AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT PAPER FACESHEET

TO BE COMPLETED BY ORIGINATING OFFICE

1. TRANSACTION CODE ("X" appropriate box)
☐ Original ☒ Change ☐ Add ☐ Delete

PP
DOCUMENT CODE 3

2. COUNTRY/ENTITY: Worldwide

3. DOCUMENT REVISION NUMBER:

4. PROJECT NUMBER: 931-11-580-971

5. BUREAU: a. Symbol TAB; b. Code 6

6. ESTIMATED FY OF PROJECT COMPLETION: FY

7. PROJECT TITLE - SHORT (stay within brackets): [Integrated Health Delivery Systems]

8. ESTIMATED FY OF AUTHORIZATION/OBLIGATION (mo. yr.): a. INITIAL 2 76; b. FINAL FY 2 78

9. ESTIMATED TOTAL COST ($000 or equivalent, $1 =)

a. FUNDING SOURCE	FIRST YEAR FY ___ b. FX	c. L/C	d. Total	ALL YEARS e. FX	f. L/C	g. Total
AID APPROPRIATED TOTAL						
(Grant)	( )	( )	( )	( )	( )	( )
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
HOST GOVERNMENT						
OTHER DONOR(S)						
TOTALS						

10. ESTIMATED COSTS/AID APPROPRIATED FUNDS ($000)

a. Appropriation (Alpha Code)	b. Primary Purpose Code	c. Primary Tech. Code	FY 76 d. Grant	FY 76 e. Loan	FY 77 f. Grant	FY 77 g. Loan	FY 78 h. Grant	FY 78 i. Loan	ALL YEARS j. Grant	ALL YEARS k. Loan
PH			1,058		1,097		1,115		3,270	
TOTALS										
11. ESTIMATED EXPENDITURES										

12. PROJECT PURPOSE(S) (stay within brackets) ☐ Check if different from PID/PRP

[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.]

13. WERE CHANGES MADE IN BLOCKS 12, 13, 14, or 15 OF THE PID FACESHEET? IF YES, ATTACH CHANGED PID FACESHEET.
☐ Yes ☒ No

14. ORIGINATING OFFICE CLEARANCE

Signature

Title

Date Signed mo. day yr. n.d.

15. Date Received in AID/W, or For AID/W Documents, Date of Distribution mo. day yr.

AID 1330-4 (7-75)

Preface:

In the past three years (FY-73-76) strong legislative, executive, and international interest have focused on the development of integrated systems for the delivery of health, population, and nutrition services to national majorities at a cost within existing limited national resources. Without effective access to the majority, neither health, population nor nutrition goals can be rapidly achieved.

The Foreign Assistance Act of 1973 specified provision of health services to the majority. Legislative interest documented the rationale for joint programming. H.R. 9005 provides even stronger legislative direction: "Assistance provided under this section shall be used primarily for extension of low cost, integrated delivery systems to provide health and family planning services, especially to rural areas and to the poorest economic sectors."

AID programs have precipitously increased from one program four years ago to twenty-two planned or implemented in 1976. In support of this trend Mr. Kissinger's statement to the UNGA involved a new U.S. emphasis to support such delivery systems in collaboration with other donors.

From the viewpoint of the poor countries, the May 1975 World Health Assembly resolution on "primary health care" (WHO synonym) expressed official desire for health delivery system programs, a consensus confirmed by AID experience in the direct expression of interest of AID-assisted countries.

The rapidity with which this trend has been accepted by donors and poor countries has placed service demands on technical assistance agencies with limited manpower capability, let alone provide time for adequate design and evaluation.

[redacted]. It seeks further to accumulate information and experience in one institution for practical purposes of evaluation, information dissemination, and identification of services of scarce experience and technical expertise.

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 availability. "Low Cost" implies a rationally efficient and sustainable 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 combined health, population and nutrition services to the ultimate consumer through one delivery system. 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.

4. Other Characteristics

a) Achievement of out reach beyond existing organized health systems through paid para-professional mid-level personnel and 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 under-served majority.

c) Initial focus on the mother and child as starting point for service delivery.

d) Participation of the majority through consultation with the consumer or village representatives 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. Only one demonstration project in Thailand has been designed and 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 may have been assisted in design and development through the APHA DEIDS contract but which are implemented by the Bureaus rather than by AID/csd-3423.

B. Recommendation

Grant:

FY 1976	$ 1,058,000
FY 1977	1,097,000
FY 1978	1,115,000
[redacted]	

C. Description of the Project

1. This project, through a variety of interrelated and mutually reinforcing activities, will:

   a. [redacted] demonstration project in Thailand designed to test the hypothesis that delivery to and utilization of the majority of target populations (women of childbearing age and children under five) can be achieved within resources available to the host nation.

   b. Provide technical assistance (approximately 226 mm) to [redacted] Missions and LDCs for determining feasibility, planning, designing, implementation and evaluation of low cost integrated delivery systems.

   c. Develop guidelines for evaluation of health delivery systems.

   d. Establish a network for promotion, information gathering and dissemination, and identification of needs and resources available for health delivery systems.

2. The project will be managed by the Technical Assistance Bureau, Office of Health. Through contract, a core staff of the American Public [redacted] Association will organize and [redacted] above. Technical assistance can be provided by TA/H staff, by contract APHA staff, by consultants, or by subcontractors. The demonstration project in Thailand is being carried out by an APHA subcontract with the University of Hawaii. Evaluation guidelines and the network will be developed by APHA core staff, consultants , or subcontract.

3. For the purpose of fostering adoption and replication of health delivery systems on a national scale, [redacted] will be followed:

   a. [redacted] a carefully designed and structured prototype [redacted] which will provide information of country-specific value in the designing of a plan for replication throughout the country. The demonstration project will also serve as a field laboratory for testing alternative mechanisms for providing services and evaluation. As a carefully documented prototype of a low cost integrated delivery system, the results of the Thai project will be of regional and international relevance.

   b. The provision of technical assistance to countries through AID Missions and Regional Bureaus allows easy access to a wide variety of professional experience for determination of feasibility, design and evaluation of health systems or their components.

   c. Because of the variety of global experience, expertise, the geographic dispersion of resources, the early and rapid evolution of interest in affordable health delivery systems, no single group, association or other institution can effectively serve as a center for global experience. The project will support the development of an international network which will provide information collection and exchange, identification of resources, stimulation of voluntary and private participation, and [redacted] in order to facilitate the adoption [redacted] of affordable health delivery systems [redacted]

4. At the End of the Project

   a. The Thailand sub-project will be proceeding as planned. Field experience will be evaluated and globally shared.

b. Through the provision of technical assistance, [redacted], and as a result other large scale demonstrations or improvements in existing delivery systems to increase coverage will have occurred.

c. Guidelines for evaluation of deliver[redacted] at the local and national levels will assist countries in incorporating appropriate evaluation components during the planning and project design stages. Additionally, utilization of common guidelines for evaluation will permit some degree of project comparability.

d. Through a network, the concept of low cost integrated health delivery, s[redacted] widely distributed throughout AID-assisted countries and supporting bilateral and multilateral institutions in the U.S. There will be increased participation by the voluntary and private sector in the provision of health services; gaps in knowledge will be identified and targeted; and expansion of this network into a WHO-centered international network explored.

