

PD-111J-G34
1510-1159

936-5916/42

AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT PAPER FACESHEET	1. TRANSACTION CODE <input checked="" type="checkbox"/> A ADD <input type="checkbox"/> C CHANGE <input type="checkbox"/> D DELETE	PP <hr/> 2. DOCUMENT CODE 3
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3. COUNTRY/ENTITY DSB Inter-regional	4. DOCUMENT REVISION NUMBER <input type="checkbox"/>
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5. PROJECT NUMBER (7 digits) <input type="text" value="936-5916"/>	6. BUREAU/OFFICE A. SYMBOL DSB	B. CODE <input type="text" value="08"/>	7. PROJECT TITLE (Maximum 40 characters) <input type="text" value="AID/CDC International Hea. Initiative"/>
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8. ESTIMATED FY OF PROJECT COMPLETION FY <input type="text" value="8"/> <input type="text" value="3"/>	9. ESTIMATED DATE OF OBLIGATION A. INITIAL FY <input type="text" value="8"/> <input type="text" value="1"/> B. QUARTER <input type="text" value="1"/> C. FINAL FY <input type="text" value="8"/> <input type="text" value="3"/> (Enter 1, 2, 3, or 4)
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10. ESTIMATED COSTS (\$000 OR EQUIVALENT \$) -						
A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. TOTAL	E. FX	F. L/C	G. TOTAL
AID APPROPRIATED TOTAL						
(GRANT)	2,700		2,700	11,200		11,200
(LOAN)						
OTHER U.S.	1.					
	2.					
HOST COUNTRY						
OTHER DONOR(S)						
TOTALS	2,700		2,700	11,200		11,200

11. PROPOSED BUDGET APPROPRIATED FUNDS (\$000)									
A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. 1ST FY <u>81</u>		H. 2ND FY <u>82</u>		K. 3RD FY <u>83</u>	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	I. GRANT	J. LOAN	L. GRANT	M. LOAN
(1) HEA	510			2,700		3,000		5,500	
(2)									
(3)									
(4)									
TOTALS									

A. APPROPRIATION	N. 4TH FY		O. 5TH FY		LIFE OF PROJECT		12. IN-DEPTH EVAL. SCHEDULED
	D. GRANT	P. LOAN	R. GRANT	S. LOAN	T. GRANT	U. LOAN	
(1)					11,200		MM YY <input type="text" value="0"/> <input type="text" value="3"/> <input type="text" value="8"/> <input type="text" value="2"/>
(2)							
(3)							
(4)							
TOTALS							

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

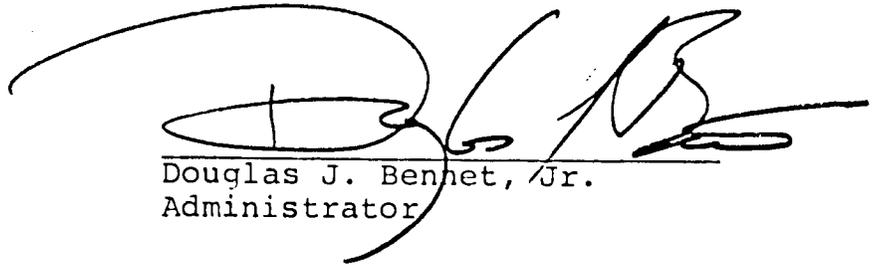
1 = NO
 2 = YES

14. ORIGINATING OFFICE CLEARANCE				15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W OCCU. MENTS, DATE OF DISTRIBUTION MM DD YY <input type="text" value="0"/> <input type="text" value="3"/> <input type="text" value="8"/> <input type="text" value="2"/>			
SIGNATURE	John Alden <i>John Alden</i>						
TITLE	Director, DS/HEA			MM	DD	YY	

PROJECT AUTHORIZATION

ENTITY : Center for Disease Control (CDC)
PROJECT : AID-CDC International Health Initiative
PROJECT NO: 936-5916

Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the AID-CDC International Health Initiative project involving planned obligations of not to exceed \$11.2 million in grant funds over a three-year period from date of authorization, subject to the availability of funds in accordance with the AID OYB/allotment process, to help in financing foreign exchange and local currency costs for the project.



