Bureaus fully informed of activities affecting the Regional Bureaus.

Administrative arrangements for the Thailand sub-project are as set forth in Prop Amendment 3, and are briefly summarized below:

The APHA has a signed agreement dated September 23, 1974 with the Ministry of Public Health, representing the Royal Thai Government, to conduct the demonstration project in Thailand.

Under a subcontract dated December 11, 1974 between APHA and the School of Public Health of the University of Hawaii (SPHUH), SPUHUH has been selected to provide technical assistance to the demonstration project.

The APHA and the RTG agreed also to participate in designing an evaluation system for the Thai project, including evaluation of cost implications and feasibility of replication. They further agreed to review progress, problems and lessons learned 12 months after the start of the project, and every 12 months thereafter and to recommend adjustments to the system. The review group includes representatives of APHA, the subcontractor, AID and the RTG, including the Thai Department of

Technical and Economic Cooperation, the Bureau of the Budget, and, as the parties agree, other groups.

The contractor is accountable to AID (TA/H) for monitoring, supervising, guiding, evaluating and reporting on subcontractor performance in the Thai subproject.

Because of its worldwide constituency, the activities of the World Health Organization are of special importance in the improvement of health status through the provision of health services. The recent emphasis by WHO on the support of primary health care is completely complementary to the goals of this activity. Accordingly, AID will continue the regular meetings with WHO begun by the Administrator of AID and the Secretary General of WHO in 1974 to exchange views and review activities related to integrated health delivery. The meetings are held at least once annually. Additionally, AID will continue to encourage meetings with the WHO regional offices to exchange information and coordinate activities. The contractor will ensure that its activities in the State-of-the-Art, information exchange, evaluation and promotion will be coordinated to the greatest extent possible with the efforts of WHO.

APHA additionally will convene and support conferences related to integrated health delivery which will include WHO and other involved agencies and will allow further liaison and coordination.

B. Implementation Plan

1) First Year

- a. Adjustment of staff requirements.
- b. Prepare evaluation guidelines format.
- c. Identification and arrangements for access to 3-4 DEIDS-like projects.
- d. Manage the DEIDS/Thailand sub-project including participation in the annual review.
- e. Provide responsive short term consultancy services to Regional Bureaus, Missions, and LDCs for determining feasibility, planning, designing and evaluation of affordable health delivery systems.
- f. Collect, analyze and disseminate information on affordable health delivery systems, including i.e., State-of-the-Art survey, quarterly newsletter, and special monographs.
- g. Promote the concept of affordable health delivery systems through the conduct of at least one regional or international conference, workshop or seminar and support LDC participation in at least three others.
- h. Establish information channels with at least 10 international donors, 10 universities and 10 private voluntary organizations.
- i. Prepare annual report.

2) Second Year

- a. Supervise DEIDS/Thailand Project, including Annual Review.
- b. Provide technical assistance to requesting LDCs.
- c. Continue to collect, analyze and disseminate information on affordable health delivery systems to USAIDs and other interested organizations, i.e., State-of-the-Art in depth study, quarterly newsletter, monograph.
- d. Promote the concept of affordable health delivery systems through the conduct of at least one regional or international conference workshop or seminar, and support of LDC participation in at least three others.
- e. Prepare annual report.
- f. In depth report 6-10 State-of-the-Art projects.
- g. Draft evaluation guidelines prepared.

3) Third Year

- a. Supervise the DEIDS/Thailand project and conduct Fourth Annual Review.
- b. Provide T.A. to LDCs for a total of 195 mm (life of project).
- c. Collect, analyze and disseminate information on affordable health delivery systems to USAIDs and other interested organizations, i.e., reports, quarterly newsletter.

- d. Promote the concept of affordable health delivery systems through at least one regional or international conference, and support of LDC participation in at least three others.
- e. 300 copies of evaluation guidelines available and distributed to AID assisted LDCs and requesting organizations.
- f. Prepare final report.