D. Summary Findings

This project is designed to assist less-developed countries in development of low cost integrated health delivery systems, including family planning and nutrition for the poor majority. This is in direct response to the proposed amendment (Section 304), to Section 104 of the Foreign Assistance Act of 1961, which reads " (b) Assistance provided under this section shall be used primarily for extension of low cost, integrated delivery systems to provide health and family planning services, especially to rural areas and to the poorest economic sectors, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems and other modes

of community outreach; health programs which emphasize disease prevention; environmental sanitation and health education; and population planning programs which include education in responsible parenthood and motivational programs, as well as delivery of family planning services which are coordinated with programs aimed at reducing the infant mortality rate, providing better nutrition to pregnant women and infants, and raising the standard of living of the poor ...."

In addition, the 1975 World Health Assembly voted a resolution in support of "primary health care", the WHO equivalent for low cost delivery systems as described in this project. Secretary Kissinger committed the U.S. to support a major expansion of h ealth delivery systems in his address to the last session of the U.N. General Assembly. This project is not only the cornerstone for Agency efforts to reach the majority poor, but will be an important component of the collaborative international effort now being advanced.

The analyses provided under Part III of this document provide additional support for this project activity. Activities included in this project have already been initiated under a previously approved project document (1971). This document authorizes continuation of those activities, rather than new starts, with a reduction in total project funding from the 1971 approved level of $15,000,000 to $8,575,000.

E. Project Issues

The DEIDS project was reviewed on August 14, 1975. The PAR Committee recommended that two project papers be prepared, one for the DEIDS Thailand project and a second to include: provision of technical assistance to AID Missions, evaluation assistance and the establishment of a network for information dissemination, analysis. The rationale for the Committee's recommendation was based on the fact that the DEIDS Thailand

Project was designed to test the condepts of affordable integrated health delivery systems. The original PROP was amended after eighteen months to "....provide the Agency with the necessary technical assistance and resources to support a nationwide effort in expanding low cost health delivery system development and implementation of the present projects as well as to provide the Agency with the response capability to enhance the development of LCHDs in the LDCs and to build on new advances and developments in the development of LCDHs...." The Committee felt this amendment was a significant departure from the original concept and in effect created a new project.

After an intensive review of the historical background of the project (see Para II, A) [redacted] nical Assistance, Evaluation Assistance and the establishment of an information network into one project paper for the following reasons:

1. DEIDS/Thailand Project was developed after complex negotiations between the RTG, AID/W, USOM/Thailand, APHA and the University of Hawaii.
2. The mechanism to make changes in the DEIDS/Thailand sub-project, e.g., to add more specific targets, already exists through an annual program review agreed upon by APHA and the RTG, with the concurrence of AID, about one year ago. The first annual review will be in November, 1975.
3. The DEIDS/Thailand Project offers a field laboratory for APHA and AID. As such, the project is part of the worldwide project.
4. [redacted] Developing a separate core staff to backstop the DEIDS/Thailand Project would be wasteful and duplicative.
5. [redacted] would make it nearly [redacted] the DEIDS/Thailand project in PP form after the first annual review in November 1975 and before December 31, 1975 as recommended by the Committee.

II. Background and Detailed Description

A. Background

In 1970, AID identified the lack of delivery systems capable of reaching national population majorities as a key constraint to development of the poor countries of the world because absence of a system precluded achievement of the coverage required for population, child nutrition and basic health services. Existing systems in the developing nations were molded on inappropriate western models in that they failed to provide basic services to more than 10-15 percent of their populations.

In 1971, the Agency approved the DEIDS (Development and Evaluation of Integrated Delivery Systems) project 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 was to be done by a demonstration project in each of AID's four geographic regions. (See "Key Problems Impeding Modernization of Developing Countries, the Health Issues", AID 1970.)

Because of the small number of AID health personnel, the APHA, with access to more than 20,000 members, [redacted] The projects would deliver maternal and child health, family planning and nutrition services to the majority of women of childbearing age and children under five years at a cost acceptable to the country within its own resources. If successful, pilot projects would be nationally replicated, wide dissemination of experience would be achieved through progress reports and international conferences.

[redacted] the PROP was amended to task APHA to provide personnel to AID missions for both long term and short term assignments on specialized aspects of low cost health delivery, including determination of feasibility, project design, health sector analysis, evaluation, and conducting symposia or conferences related to affordable health delivery systems.

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

Poor to Use/ess

At the beginning of the project, APHA staff started accumulating references and literature that related to existing experience. However, it became evident at an early stage that with the many demands for developing field services, there would be inadequate staff time for a systematic and thorough review of the relevant literature. A plan was then devised to subcontract with the Biological Sciences Communication Project, George Washington University, for this task. These bibliographies were and are

being used by APHA as a guide for study of conditions in specific countries and other aspects of delivery having relevance to DEIDS.

2. [redacted]

In response to regional bureau, AID Mission and LDC initiative, [redacted], including Pakistan, Panama, Ecuador, Nicaragua, Honduras, Paraguay, Thailand, Korea, Philippines, Nigeria, Niger and Zaire.

The typical reconnaissance comprised four expert team members and represented the team's judgement on the feasibility of attempting to pursue a DEIDS program in the country visited. 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 the Report is an analysis of the health delivery systems in terms of its major components. These inter-relationships, strengths and weaknesses and their potential contribution are analysed in careful, subjective value judgements.

3. Phase II. In depth planning and surveys.

As Phase I activities were being completed, Phase II planning proceeded in those countries considered to offer the best possibility of success for project field work. Country planning and design of field projects were begun by the APHA for Pakistan, Ecuador, Thailand and Panama. Subsequently, due to a variety of complex issues, the Pakistan and Panama programs were reoriented toward an altered program emphasizing specialized aspects of health delivery and in that sense remained outside of the original design of the project. DEIDS-like activities that were promoted by the project are described more fully in paragraph 5, below.

In APHA's approach to both Phases I and II, arrangements were made to involve, as consultants, staff members of institutions that would

later be interested in continuing work with APHA in providing consultants or serving as sub-contractor for Phase III operations. In this manner consultants from the University of Texas, University of California, University of Hawaii and Tuskegee Institute have gained experience and first-hand knowledge of the DEIDS endeavor from the beginning.

4. Phase III, Implementation of Field Test Projects

Of the four demonstration projects originally planned, [redacted] the program in Thailand has been implemented.

The Thailand sub-project was formally implemented in late 1974. In keeping with basic planning precepts, the Plan which now comprises some 200 pages is largely a Thai product. It was 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.