Douglas J. Bennet, Jr.
Administrator

Date Nov 17, 1980

Clearances:

AA/DS, S. Levin
AA/PPC, A. Shakow See Memo dtd Oct 27
AA/LAC, E. Coy See Memo dtd Oct 9
AA/AFR, G. Butcher See memo dtd Oct 31
AA/ASIA, J. Sullivan See memo dtd Oct 3
AA/NE, A. White See memo dtd Oct 6
GC, N. Holmes See 11/10/80
GC/TFHA, A. R. Richstein See Memo dtd 11/18/80
Mick

Attachments:

1. Scope of Work
2. Budget

AID-CDC International Health Initiative

Project Description

The proposed three year project with CDC will provide CDC expertise to AID and host countries primarily to strengthen key areas within AID and host country Primary Health Care programs. CDC's expertise can directly strengthen the primary health care (PHC) programs by assisting LDC's to improve the key disease control components of PHC systems. The project, by recognizing that disease control and treatment are fundamental elements of PHC, will greatly enhance AID's efforts in this high priority area.

Many LDC governments, as well as AID, place highest priority on expanding and improving systems for delivering PHC. Discussions with LDC health policy officials at the Alma Ata Conference, at which the "health for all" principle was endorsed and in various other fora both in the U.S. and the LDC's, convince us that health and development leaders in the LDC's are seeking ways to improve the content of PHC systems as well as extend access to services. The heavy emphasis which AID gives to PHC is reflected by the investment of \$57 million in development assistance funds in FY 80 for 47 AID-supported PHC projects in 36 countries. Although the size and relative importance of the disease control and treatment element of the PHC programs varies with conditions in each location, such an element is a fundamental part of PHC. An increased effort and improved technical support is needed to assist LDC's to incorporate activities such as epidemiological surveillance, treatment of diarrheal diseases, immunizations, control of malaria, and provision of health information into basic health service programs.

This AID-CDC initiative, which has a broad and cohesive programmatic basis, offers an opportunity to assist worldwide in melding selected categorical activities with PHC. This programmatic perspective is important on many fronts: to build institutional capacity in the LDC's, to increase and apply knowledge and appropriate health technologies where they are most needed, and to strengthen U.S. technical capability (both AID's and CDC's).

The proposed project will emphasize the following: A) Disease Surveillance. In the context of the WHO goals of community participation and self-sufficiency, the surveillance needs of primary health care will require the development and use of surveillance systems at local, sub-national, and national levels. The potential for local surveillance systems to provide immediate feedback to the delivery system and the community is virtually untapped. It may also be important to reorient surveillance from passive collection of data for reports, to the collection of relevant data for use in project development and implementation. B) Field Epidemiologic Training. National epidemiologic training programs will be developed in 10-20 countries by CDC; CDC will assist in developing a training program, including supervised field experience on either a regional or national base. C) Control of Immunizable Diseases. Immunization programs will be assisted, as appropriate, on regional and national levels as components of primary health care programs. Immunization, for example, will be considered for measles, diphtheria, whooping cough, tetanus, poliomyelitis, and tuberculosis. Action plans would be

prepared by National Governments with the advice and assistance of AID and CDC as appropriate. D) Diarrheal Disease Control. Diarrheal disease control programs will be based mainly on the introduction and use of oral rehydration as an integral part of a PHC program, particularly with children under five years of age. Action plans would be prepared by National Governments with the advice and assistance of AID and CDC as appropriate. E) Malaria Control. CDC will provide assistance to the malaria component of national and regional PHC programs with emphasis on measures to reduce morbidity and mortality, including such areas as pesticide chemistry, formulation/analysis of pesticides, training, toxicology, parasitology, vector control, epidemiology, environmental concerns, and other specialities as required and appropriate. F) Other Selected Diseases. CDC may provide assistance as requested to national and regional programs concerned with other specific diseases which are recognized by host governments as major public health problems. Programs for disease treatment and control may receive assistance under this project only to the extent that they are an appropriate part of a primary health care strategy and program.

Scope of Work

The services under this RSSA will be performed over a 36 month period. Within the context of the technical areas outlined in the project description, this international health initiative will be developed in five stages:

1. Overall Planning and Project Development

This is an agency-wide AID initiative with prime responsibility for coordination with CDC resting in the Office of Health of the Development Support Bureau. A project manager will be appointed by DS/HEA to be the principal AID contact with CDC and the overall coordinator for AID regional bureau activities under this program. CDC will establish a unit to implement the program under the direction of the Assistant Director for International Health. A project manager within this unit will be appointed to be responsible for coordination with AID. For effective coordination, both the AID and the CDC project managers will need to be knowledgeable of activities under all other active AID-CDC RSSAs and PASAs. In order to insure adequate monitoring, coordination and equitable allocation of resources, all action requests (e.g., requests for commodities, short-term advisors, etc.) must pass through standard AID channels and no commitments to host governments may be made without concurrence of the AID mission in the concerned country and the AID and CDC project managers. This provision does not restrict communications between CDC personnel in the field and CDC headquarters for routine technical backstopping within previously agreed upon activities, but the AID mission and the project managers must receive information copies of all such correspondence to assure completeness of the official project files and an adequate global overview of project operations and problems.