C. Evaluation Plan

A formal evaluation will be conducted in Washington nine months after beginning the project and annually thereafter to assess:

- 1) Progress on implementation of work plans for Thai Project, information exchange system, and evaluation guidelines.
- 2) Effectiveness of core staff and consultants in carrying out health assessments and in developing affordable health delivery systems. Services to include health planning, project design, administration, training and other.
- 3) Quality and quantity of information prepared and disseminated, on affordable health delivery systems. Specifically, at each annual evaluation, contractor will provide a review of experience on existing low cost integrated health delivery systems identifying key facts to the extent available, e.g., location, population size, percent population regularly reached by health system, description of manpower pattern which permits outreach, identification

* The results of the Thai Annual Review will be reported in the Agency's Annual Review of this project.

of services actually provided to majority of households (family planning, health, nutrition), utilization of services provided and where possible costs per capita of population served. At each subsequent annual evaluation, the contractor will compare annual data as described above with previous annual summaries, and document changes in each of the categories to the extent that data is available.

At the first formal PAR review, the PAR committee will identify an outside management group with expertise in health to conduct the second annual evaluation according to a scope of work agreed upon by the PAR committee. Funding for the evaluation will be provided by funds provided in the project.

ANNEX A: DEFINITION OF TERMS

For the purpose of this project paper, a variety of terms related to concepts and programs of health delivery require definition.

A. Low cost integrated health delivery system: A system of personnel, facilities, and services with the following specific objectives:

1. Majority Coverage

The provision of health, nutrition and population services for the population majority with sufficient accessibility and acceptability to permit utilization on demand.

2. Low Cost

The provision of these services to the population majority at a cost which a country is prepared to support within its own public and private sector resource system. "Low cost" may not necessarily be "least cost", but it is assumed that services will have to be of very low cost if they are to be continuously available to the majority without external donor subsidy or other support.

3. Integration

The provision of health, population and nutrition services to the ultimate consumer through one delivery system which incorporates elements of all three services in the most cost efficient portion. Given the need for rapid progress within severe resource limitation, "integration" does not necessarily assume complete amalgamation of all existing national health, population and nutrition managerial systems. Although such integration may be a valid national health policy objective, "integration" in

context of the low cost, high access population delivery system refers to provision of combined elementary services to the poorest majority in order to avoid the wasteful, duplicative practices of providing closely-related health, population and nutrition services through separate unrelated manpower and service systems.

For purposes of national planning, integration of health nutrition and population services is defined as the development and implementation of alternatives which offer the most cost-efficient use of service resources even though, administratively, implementation may require a variety of single purpose operational units. For the purpose of this project however, it is the hypothesis of integration that national resources are so limited that at the most peripheral level full exploration must be made to combine health, nutrition and family planning services in one organizational infra-structure.

4. Other Characteristics

- a) Expansion of population coverage by existing organized health systems through paid mid-level para-professional personnel supplemented by a larger proportion of unpaid or minimally paid, minimally trained village or community level volunteers, midwives, indigenous practitioners, or other village-resident representatives.
- b) Reassessment of existing health facilities and resources with a view to more equitable distribution in favor of the underserved majority.
- c) Initial focus on the mother and child as starting point for

- d) Participation of the majority through consultation with the consumer or village representative to ascertain views on cultural attitudes and perceived needs.
- e) Encouragement of private and voluntary organizational support and cooperation.
- f) Evaluation of population access, utilization and ultimately, health effects.

B. DEIDS - Development and Evaluation of Integrated Delivery Systems: A TAB project activity begun in 1971 incorporating principles described in Para A.

C. The DEIDS Project. A TAB contract (AID/csd-3423) with the American Public Health Association (APHA) to develop prototype demonstration projects of low cost delivery systems in four countries, and to provide consultant services on health delivery systems for Missions and Bureaus.