A National Family Planning Policy has been adopted by the Royal Thai Government. As a result, integrated services will utilize the 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. Similarly, nutrition programs have been initiated in the province primarily through Child Nutrition Centers which are scattered throughout the districts. While nutrition services now appear sporadic, the plan is geared to evaluate and supplement these efforts so that nutritional services will receive prominent attention.

The Ministry of Public Health provides health 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 is due to fragmented facilities and the scarcity of competent mid-level manpower. To address this situation and the very low doctor/population ratio (1:25,000) the [redacted] Tailor-made programs for extensive training in seven categories of instruction have been designed. These categories and trainee outputs are: cross training for service personnel, 616; Medex 85; volunteer health post workers, 540; communicators to provide information between the consumers and providers of health services, 5,400; midwifery, 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. Eight types of information will be gathered in order to assess, evaluate and replan project goal path and strategy. Comparisons will be run against conditions in neighboring provinces and districts as controls.

Annual reviews to review progrss, problems, lessons learned, and systems costs, will be held in order to recommend adjustments to the system as may be necessary. The first review was held in November 1975.

5. Specialized Consultation 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 involve project design and development, evaluation or the hosting of symposia.

In this activity APHA staff or consultant teams have performed such assistance as appraising alternative evaluation proposals pertaining to the rural health technician program of Guatemala, participating in health sector assessment programs in Bolivia and Honduras; surveying delivery systems in Cambodia and health planning in Laos; participating in project design in Zaire, Korea and the Central African Republic.

6. Current Status

The 1973 Foreign Assistance Act gave strong stimulus to health activities in AID-assisted countries worldwide.

As emphasized in the Act, Section 102(b)(5) "the United States bilateral development assistance should give the highest priority to undertakings submitted by host governments which directly improve the lives of the poorest of their people and their capacity to participate in the development of their country." Provision of health services [redacted] acceptable socially and politically for encouraging social equity."

The Act had as one of its objectives: "....to help provide health services for the great majority". The Congress underlined its intent by earmarking funds for the health sector.

Implementation of the Congressional mandate should, then, include support to developing nations in the development and expansion of health delivery systems which will make health, nutrition, and family planning

services available and accessible to the poor majority at a cost sustainable by the country within the limits of its own resources.

Since the original DEIDS PROP was signed and the '73 Congressional mandate issued, [redacted] and [redacted] project.

1) [redacted] 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 24 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 [redacted] The timely collection and dissemination of information on the various components of low cost systems (i.e., lessons learned, evaluation techniques, manpower development) must be expanded if the needs of these nations are to be met. A systematic collection, analysis and dissemination of information is necessary. [redacted] has been undertaken by the APHA, but this activity will only partially address the needs. In order to facilitate the widespread adoption of affordable health delivery systems the need exists for a network which will permit information collection, analysis and dissemination, identification of needs and resources.

3) [redacted] This is particularly true of the WHO. 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) Originally continuous evaluation was to be made of the four pilot projects in the DEIDS project. The current requirement for evaluation of 22 FY '76 Bureau projects including the Thailand project requires specific guidelines if comparability of evaluation is to be achieved.

Although Bureaus are accountable for evaluating their own projects,

[redacted]

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 Subsector Goal

To make basic health services, particularly those related to MCH, nutrition and family planning available and accessible to majority of LDC populations at affordable costs. 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.

3. Project Purpose

a. Statement of Purpose

[redacted]

b. Conditions Expected at the End of Project

By the end of FY 78 (3 years) the demonstration project in Thailand will have replicated into more than half of the districts (6) of the 10 in the pilot province. Ongoing evaluation will have resulted in some elements of the model being replicated in other provinces in the country. Experience there will have been analyzed and widely distributed.

Technical assistance for promotion, planning, project design, operation , and evaluation will have contributed towards planning, implementation, or improvement of 24-30 field projects, 22 of which are currently in planning or in process during FY 76.

Guidelines for evaluation of health delivery systems at the local and national levels will assist LDCs in incorporating evaluation components in the planning stage of project design. Additionally, [redacted]

As a result of an established network, the concepts of affordable health delivery are widely distributed throughout the U.S. and AID assisted countries, gaps in knowledge have been identified and targeted, and incorporation of the U.S. network into an international network (probably developed by WHO) explored and possibly underway.

c. Basic Assumptions

1) The World Health Assembly resolution (May 1975) represents a [redacted]

2) U.S. Legislative emphasis, [redacted] and AID policy support continued growth of delivery systems programs.

3) That e[redacted] to a point that they p[redacted] comparability of alternative [redacted] mentioned.

4) That universities, LDCs, private and voluntary organizations, and other donors are willing to share their experiences (negative as well as positive) to permit network establishment.

4. Statement of Project Outputs

Specific outputs will result from Bureau and TAB sponsored field and other projects for which this project provides inputs and will be [redacted] Regional Bureaus for technical assistance. The following kinds of outputs are expected if the specific inputs given later are provided. 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 and by contractor, sub-contractor, and conference reports.

a) Supervision of the [redacted] This will include continuing assistance in developing an evaluation plan which will be useful not only in Thailand, but will also contribute to general evaluation guidelines development. Additionally, it provides for APHA core and consultant staff participation in the annual project review.

* The DEIDS Thai sub-project is funded as a separate amendment to the DEIDS Project. The sub-project is approved through FY 78 and includes costs for University of Hawaii (subcontractor) and direct project support in Thailand. It does not include supervision, monitoring, or evaluation by APHA (contractor)

b) Provision of [redacted] planning, operation and evaluation of nation-specific affordable [redacted] delivery systems in AID-assisted countries worldwide.

c) [redacted] of local and national delivery systems formulated and disseminated.

d) [redacted] Information gathering on integrated delivery systems is an inherent component of broader health information systems within independent organizations such as AID, WHO, UNICEF, and possibly, the National Council for International Health. [redacted] systems per se on a global scale for the purpose of analysis, comparison, and rapid dissemination to U.S. national or international users. Specific U.S. legislative, State Department, and AID emphasis on integrated systems now makes it necessary to develop an organized network to learn from the past and plan effectively for the future.

WHO, a logical center for activities of this kind, has neither staff nor resources to develop a global network. While WHO is a valid future option, [redacted] Accordingly, the APHA will serve as the network center for at least the next three years.

The [redacted]k will include the following:

1. [redacted] public and private, U.S. national and international (including WHO) [redacted]s and [redacted] in support of low cost health delivery systems, for purposes of

encouraging information exchange and program collaboration. Identification of gaps in provision of assistance. Recommendations for provision of assistance to fill identified gaps.

2. [redacted] and who have potential for contribution/expertise through the network.

3. [redacted] involving identification of the most significant and innovative LCHDS or elements of health delivery systems currently in operation. Following analysis of basic data collected on a large number of projects, more detailed data for a smaller number of selected projects will be compiled, analyzed and stored in a manner permitting ready retrievability for the use of interested agencies, USAIDS and organizations. Cross-project comparisons will be made for designated elements of projects such as the use of physician assistants, techniques of logistic support, supervision techniques and means and effectiveness of community support.