An AID Coordinating Committee will be established to advise the AID project manager on policy, to review progress as projects are implemented, and to keep abreast of changing priorities, conditions, etc. in the developing countries that will impact on the overall progress and direction of the RSSA. Members of

the Committee will include health professionals from DSB, PPC, and the four regional bureaus. They will meet regularly two times a year and more frequently if circumstances require. It is expected that this mechanism will enable AID/W to closely monitor this program and to ensure that it is fully supportive of and carefully coordinated with AID priorities and programs.

Annually, CDC will prepare a budget for implementation of this agreement for review and approval by AID. CDC will provide quarterly financial reports of expenditures. Unless otherwise agreed upon, procurement of equipment and supplies will be handled through AID channels. Planning cycles will be coordinated to the maximum extent possible to meet the planning and budgetary deadlines of each agency.

A three person external review group, composed of non U.S. government health experts, will be established to periodically review the progress and direction of the overall project and submit their findings and recommendations to AID and CDC. The review group may request that in-depth evaluations of certain components of, or activities under, the project be conducted and may recommend experts to be included on evaluation teams. All administrative arrangements for the review group will be handled by CDC under this RSSA.

In-depth evaluation of the total program will be carried out at the end of 18 month and of 36 months. Members for any evaluation teams may be nominated by AID and/or CDC. The final composition of the evaluation teams and the external review group, as well as the criteria and scope of work for the evaluation, will be mutually agreed upon by AID and CDC.

2. Development of Regional Work Programs

A primary emphasis at the beginning of this project will be the development of work programs for each of the four AID geographic regions. Development of the work programs will be undertaken by the AID and CDC project managers jointly with AID regional bureau personnel (including mission staff where appropriate) and appropriate CDC technical and administrative personnel. The work program for each region will set the general guidelines for activities within that region. The situation within each country, including disease problems and current health programs, will be examined to determine the potential activities which might be usefully carried out under this project. An estimate of the budget requirements to implement the plans will be developed and a rough order of priorities for the country and regional activities will be established. The regional work program will also establish the methods and procedures to be used in working with the USAID's and host country governments to develop and administer projects and activities within each region. The regional work programs will be re-evaluated semi-annually by AID and CDC and updated as necessary.

3. Technical Consultation

In order to implement the Regional work programs, CDC will provide short-term consultants to USAID's and LDC's to evaluate health constraints and provide technical consultation which may result in the development of specific country programs. These exploratory visits to discuss health problems and constraints of joint/mutual interest, will be channeled through the AID project manager

who will be responsible for obtaining the appropriate AID clearances.

4. Country Programs and/or Projects

Overtures to governments to ascertain the level of interest and commitment will be made by USAID mission staff with the participation of CDC as mutually agreed and appropriate. These programs will be collaborative efforts with the host governments. Following approval by AID/W and CDC, project agreements with the host governments will be negotiated by the USAIDs. Missions will have full responsibility for all country projects in accordance with AID procedures and delegations of authority.

The country projects will define detailed program content and the responsibilities of each of the participating parties (host governments, USAIDs, AID/W, and CDC). Each project developed under the work program will be approved by all parties and will specify detailed plans for implementation and requirements for evaluation and periodic review.

CDC health professionals will be available under this project for both short- and long-term assignments in-country to assist in carrying out country projects. All CDC staff on long-term or short-term assignment will work under the USAID director and/or his delegated representative. Since CDC staff are U.S. government employees, mode ceilings will be required from the mission prior to placement of long-term CDC advisors in the field. Assignment of CDC personnel to host governments and/or USAID's will have to be approved in advance by USAID missions, the AID project manager and the host government.

CDC staff will be considered an integral part of USAID missions. USAID's will provide CDC staff with similar support as for AID direct hire. CDC personnel overseas will be responsible administratively to the USAID mission and receive technical advice and support from CDC. Program implementation will be undertaken by the host government in collaboration with AID and CDC. Host governments will decide what technical inputs are necessary based on CDC and AID advice and recommendations. USAID's and CDC will also advise on the country's technical and administrative capacity to effectively implement a cooperative program.

Country programs will be developed as appropriate, taking into consideration other available donor support. These country programs will be developed with the host governments in the field and submitted to AID/W and CDC for approval. Individual projects undertaken under the terms of this initiative will be documented by a project agreement between AID and the host government that describes the scope of work including the objectives, the plan of operation, the detailed budget (with all sources specified - AID, CDC, host governments, etc.), job descriptions of expatriate personnel, criteria for evaluation, etc.