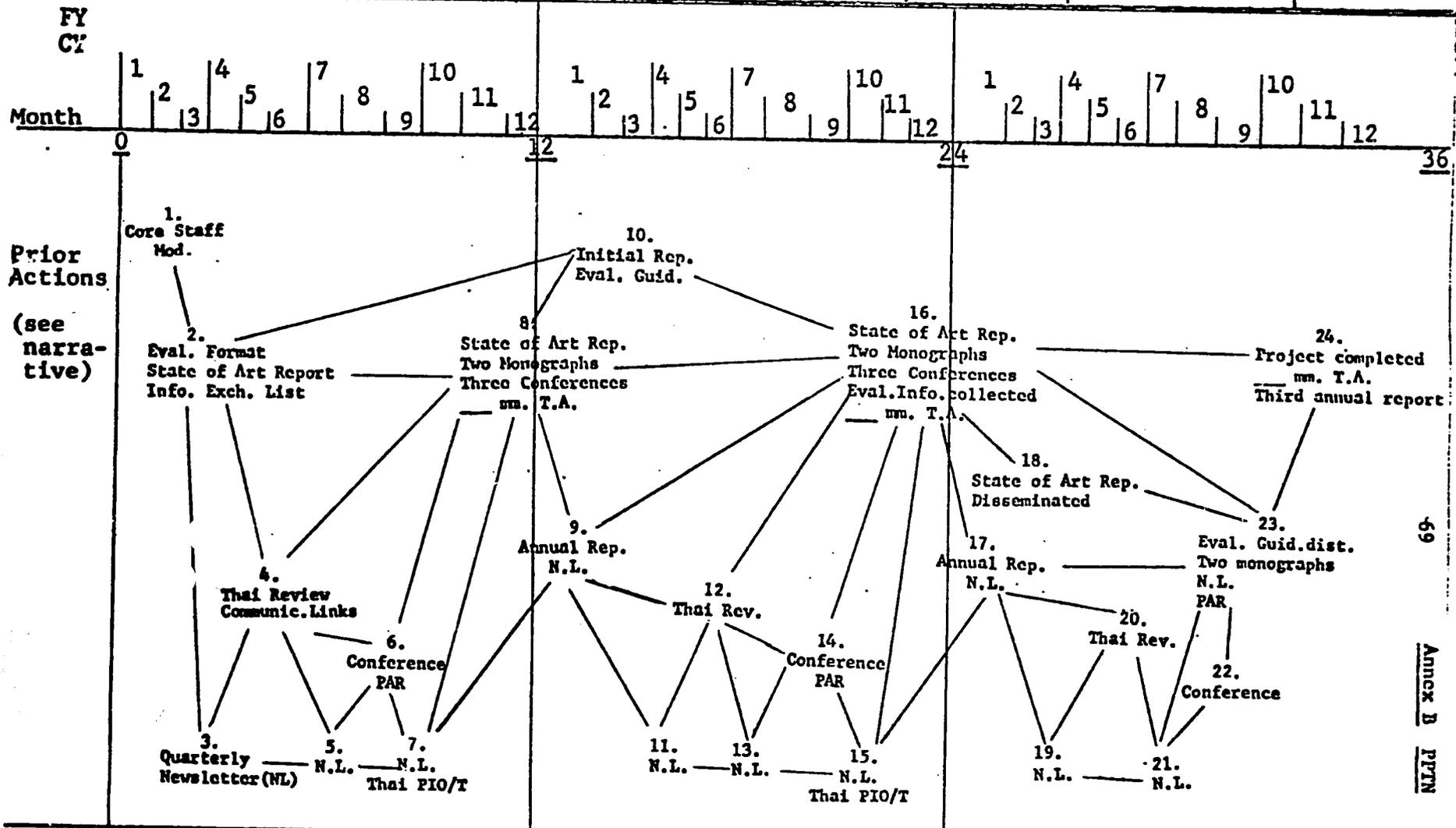
The demonstrations were to serve a large population (approximately 500,000 people), target women of childbearing age and children under five, and sought to establish the concept that a continuous testing and evaluation in a defined study area may serve as a guidance system for national planning of cost-effective delivery systems.

Only one demonstration project in Thailand is being implemented under the above contract. The rapid development of DEIDS-like country projects in the last three years has precluded the urgency of prototype pilot programs under the DEIDS project.

D. DEIDS-like projects. A low-cost health delivery system or demonstration which embodies many of the concepts listed under A above. Generally, these are Regional Bureau sponsored projects which have been assisted

in design and development through the APHA DEIDS contract but which are implemented by the Bureaus rather than by TAB.