4. After publication of "the State-of-the-Art", [redacted] collection, analysis, comparison and dissemination of [redacted] on health delivery systems, stressing innovative features of the systems and lessons learned.

5. [redacted] in the [redacted] and o[redacted] for promotion of information exchange relating to health delivery, including progress, constraints, innovations, financing, and research.

5. Magnitude of Outputs

a. 57 man months of core and consultant manpower. A work plan will be presented within two months of onset of the project.

b. Technical assistance. 226 man months.

c. Guidelines for evaluation. Work plan presented within nine months of project beginning. Guidelines for the evaluation of local and national delivery systems published and distributed to all AID missions, AID-assisted centers, and requesting organizations by end of project. 300 copies.

d. Network. Work plan - 6 months after start of project.

1) State-of-the-Art

(a) 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 (3 months after project begins).

(b) A [redacted] with particularly innovative features. A descriptive report of thirty such systems.

(c) In depth [redacted] of the above published within 18 months after start of project.

2) [redacted]. A quarterly newsletter on low cost integrated health delivery systems for distribution throughout the network membership. First edition nine months after project inception.

3) [redacted] established with at least [redacted], [redacted], and [redacted] (including corporate interests)

with an interest in health delivery. Accomplish one year after start of project.

4) At least [redacted] and [redacted] sponsored or supported annually.

5) One report annually of identified areas of research required and recommended for AID consideration.

6. Project Inputs

a. AID:

1) Project monitoring - TA/H

2) [redacted] for contract service

3) Provide access by contractor to AID projects for analysis of health systems, including evaluation methodologies.

b. Contractor:

1) [redacted] - The core staff is an [redacted] disciplinary group and individual members will be assigned to a variety of program elements throughout each year.

The core staff should [redacted] 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 [redacted] requirements are the following:

(a) [redacted] - 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) [redacted] - responsible for contract negotiations and management, management of consultants.

(c) [redacted]

[redacted]t.

(d) [redacted] and maternal child health specialist with expertise concerning the role of women in health services delivery.

(e) [redacted] - Development of Evaluation guidelines and analyses of evaluations.

(f) [redacted] - Liaison with and stimulation of corporate and voluntary resources interested in health delivery.

(g) [redacted] - Establish information exchange mechanisms; oversee collection, storage and retrievability.

(h) [redacted] - Overall management of network.

(i) [redacted] - for network - 1 reports-editorial assistant
2 secretaries

for other professional staff -
1 admin. assistant
2 secretaries

2) [redacted] - the contractor will provide the services of consultants to [redacted]

[redacted]

Host Countries:

The inputs of host country will vary, depending upon the projects developed by the use of the above and other resources.

The inputs of Thailand in the demonstration project are included in the Thailand PROP.

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 preventible 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 technology is widely available, knowledge of mechanisms which allow these technologies to be translated into human 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 preventive and curative services appropriate to the setting of the individual developing nations in order to reach the majority population. Severe financial and manpower constraints however, preclude major testimonial investment or infrastructure development. The applied technology will heavily emphasize information and will therefore have little environmental impact.

[redacted] 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 technology, such transfers 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, will be encouraged.

There is no standard of the level of technology applicable for any specific country; [redacted] 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. Using satellite-gathered demographic data might be more appropriate for remote areas of Bolivia than less complex, but possibly less accurate and more costly census techniques. A country may not be able to absorb the cost of widespread use of disposable syringes and needles, yet could find profitable uses 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 [redacted]. 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 subsidies in the form of employment. There will be in some countries increased numbers of middle and lower level paraprofessionals employed by the host countries. The overall expected effects of the project on the job market, while likely marginal, will be for greater employment.

Technologies resulting from technical assistance activities in each developing country will be geared to the operation and maintenance capability of that country in order that replication of the health system developed may be accomplished.

Effects upon the environment projects resulting from technical assistance in this project very largely will be favorable. 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.

The cost estimate is as firm an estimate as is possible given the variation in program requirements and timing. The cost estimates for the demonstration project are the most firm, having been derived after intensive planning sessions with Thai health and economic professionals. Annual reviews (the first being in November, 1975) will allow adjustments as necessary.

Other cost estimates are of varying precision. Funds allocated to the provision of technical services are based on utilization factors of two 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.

Costing of the development of evaluation guidelines [illegible]

Past experience, however, has meant that 'evaluation' means widely different things to different groups and people. Costing is formulated on the assumption that a commonality of evaluation approach can be achieved.

Costing of network functions are less precise. 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.

In summary: This project generally supports the utilization of existing technologies by LDC's in a more efficient manner. While it

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

Technologies utilized by health delivery projects supported by this activity must be carefully selected and tailored for use in each country assisted. The specific technologies selected will vary widely in degree of sophistication within each country, and from one country to another.

The technical design is appropriate to agency needs and is in keeping with the intent of congress "to help provide health services for the great majority".

Cost estimates are "best guess" estimates developed from two years previous experience provided under the initial PROP and its amendments, and with a projection of anticipated demands as indicated by the Regional Bureaus.

Pursuant to Section 611 of the Foreign Assistance Act, while this is not a capital assistance project, cost elements are reasonably firm and adequate planning has taken place.

B. Financial Analysis and Plan

Summary Opinion

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 supported by the intent of AID legislation.

The costing of technical assistance has been done as carefully as currently expressed agency anticipation for technical assistance allow. Changing demand would influence these costs; our best estimate is no more than 15% in either direction.

Costing of the evaluation component is liable to the greatest error. Examination of the workplan for this activity, to be presented to AID nine months from the projects' inception, will allow greater precision.

Establishing the network is predicated on the assumption that other donors, project managers, universities, private and voluntary organizations, and LDC's are willing to enter into a free exchange of information. Establishment of these channels, to be completed by the end of the first year, again will allow greater precision.

In summary, [redacted], while appearing firm for the first twelve months, [redacted].

C. Social Analysis

No nation can afford to provide every health service (promotive, preventive, curative, rehabilitative) to every citizen at all times. [redacted] This target group represents a major human resource and is the group most vulnerable to preventable morbidity and mortality. It is this group which is most affected by rapid population growth, 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 , for example through traditional practitioners, exorcists, shamans, wizards, herbalists.

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. 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 services where they are freely available. The rate of acceptance of service varies by category; [redacted] but there have been remarkable successes even in preventive services - such as yellow fever, malaria and smallpox.

There should be little resistance on any front to the intent of the project. 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.Ds, R.Ns) 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 as in the clear example of Guatemala and Brazil.

The role of women as intended beneficiaries has been described above. Women in many societies traditionally have been primary providers of health services. Delegation of health roles, traditionally performed by male professionals, to paraprofessionals will increase participation. With increasing participation of women in political, professional and social leadership roles, the status of women will be enhanced.

A blanket statement concerning the spread effects of this project is not possible to make with accuracy. Wherever possible technical assistance provided by this project will encourage project development

of innovative health service delivery demonstrations from which countries can select components for replication. 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 area rapidly available to others, so that experience can be rapidly disseminated.