5. Availability of Reference Expertise

CDC will maintain and, where appropriate, develop a core staff of technical experts to fully backstop the various project activities on a long-term basis. These individuals will be available as short-term consultants to provide backstop for primary health care components such as epidemiology, vector control, toxicology, parasitology, training, and environmental concerns.

In areas that are mutually agreed as being necessary to fulfill the requirements of the RSSA (i.e., schistosomiasis, health anthropology, etc.) CDC will develop staff expertise.

6. Funding Arrangements

DSB funds will be obligated under a RSSA to support all core costs of the project. This will include costs for support of the overall planning, for development of regional work programs, and for short-term country consultations. The RSSA agreement will provide technical support for the development of country projects up to the point at which a project agreement and a PASA are negotiated and signed.

The funding source for the PASAs to implement country projects which are covered by project agreements will depend on the total cost of the PASA and on the availability of funds. Approximately fifty percent of the DSB funds allocated to this project will be obligated under the RSSA. The remaining fifty percent will be available to fund PASAs for specific country projects. If the total cost over the life of the PASA is not more than \$200,000, it may be funded entirely with central funds. If the total cost of the PASA is greater than \$200,000, the funds should be provided primarily by the regional bureau or mission.

7. Staffing Requirements

During the first implementation year (FY 81) approximately 14 positions will be made available (4 from AID and 10 from CDC) to operate under CDC auspices for the initial planning and development phases, including the completion of the four regional strategies. This includes all core staff and any overseas personnel.

During the second implementation year (FY 82) an additional 16 positions (6 from AID and 10 from CDC) will be provided to implement the requirements of the RSSA. This includes core staff and all overseas personnel.

→ W. H. H.
File

F. C. G. P. O. R. I.
This is essentially a project to provide a critical mass of health personnel in tropical countries to develop, manage & evaluate projects. What's missing is a statement that professional positions are being filled within joint AID-CDC centers. Since these professionals will become AID's approved staff of course, this is recorded. CDC

ACTION MEMORANDUM FOR THE ADMINISTRATOR
THRU: ES, Douglas Clark
THRU: AA/DSB, Sander Levin
FROM: DAA/DS/HRD, Stephen Joseph, M.D.

Problem: Approval of the PAF for a 36 month project to fund a RSSA and a series of PASAs with the Center for Disease Control of the Department of Health and Human Services. 936-5916

Discussion: As you will recall, a cable was sent to AID missions in June 1980 requesting their comments on an AID/CDC health initiative for the disease control component of primary health care programs. An analysis of mission responses was prepared by DS/HEA and sent to you in an action memo dated July 14, 1980.

On the basis of the Mission responses, you approved our proceeding with the development of the project for initial obligation in FY 1980. After extensive discussions with the concerned persons at CDC, we have prepared the attached description, scope of work, and budget for a thirty six month activity. As shown in the Budget, approximately \$6.0 million will be used to fund the core costs for the RSSA. The remainder of the \$11.2 million proposed will be available for PASAs to implement specific country programs.

An Advice of Program Change has been submitted to the Congress for the required \$500,000 of FY 80 funds and funds have been set aside within the DS/HEA OYB.

The remaining, unresolved issue of which you should be aware involves the staff arrangements for the RSSA. As described in Sector 7 of the attached scope of work, AID will be committed to provide four new positions in FY 1981 and six new positions in FY 1982, from within AID's personnel ceiling, to work for CDC to implement the RSSA. These positions are additional to the one new AID position which will be required for an AID project manager to be located in DS/HEA.

Information copies of this action memo with attachments have been sent to each of the regional bureau Assistant Administrators.

Recommendation: That you ask the regional bureau Assistant Administrators to clear the attached PAF and that you approve a three year, \$11.2 million project by signing the PAF.

- Attachment:
1. PAF with attachments
2. Action Memo, July 14, 1980

AGENCY FOR INTERNATIONAL DEVELOPMENT
**PROJECT AUTHORIZATION AND REQUEST
 FOR ALLOTMENT OF FUNDS PART I**

1. TRANSACTION CODE

A

A ADD
 C CHANGE
 D DELETE

PAF

2. DOCUMENT CODE
 5

3. COUNTRY/ENTITY

DSB Inter-regional

4. DOCUMENT REVISION NUMBER

5. PROJECT NUMBER (7 digits)

[936-5916]

6. BUREAU/OFFICE

A SYMBOL B. CODE

DSB [08]

7. PROJECT TITLE (Maximum 40 characters)

[AID/CDC Internat'l Hea. Initiative]