Country: Worldwide	Project No. 931-11-580-971	Project Title: Development and Evaluation of Integrated Delivery Systems (DEIDS)	Date: 2/76	/ / original /X / revision #4	Approved
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Financial Plan:	FY 76: 1,115,000	FY 77: 1,148,000	FY 78: 1,108,000
Evaluation Plan:	X	X	X

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Annex B
PTN

Annex C. CRITICAL PERFORMANCE INDICATORS

Country: Worldwide	Project No. 931-11-580-971	Project Title: Development and Evaluation of Integrated Delivery Systems (DEIDS)	Date: 2/76	/ / original / X/ revision # 4	Approved
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PRIOR ACTIONS

DEIDS:

PROP	12/6/71	Phase I and II Authorization
Revision #1	1/9/73	Phase III and additional Technical Assistance
Revision #2	6/19/74	Five-year Thai Sub-project
Revision #3	9/14/75	Five-year Ecuador Sub-project
Contract - APHA	5/3/72	Phases I and II
Amendment 1	11/9/72	\$14,000 added for subcontract G.W.U. - Literature Search
" 2	3/11/74	Adjustment in overhead rates
" 3	3/14/74	Provided \$550,000 additional funds for technical assistance:
'B' Budget		<ol style="list-style-type: none"> 1. initial survey work on planning up to ten LCHDS. 2. 300 mandays survey work LCHDS to discover innovative activi- ties which may be replicable. 3. develop and review up to ten LCHDS evaluations. 4. respond to approximately ten requests for project develop- ment and design. 5. maintain a listing of manpower available to AID to respond to other needs in LCHDS.

Annex C.

Country: Worldwide	Project No. 931-11-580-971	Project Title: Development and Evaluation of Integrated Delivery Systems (DEIDS)	Date: 2/76	/ / original / X/ revision # 4	Approved
Amendment 4	6/28/74	Added \$1,117,000 for Thailand and \$383,000 for 'A' Budget. (Total obligation \$3,205,352)			
"	5	6/28/74	Corrected a 'typo'.	PAR 8/75	
"	6	10/1/74	Established Federal Reserve letter of credit for advance payment.	<u>Thailand Sub-project</u>	
"	7	12/1/74	Added \$1,020,000 for Ecuador pilot project. (Total obligation: \$4,225,352)	6/19/74 PROP Revision #2	
"	8	1/10/75	1) Utilized funds from 'consultants' portion of 'B' budget to provide sub-contract PCI. 2) Authorized Buy U.S. Here (BUSH).	9/23/74 APHA/RTG Agreement	
"	9	6/27/75	1) Added \$599,909 for eight-month extension of basic contract. (Total obligation: \$4,825,261) 2) Pilot projects cut from 4 to 2. 3) Consultant man days increased. 4) Specific source waivers granted.	12/11/74 APHA/University of Hawaii Contract	
"	10	12/31/75	1) Decrease total estimated cost from \$4,825,261 to \$3,805,261 by deobligating Ecuador sub-project funds. 2) Extend completion date from 1/2/76 to 2/28/76.	11/75 First Annual Review	

Country: Worldwide	Project No. 931-11-580-971	Project Title: Development and Evaluation of Integrated Delivery Systems (DEIDS)	Date: 2/76	Original Revision #4	Approved:
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CPI NARRATIVE

FIRST YEAR

1. Second Month Modification of Core Staff
2. Third Month Evaluation
 - a. Format of guidelines
 - b. Projects identified

State of the Art

 - a. Report on analysis of questionnaire

Information Exchange

 - a. Mailing list submitted
 - b. Identification of support to three conferences convened by other sponsors
3. Fourth Month First quarterly newsletter
4. Sixth Month Thai Review

Communication links established in 20 LDCs with 10 donors, 10 PVOs and 10 universities.
5. Seventh Month Second quarterly newsletter
6. Ninth Month First Contractor sponsored annual conference
PAR

7. Tenth Month Third quarterly newsletter
Thai PIO/T
8. State of the Art
 - a. Report on 20-30 projects

Promotion and Information Exchange

 - a. Two monographs distributed
 - b. Three conferences supported

Technical Assistance

 - a. 62 mm. provided

SECOND YEAR

9. First Month Annual Report
Fourth quarterly newsletter
10. Third Month Evaluation
 - a. Initial report on evaluation guidelines submitted
11. Fourth Month Fifth quarterly newsletter
12. Sixth Month Thai Review
13. Seventh Month Sixth quarterly newsletter

Country: Worldwide	Project No. 931-11-580-971	Project Title: Development and Evaluation of Integrated Delivery Systems (DEIDS)	Date: 2/76	Original Revision #4	Approved:
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CPI NARRATIVE