In summary: The intended 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. [redacted]. 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 in 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 factors which contribute to overall development.

Most authorities agree as few as 10% and no more than 30% of the populations in 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. Increased productivity in

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

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 aspects of their development, including economic development goals achieving desired population levels, the amounts of necessary, effective health outreach systems.

The argument has been made that development in the social sectors is a natural and evolutionary result of economic development, nad 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 population 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 growth to health status cannot be overlooked. aAlthough 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 and the

net effects of such programs, by themselves, will not significantly alter the health status of the majorities during the forthcoming decade.

When compared to amounts of private and public funds expended by the AID assisted nations, [redacted] In AID assisted nations, for instance, estimated government health expenditures are $3.5-$7 billion annually, plus $5-$10 billion in private expenditures. Donor contributions 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 expand costly medical-care based health delivery systems.

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

[redacted] The economic analysis presented in this project paper is a cost effectiveness 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 receipients.

A. Cost of Low Cost Health Delivery Systems

[redacted]. One small scale experiment in Guatemala operated at a per capita cost of $2.26[1] using the population served as the denominator.

The capital project paper 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-capital project paper estimated replication costs there at $262,000 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 Systems.

[redacted] 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 that public facilities

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

2. DEIDS (Thailand Subproject) Capital Project Paper (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.

serve only 17% of the population. This raises per capita public health expenditures to $11.37. In this case, the annual total cost would be $18.87. In actuality, Thailand provides the common example of inequitable distribution of limited resources.

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 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 would be judged as "well-managed".[5]

D. Summary

Thus 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 that 50% that of the existing system.

The specific savings of efficiencies introduced include:

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

It has been variously estimated that [redacted] In Guatemala, for instance, it was estimated

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

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 nurse have no place in the delivery system. Their presence will be continually required at the central level in preventive medicine, and in the referral cycle for medical care. Of equal importance, the role of the physician and nurse in the lowere echelons of the delivery systems must change from the conventional ones of providing care to individuals to roles of leadership, supervision and training.

(2) [redacted]

It is [redacted] which reach a small perventage (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. National budgetary allocations is a more appropriate effort for macro-level national health planning, a parellel and complementary program activity of AID.

The above economic analysis explicitly avoids placing a value on the social worth of the services provided and implicitly understates the probable value of the services. This happens because it is assumed that the services delivered by the low-cost delivery systems will be directed at the same target groups and health problems as the extant delivery systems. In fact, it is

expected that the [redacted] 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.

Summary Statement: This project is designed to assist developing nations to deliver health, family planning and nutrition services at a lower per capita cost, thus enabling existing resources to cover a larger portion of the poor populations.

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 PROP since its inception. APHA's more than 20,000 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, determining availability and pass the information obtained to the appropriate Regional Bureau. When a consultant is selected, the APHA arranges travel, briefing and debriefing sessions, and the preparation of consultant 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 effecting the Regional Bureaus.

Administrative arrangements for the Thailand demonstration projects subcontract areas follows:

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. The project is described in an amendment to the PROP dated June 19, 1974.

Under a subcontract dated December 11, 1974, between APHA and the School of Public Health of the University of Hawaii (SPHUH), SPHUH 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.

B. Implementation Plan

1) First Year

a) Recruitment of staff

b) Prepare and implement workplans for supervision of Thai Project, information network and evaluation guidelines.

c) Supervise the DEIDS/Thailand sub-project contracted to the University of Hawaii.

d) Provide quick responsive short-term consultancy services to regional bureaus, missions, and LDC's for determining feasibility, planning, designing and evaluation of affordable health delivery systems.

e) Collect, analyze and disseminate information on affordable health delivery systems, i.e., State of the Art document, Quarterly Newsletter.

f) Promote the concept of affordable health delivery systems through one domestic and one international conference which includes the Thailand Annual Review.

g) Establish information channels with 10 international

donors, 50 universities and 30 private and voluntary organizations.

h) Prepare annual report

2) Second Year

a) Supervise DEIDS/Thailand Project.

b) Provide technical assistance to requesting LDC's.

c) 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.

d) Promote the concept of affordable health delivery systems through one domestic and one international conference which includes the Thai Annual Review.

e) 300 copies of evaluation guidelines available and distributed to AID assisted countries and requesting organizations.

f) Prepare final report.

3) Third Year

a) Supervise the DEIDS/Thailand Project and conduct Fourth Annual Review.

b) Provide T.A. to LDCs for a total of 226 mm.

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 one domestic and one international conference which includes the Thai Annual Review.

e) 150 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 twelve months after beginning the project and annually thereafter to assess:

1) Progress on implementation of work plans for THAI Project, project information network, and evaluation guidelines.*

2) Effectiveness of Core staff in providing services in relation to outputs.

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

3) Effectiveness of consultants in carrying out health assessments and in developing affordable health delivery systems. Services to include health planning, project design, administration, training and other.

4) Quality and quantity of information prepared and disseminated, on affordable health delivery systems. Specifically, at each annual evaluation, contractor will provide a summary of global experience on existing low cost integrated health delivery systems identifying key facts to the extent available, e.g., location, population size, per cent population regularly reached by health system, frequency of household visits, description of manpower pattern which permits outreach, identification of services actually provided to majority of households, (family planning, health, nutrition), utilization of services provided, and costs per capita of population served. At each subsequent annual evaluation, the contractor will compare annual data as described above with previous annual summaries, document changes in each of the categories to the extent that data is available.

COUNTRY:	PROJECT No:	PROJECT TITLE:	DATE:	(x) ORIGINAL	APPROVED:
Worldwide	931-11-580-971	Integrated Health Delivery Services	11/20/75	( ) REVISION No.:	

PRIOR ACTIONS:

1/76 PROP signed
PIO/T

PI NARRATIVE:

1. 3/76 Thai Project workplan
"State of Art" document

2. 6/76 CORE Staff recruited
Information network workplan

3. 9/76 Evaluation guidelines workplan

4. 9,12/76 Quarterly Newsletter dissiminated

5. 10/76 U.S. Conference on health delivery systems

6. 11/76 Overseas Conference in Thailand to include Thai Second Annual Review

7. 12/76 Information exchange channels established with 10 International Donors, 50 universities, 30 private and voluntary organizations

8. 2/77 Annual Report
PAR Review

9. 3,6,9,12/77 Quarterly Newsletter disseminated

10. 6/77 "State-of-Art" indepth studies of six HDS completed

11. 8/77 Overseas Conference on affordable HDS

12. 10/77 U.S. Conference on HDS

13. 11/77 Thai Third Annual Review

14. 2/78 Annual Report
PAR Review

15. 3,6,9,12/78 Quarterly Newsletter disseminated

16. 10/78 U.S. Conference on HDS

17. 11/78 Overseas Conference in Thailand to include Thai Fourth Annual Review and Interregional Seminar

18. 1/79 226 MM technical assistance provided to LDCs
150 copies Evaluation Guidelines available for distribution to AID-assisted LDCs and requesting organizations