14. Ninth Month Second Contractor sponsored annual conference
PAR (external evaluation)
15. Tenth Month Seventh quarterly newsletter
Thai PIO/T
16. Twelfth Month State of the Art
a. Report of 6-10 projects
- Promotion and Information Exchange
a. Two monographs distributed
b. Three conferences held
- Evaluation
a. Information collected for preparing evaluation guidelines
- Technical Assistance
a. 63 mm. provided

THIRD YEAR

17. First Month Annual Report
Eighth quarterly newsletter
18. Third Month State of the Art Report disseminated

19. Fourth Month Ninth quarterly newsletter
20. Sixth Month Thai Review
21. Seventh Month Tenth quarterly newsletter
22. Ninth Month Third Contractor sponsored annual conference
23. Tenth Month Two monographs distributed. Evaluation guidelines distributed. Eleventh quarterly newsletter PAR
24. Twelfth Month Project completed.
70 mm. T.A. provided
Third Annual Report

Annex C. CRITICAL PERFORMANCE INDICATORS

Country: Worldwide	Project No. 931-11-580-971	Project Title: Development and Evaluation of Integrated Delivery Systems (DEIDS)	Date: 2/76	/ / original / X / revision # 4	Approved:
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PRIOR ACTIONS

DEIDS:

PROP	12/6/71	Phase I and II Authorization
Revision #1	1/9/73	Phase III and additional Technical Assistance
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" 3	3/14/74	Provided \$550,000 additional funds for technical assistance:
		1. initial survey work on planning up to ten LCHDS.
		2. 300 mandays survey work LCHDS to discover innovative activities which may be replicable.
		3. develop and review up to ten LCHDS evaluations.
		4. respond to approximately ten requests for project development and design.
		5. maintain a listing of manpower available to AID to respond to other needs of LCHDS.
'B' Budget		

AID SUPPORTED INTEGRATED HEALTH DELIVERY PROJECTS

Countries in which AID projects underway or planned for FY 77 seek to provide as an end of project objective health, nutrition and family planning information or services for the majority in the project area.

AFRICA

Ghana (2 projects)
Liberia
Senegal
Tanzania
Central West Africa Regional

LATIN AMERICA

Bolivia
Brazil (2 projects)
Colombia (2 projects)
Dominican Republic
Guatemala
Nicaragua
Panama

ASIA

Korea
Nepal
Pakistan
Thailand

NENA

Afghanistan
Egypt

**PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK**

Life of Project:
From FY 76 to FY 78
Total U. S. Funding 3,371
Date Prepared: 2/10/76

Project Title & Number: Development and Evaluation Integrated (Health) Delivery Systems