Project completed

19. 2/79 Final Report
PAR Review

ANNEX A

COUNTRY: Worldwide

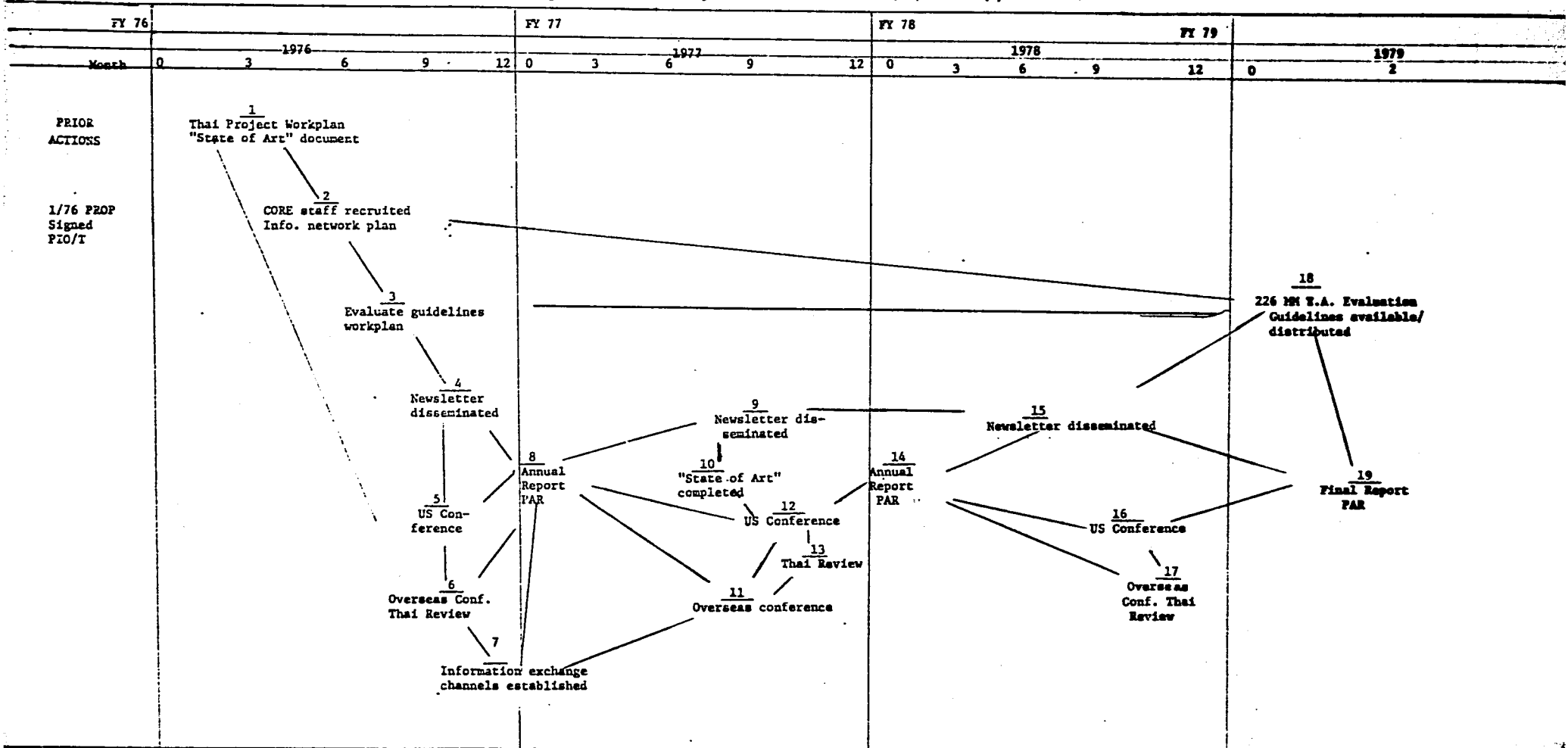
PROJECT No:

PROJECT TITLE: Integrated Health Delivery Services

DATE: 11/20/75

( ) Original Approved:

( ) Revision #



Financial Plan	1,058	1,097	1,115	
Evaluation Plan		X	X	X

Annex B

ESTIMATED SALARY COSTS

PERSONNEL	YEAR 01	YEAR 02 [1]	YEAR 03 [1]
DEIDS Director	37,800	39,690	41,674
Contract & Special Projects	25,622	27,730	28,662
Community Health & Health Education	31,700	34,333	35,424
MCH & PHN	25,622	27,730	28,662
Evaluation Specialist	36,000	37,800	39,690
Network Coordinator	24,795	25,622	26,449
Information Specialist	12,432	13,644	13,896
PVO Specialist	26,449	28,598	29,560
Administrative Assistant	16,215	17,025	17,876
Reports-Editorial Assistant	12,951	13,880	14,543
Secretary	11,968	12,569	13,197
Secretary	9,819	10,616	11,270
Secretary	9,205	9,972	10,625
Secretary	10,126	10,433	10,740
SUB-TOTAL	290,784	309,642	322,268
BENEFITS (30%)	87,235	92,893	96,680
OVERHEAD (69.39%)	262,307	279,319	290,708
TOTAL	640,326	681,854	709,656

[1] Calculated on an inflation rate of 5%.

Annex B2

Budget		Year 01	Year 02	Year 03
PERSONNEL				
Salary		290,784	309,642	322,268
Benefits		87,235	92,893	96,680
CONSULTANTS				
1320 days@ $138/day		182,160	174,570	166,290
TRAVEL & PER DIEM				
International:				
68 trips@ approx. $1500	102,010			
Per Diem 1400 days @ approx. $40	55,920			
Domestic:				
18 trips @ $420 (average)	7,560			
Per Diem 122 days @$25	3,050	168,540	175,100	173,100
OTHER DIRECT COSTS				
Rent 2557.1 sq. ft. x $60/mo.	18,500			
Telephone/Telegraph	8,000			
Postage	3,000			
Printing	15,000			
Supplies	8,700			
Contract Services (Complete usage)	10,000			
Magazines/Journals	3,500	66,700	65,150	65,475
Subtotal		795,419	817,355	823,813
Overhead	69.39%	262,307	279,319	290,708
TOTAL		1,057,726	1,096,674	1,114,521

Annex B3

SUMMARY OF COSTS OF OUTPUTS

OUTPUT ELEMENT	Year 01	Year 02	Year 03	Total	Percentage Cost
1. Management of Thailand DEIDS Project					
a. General Supervision	30,900	32,070	30,360	93,330	2.85
b. Evaluation Activity	21,390	22,120	20,110	63,620	1.95
c. Dissemination of Results	6,750	9,585	14,960	31,295	.96
d. Work Plan	4,510	2,395	2,490	9,395	.29
2. Tech. Assistance to AID Reg. Bureau sponsored LCHDS Programs					
a. Sector Analysis & Feasibility Studies	117,300	127,160	108,640	353,100	10.80
b. Planning Questions	84,420	90,672	76,540	251,632	7.70
c. Operations Questions	42,400	36,380	48,590	127,370	3.90
d. Evaluation	41,780	45,335	71,210	158,325	4.84
3. Evaluation Guidelines					
a. Work Plan	11,250	2,395	2,490	16,135	.49
b. Conclusion of Literature Search Program	8,209	------	-----	8,209	.25
c. Analysis of Methodologies					
(1) Preparation of General Reports and Conclusions	17,460	27,775	31,150	76,385	2.34
(2) On-site visits	33,530	34,555	35,240	103,325	3.16
(3) Publication of Special Analyses	14,700	33,255	60,230	108,185	3.31
d. Preparation of Guidelines and Dissemination					
(1) Local Projects	11,250	16,775	-----	28,025	.86
(2) For National Systems	11,250	16,775	-----	28,025	.86
4. [redacted]					
a. Work Plan	18,000	2,395	2,490	22,885	.70
b. State of the art	[redacted]	-----	24,940	107,180	3.28
c. Identification/dissemination of innovative features	[redacted]	[redacted]	[redacted]	201,188	6.15
d. Identification of Resources					
(1) Potential Donors	18,260	24,095	8,858	51,213	1.57
(2) Resources available in private (or professional) and VolAg Orgs.	31,210	23,515	11,360	66,085	2.02
e. Encouragement of Private and VolAg Participation	38,190	39,792	33,640	111,622	3.41
f. Conferences (US and overseas)	11,250	19,168	28,440	58,858	1.80
g. Publications	45,500	63,505	54,870	163,875	5.01
SUBTOTALS	728,719	752,205	758,338	2,239,262	(68.50)
OTHER DIRECT COSTS	66,700	65,150	65,475	197,325	6.04
OVERHEAD	262,307	279,319	290,708	832,334	25.46
TOTAL	1,057,726	1,096,674	1,114,521	3,268,921	100.00

Annex B_4

ESTIMATED COSTS OF OUTPUTS 01 YEAR

CORE Staff 14 man years
1 mm = $2,250

OUTPUT ELEMENTS	CORE STAFF MM	CORE STAFF $	CONSULTANTS MD	CONSULTANTS $	TRAVEL PER DIEM	TOTAL
1. Management of Thailand DEIDS Project						
a. General supervision	8	18,000			12,900	30,900
b. Evaluation activity	5	11,250	30	4,140	6,000	21,390
c. Dissemination of results	3	6,750				6,750
d. Work plan	2	4,510				4,510
2. Technical Assistance to AID Bureau sponsored LCHDS Programs						
a. Sector Analysis & Feasibility Studies	12	27,000	350	48,300	42,000	117,300
b. Planning questions	10	22,500	240	33,120	28,800	84,420
c. Operations questions	8	18,000	100	13,800	10,600	42,400
d. Evaluation	6	13,500	110	15,180	13,100	41,780
3. Evaluation Guidelines						
a. Work plan	5	11,250				11,250
b. Conclusion of literature search program	2	4,509	20	2,760	940	8,209
c. Analysis of evaluation methodologies						
(1) Preparation of general reports and conclusions	5	11,250	45	6,210		17,460
(2) On-site visits	7	15,750	10	1,380	16,400	33,530
(3) Publication of special analyses	5	11,250	25	3,450		14,700
d. Preparation of guidelines and dissemination						
(1) For local projects	5	11,250				11,250
(2) For national systems	5	11,250				11,250
4. Establishing Information & Resources Network						
a. Work plan	8	18,000				18,000
b. State of the art.	18	40,500	130	17,940	23,800	82,240
c. Identification/dissemination of innovative features	8	18,000	65	8,970		26,970
d. Identification of Resources						
(1) Potential Donors	6	13,500	20	2,760	2,000	18,260
(2) Resources available in private (or professional) and Volag Org	8	18,000	45	6,210	7,000	31,210
e. Encouragement of private and Volag participation	9	20,250	130	17,940		38,190
f. Conferences (in U.S. and overseas)	5	11,250				11,250
g. Publications	18	40,500			5,000	45,500
SUBTOTALS	168	378,019	1,320	182,160	168,540	728,719
OTHER DIRECT COSTS						66,700
OVERHEAD						262,307
TOTAL FOR YEAR						1,057,726

Annex B_5

ESTIMATED COSTS OF OUTPUTS 02 YEAR

	CORE STAFF MM	CORE STAFF $	CONSULTANTS MD	CONSULTANTS $	TRAVEL $ PER DIEM	TOTAL
CORE Staff - 14 Man Years						
1 MM = $2,396						
OUTPUT ELEMENTS						
1. Management of Thailand DEIDS Project						
a. General supervision	8	19,170			12,900	32,070
b. Evaluation activity	5	11,980	30	4,140	6,000	22,120
c. Dissemination of Results	4	9,585				9,585
d. Work Plan	1	2,395				2,395
2. Technical Assistance to AID Regional Bureau sponsored LCHDs Programs						
a. Sector Analysis & Feasibility Studies	10	23,960	400	55,200	48,000	127,160
b. Planning Questions	12	28,752	240	33,120	28,800	90,672
c. Operations Questions	5	11,980	100	13,800	10,600	36,380
d. Evaluation	6	14,375	120	16,560	14,400	45,335
3. Evaluation Guidelines						
a. Work Plan	1	2,395	-			
b. Conclusion of literature search program	-		-			2,395
c. Analysis of evaluation methodologies						
(1) Preparation of general reports and conclusions	9	21,565	45	6,210		27,775
(2) On-site visits	7	16,775	10	1,380	16,400	34,555
(3) Publication of special analyses	11	26,355	50	6,900		33,255
d. Preparation of guidelines and dissemination						
(1) For local projects	7	16,775				16,775
(2) For national systems	7	16,775				16,775
4. Establishing Information & Resource Network						
a. Work Plan	1	2,395				2,395
b. State of the art	-					
c. Identification/dissemination of innovative features	18	[redacted]	120	16,560	22,800	82,488
d. Identification of Resources						
(1) Potential donors	6	14,375	40	5,520	4,200	24,095
(2) Resources available in private (or professional) &VolAg Org.	6	14,375	30	4,140	5,000	23,515
e. Encouragement of private & VolAg participation	12	28,752	80	11,040		39,792
A f. Conferences (in U.S. and overseas)	8	19,168				19,168
g. Publications	24	57,505			6,000	63,505
SUBTOTALS	168	402,535	265	174,570	175,100	752,205
OTHER DIRECT COSTS						65,150
OVERHEAD						279,319
TOTAL FOR YEAR						1,096,674