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>To improve the health status and thus the quality of human life of the populations of LDCs through assistance in health planning, integrated health delivery services and improvements in the environment.</p> <p>Subsector goal: To make basic health services, particularly those related to MCH, nutrition & family planning available and accessible to majority of LDC populations at affordable costs. Target is women of childbearing age and children under 5.</p>	<p>Measures of Goal Achievement:</p> <ol style="list-style-type: none"> Increase in age specific life expectancy. Decrease in age specific mortality rates. Reduction in age/parity specific birth rates. 	<p>WHO and LDC statistics.</p> <ol style="list-style-type: none"> Surveys, project statistics, projects evaluations, facility records. LDC evaluation and decision to retain or modify the developed system. Nationwide replication of major elements. 	<p>Assumptions for achieving goal targets:</p> <ol style="list-style-type: none"> LDCs are interested in improving the health status of their population. Assistance in health sector will be acceptable to LDCs, and will improve health status. 																																																								
<p>Project Purpose:</p> <p>To support the Agency's capability to respond rapidly to requests from USAIDs and LDCs for information, feasibility assessment, project design assistance and evaluation of systems to deliver combined health population and nutrition services to a national majority within the limits of national resources, and to manage the testing of one means of developing such services in an LDC.</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <ol style="list-style-type: none"> Thailand sub-project proceeding as planned (see PROP). By end of 1978 the Agency will have 24-30 delivery systems projects planned or implemented. Guidelines for evaluation will be available for use by USAIDs and health planners in LDCs. Concepts and experience distributed throughout AID-assisted countries. 	<ol style="list-style-type: none"> Annual project review. Consultant reports, resulting AID program documents. Evaluation reports. Host country documents; seminars and conferences. 	<p>Assumptions for achieving purpose:</p> <ol style="list-style-type: none"> May 75 World Health Assembly resolution reflects growing demand for integrated health services. U.S. legislative & Agency support for integrated health services will continue. Evaluation guidelines can be sufficiently comprehensive for general use. Universities, LDCs, PVOs and other donors willing to share experience. 																																																								
<p>Outputs:</p> <ol style="list-style-type: none"> Continued testing of the hypothesis that majority coverage can be provided target populations at affordable costs. Technical assistance provided to requesting countries. Guidelines for evaluation. State-of-the-Art survey completed. Information exchange system operating. Promotion, coordination integrated health delivery activities. 	<p>Magnitude of Outputs:</p> <ol style="list-style-type: none"> 27 mn of management at sub project. 195 mn for TA. Evaluations of 3-4 bureau sponsored projects compared with DEIDS Thai and techniques. 300 copies guidelines distributed. Questionnaire analysis document 3 months after project initiation. In depth study 6-10 systems 24 months after initiation. Quarterly newsletters in 3 months. 1 annual promotion convened. Attendance 2-3 others supported. Channels with 10 donor agencies, 10 univ., 10 PVO's, 20 LDCs. 	<ol style="list-style-type: none"> Annual review report. Project report. Consultant reports; AID reports; contractor documents. Guideline documents. State-of-the-Art report. Published documents. Newsletter. Special reports. Written requests for information. Conference, trip reports. Contractor reports. 	<p>Assumptions for achieving outputs:</p> <ol style="list-style-type: none"> AID and the Thai government continue support of the demonstration project. Contractor can provide suitable consultants. Mechanism for contractor access to project evaluation plans can be established. 6 other donors, universities and PVOs are willing to exchange information. Contractor can design suitable exchange management system. 																																																								
<p>Inputs:</p> <p>AID</p> <ol style="list-style-type: none"> Project monitoring, TA/M \$3,371 for contract services. Access provided to AID projects. <p>Contractor</p> <ol style="list-style-type: none"> Core staff Consultants Subcontractors <p>Host Country</p> <ol style="list-style-type: none"> Thai inputs per PROP No other inputs per se except sharing of experience 	<p>Implementation Target (Type and Quantity)</p> <table border="1"> <tr><td>Budget</td><td>02</td><td>02</td><td>03</td></tr> <tr><td>Personnel</td><td>301</td><td>310</td><td>320</td></tr> <tr><td>Fring. Benefits</td><td>81</td><td>84</td><td>86</td></tr> <tr><td>Consultants</td><td>144</td><td>145</td><td>130</td></tr> <tr><td>Travel & Per Diem</td><td>209</td><td>196</td><td>179</td></tr> <tr><td>Supplies</td><td>9</td><td>8</td><td>7</td></tr> <tr><td>Printing</td><td>10</td><td>10</td><td>10</td></tr> <tr><td>Contract Services</td><td>55</td><td>79</td><td>56</td></tr> <tr><td>Other Direct Costs</td><td>229</td><td>236</td><td>243</td></tr> <tr><td>Overhead</td><td>1038</td><td>1068</td><td>1030</td></tr> <tr><td>subtotal</td><td>78</td><td>80</td><td>77</td></tr> <tr><td>Contingency/Inflation</td><td></td><td></td><td></td></tr> <tr><td>0 7 1/2%</td><td></td><td></td><td></td></tr> <tr><td>TOTAL</td><td>1115</td><td>1148</td><td>1108</td></tr> </table>	Budget	02	02	03	Personnel	301	310	320	Fring. Benefits	81	84	86	Consultants	144	145	130	Travel & Per Diem	209	196	179	Supplies	9	8	7	Printing	10	10	10	Contract Services	55	79	56	Other Direct Costs	229	236	243	Overhead	1038	1068	1030	subtotal	78	80	77	Contingency/Inflation				0 7 1/2%				TOTAL	1115	1148	1108		<p>Assumptions for providing inputs:</p> <ol style="list-style-type: none"> Congress will make funds available. Contractor can provide required services. LDCs are willing to support affordable health systems.
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