Annex B_6

CORE STAFF - 14 Man-years

1 Man-month = $2,494

ESTIMATED COSTS OF OUTPUTS 03 YEAR

OUTPUT ELEMENTS	CORE STAFF MM	CORE STAFF $	CONSULTANTS MD	CONSULTANTS $	TRAVEL/ PERDIEM	TOTAL
1. Management of Thailand DEIDS Project						
a. General Supervision	7	17,460			12,900	30,360
b. Evaluation Activity	4	9,970	20	4,140	6,000	20,110
c. Dissemination of Results	6	14,960				14,960
d. Work Plan	1	2,490				2,490
2. Tech. Assistance to AID Reg. Bureau sponsored LCHDS Programs						
a. Sector Analysis & Feasibility Studies	6	14,960	360	49,680	44,000	108,640
b. Planning Questions	10	24,940	200	27,600	24,000	76,540
c. Operations Questions	5	12,470	140	19,320	16,800	48,590
d. Evaluation	12	29,930	160	22,080	19,200	71,210
3. Ecaluation Guidelines						
a. Work Plan	1	2,490				2,490
b. Conclusion of Literature Search Program	-					
c. Analysis of Methodologies						
(1) Preparation of General Reports and Conclusions	10	24,940	45	6,210		31,150
(2) On-site Visits	7	17,460	10	1,380	16,400	35,240
(3) Publication of Special Analyses	20	49,880	75	10,350		60,230
d. Preparation of Guidelines and Dissemination						
(1) Local Projects	-					
(2) For National Systems	-					
4. Establishment of Information and Resource Network Work plan						
a. Workplan	1	2,490				2,490
b. State of the art (update)	10	24,940				24,940
c. Identification/dissemination of innovative features	21	[redacted]	120	16,560	22,800	91,730
d. Identification of Resources						
(1) Potential Donors	2	4,978	10	1,380	2,500	8,858
(2) Resources available in private (or professional) and VolAg Orgns.	3	7,480	10	1,380	2,500	11,360
e. Encouragement of Private and VolAg Participation	11	27,430	45	6,210		33,640
f. Conferences (US and overseas)	9	22,440			6,000	28,440
g. Publications	22	54,870				54,870
SUBTOTALS	168	41P,948	1,205	166,290	173,100	758,338
OTHER DIRECT COSTS						65,475
OVERHEAD 69.39%						290,708
TOTAL FOR YEAR						1,114,521

AID 1020-28 (1-72)
Annex C

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 76 to FY 7
Total U. S. Funding $3,270,000
Date Prepared:

Project Title & Number: Integrated Health Delivery Services

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes: 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.	Measures of Goal Achievement: 1. Increase in age specific life expectancy. 2. Decrease in age specific mortality rates. 3. Reduction in age/parity specific birth rates.	WHO and LDC statistics.	Assumptions for achieving goal targets: 1. LDCs are interested in improving the health status of their population. 2. Assistance in health sector will be acceptable to the LDCs. 3. Assistance in the health sector will improve health status.
Subsector goal: To make basic health services, particularly those related to MCH, nutrition & family planning available & accessible to majority of LDC populations at affordable costs. Target is women of child-bearing age &children under5.	1. Majority of target population in assisted LDCs are aware of and use the health system developed. 2. Programs developed are affordable to host country.	1. Surveys, project statistics, projects evaluations, facility records. 2. LDC evaluation and decision to retain or modify the developed system. Nationwide replication of major elements.	1. LDCs will build in evaluation techniques useful in making decisions as to design, implementation, or replicability. 2. The target group is the appropriate intervention point. 3. MCH, & nutrition are appropriate primary interventions to affect health status
Project Purpose: To support the Agency's capability to respond rapidly to request from USAIDs and feasibility assesment , project design a assistance and evaluation of systems to deliver combined health population and nutrition services to a national majority within the limits of national resources	Conditions that will indicate purpose has been achieved: End of project status. 1. Thailand sub-project proceeding as planned (see PROP) 2. By end of 1978 the Agency will have 24-30 delivery systems projects planned or implemented. 3. Guidelines for evaluation will be available for use by USAIDs and health planners in LDCs. 4. Concepts and experience distributed throughout AID-assisted countries.	1. Annual project review. 2. Consultant reports, resulting AID program documents. 3. Evaluation reports. 4. Host country documents ; seminars and conferences.	Assumptions for achieving purpose: 1. The World Health Assembly resolution (May 1975) represents a growing political demand among developing countries for low cost health delivery systems. 2. U.S. Legislative emphasis, UNGA Kissinger committment, and AID policy support continued growth of delivery system programs. 3. Evaluation techniques will allow comparisons of alternative health interventions.
Outputs: 1. Thai project supervised (includes evaluation activity) 2. Technical assistance provided to requesting countries. 3. Evaluation guidelines developed for affordable HDS (local and national system). 4. Network established for information collection, analysis and dissemination, identification of needs & resources and for promotion.	Magnitude of Outputs: 1. 57 mm provided Thai project monitoring. 2. 226 MM for T.A. 3. 300 copies evaluation guidelines distributed by end of project. 4. State of art document by 3/1976 In-depth study of 6 affordable HDS by 6/77; channels established with 10 international agencies, 50 universities & 30 PVOs by 9/76; 1 overseas, 1 domestic conference annually.	1. Project statistics; project review; evaluation plan. 2. Consultant reports; AID reports; contractors' documents. 3. Guideline documents. 4. State of art report ; contractor reports; conference reports.	Assumptions for achieving outputs: 1. AID and the Thai government continue support of the demonstration project. 2. Contractor can provide suitable consultants. 3. Evaluation technique can be agreed upon by AID and LDCs to permit guidelines to be prepared. 4. Other donors, universities and PVOs are willing to exchange information. Contractor can design suitable network.
Inputs: AID: 1. Project monitoring-TA/H. 2. $3,270,000 for Contract Services 3. Provide access to contractor to AID projects for analysis of health systems including evaluation methodologie Contractor: 1. Core staff 2. Consultants 3. Sub contractors Host country: Inputs will vary depending upon the projects devaloped through the use of the contractor and other resources.	Implementation Target (Type and Quantity)		Assumptions for providing inputs: 1. Congress will make funds available. 2. Contractor can provide required services. 3. LDCs are willing to support affordable health systems.

Budget	Year 01	Year 02	Year 03
Personnel	291	310	322
Fringe Benefits	87	93	97
Consultants	182	175	166
Travel & Per Diem	169	175	173
Supplies	9	8	7
Printing	15	12	10
Contract Services (Computer)	10	10	10
Other Direct Costs	33	35	39
Overhead	262	279	291
Total	1058	1097	1115

UNITED STATES GOVERNMENT

Memorandum

FILE

TO : See Distribution

DATE: November 21, 1975

FROM : TA/H, Merrill M. Shutt, M.D.

SUBJECT: PP, ~~Integrated~~ Health Delivery Services.

Attached ~~is a copy of~~ a revision of the DEIDS worldwide project retitled Integrated Health Delivery Service. The paper has not yet been approved internally by TAB, nor has it been before the R & D Committee.

We would appreciate discussing the paper with you and reacting to your comments on Wednesday, November 26, at 10:30 a.m. in Dr. Lee Howards' office in room 630 PP. If you can't attend, could you please notify me at 235-9161.

Distribution:

1) AFRICA/DS, Dr. Ed Cross
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