8. PROJECT
 APPROVAL
 DECISION

ACTION TAKEN

A APPROVED
 D DISAPPROVED
 DE DEAUTHORIZED

9. EST. PERIOD OF IMPLEMENTATION

YRS. [0] [3]

OTRS [0]

10. APPROVED BUDGET AID APPROPRIATED FUNDS (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. 1ST FY <u>80</u>		H. 2ND FY <u>81</u>		K. 3RD FY <u>82</u>	
		C GRANT	D LOAN	F GRANT	G LOAN	I GRANT	J. LOAN	L GRANT	M. LOAN
(1) HEA	510	510		500		2,700		3,000	
(2)									
(3)									
(4)									
TOTALS				500		2,700		3,000	

A. APPROPRIATION	N. 4TH FY <u>83</u>		O. 5TH FY		LIFE OF PROJECT		11. PROJECT FUNDING AUTHORIZED		A. GRANT	B. LOAN
	D. GRANT	P. LOAN	R. GRANT	S. LOAN	T. GRANT	U. LOAN	(ENTER APPROPRIATE CODES) 1 - LIFE OF PROJECT 2 - INCREMENTAL LIFE OF PROJECT			
(1)	5,000				11,200				2	
(2)										
(3)										
(4)										
TOTALS	5,000				11,200					

C. PROJECT FUNDING AUTHORIZED THRU
 FY [8] [3]

12. INITIAL PROJECT FUNDING ALLOTMENT REQUESTED (\$000)

A. APPROPRIATION	B. ALLOTMENT REQUEST NO.	
	C. GRANT	D. LOAN
(1)		
(2)		
(3)		
(4)		
TOTALS		

13. FUNDS RESERVED FOR ALLOTMENT

TYPED NAME (Chief, SER/FM/FSD)

SIGNATURE

DATE

14. SOURCE/ORIGIN OF GOODS AND SERVICES

000 941 LOCAL OTHER _____

15. FOR AMENDMENTS, NATURE OF CHANGE PROPOSED

PROJECT AUTHORIZATION AND REQUEST FOR ALLOTMENT OF FUNDS

PART II

Entity: DS/HEA

Project: AID-CDC International Health Initiative

Project Number: 936-5916

I hereby authorize FY 1980 grant funding not to exceed five hundred thousand dollars (\$500,000) for a RSSA with the Center for Disease Control to provide technical and operational resources to A.I.D. and developing countries in a broad range of areas of disease prevention and control, primarily as an integral part of primary health care programs.

I approve a total level of A.I.D. appropriated funding for this project not to exceed eleven million two hundred thousand dollars (\$11,200,000), including the funding above, during the life of the project. I approve grant funding up to ten million seven hundred thousand dollars (\$10,700,000) during FYs 1981 thru 1983, subject to the availability of funds and in accordance with A.I.D. allotment procedures.

A/AID, Douglas J. Bennet, Jr.

Date

Attachments:

1. Scope of Work
2. Budget

Clearances:

AA/DS, S. Levin	_____	Date	_____
CC/TFHA, A. Richstein	_____	Date	_____
AA/PPC, A. Shakow	_____	Date	_____
AA/LAC, E. Coy	_____	Date	_____
AA/AFR, G. Butcher	_____	Date	_____
AA/ASIA, J. Sullivan	_____	Date	_____
AA/NE, A. White	_____	Date	_____

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT PAPER FACESHEET

1. TRANSACTION CODE
 A ADD
 C CHANGE
 D DELETE

PP
 2. DOCUMENT CODE
 3

3. COUNTRY/ENTITY
 DSB Inter-regional

4. DOCUMENT REVISION NUMBER

5. PROJECT NUMBER (7 digits)

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7. PROJECT TITLE (Maximum 40 characters)

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9. ESTIMATED DATE OF OBLIGATION
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 B. QUARTER
 C. FINAL FY (Enter 1, 2, 3, or 4)

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	B. FX	C. L/C	D. TOTAL	E. FX	F. L/C	G. TOTAL
AID APPROPRIATED TOTAL						
(GRANT)	(500)	()	(500)	(11,200)	()	(11,200)
(LOAN)	()	()	()	()	()	()
OTHER						
U.S.						
OST COUNTRY						
OTHER COUNTRY(S)						
TOTALS	500		500	11,200		11,200

11. PROPOSED BUDGET APPROPRIATED FUNDS (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. 1ST FY <u>80</u>		H. 2ND FY <u>81</u>		K. 3RD FY <u>82</u>	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	I. GRANT	J. LOAN	L. GRANT	M. LOAN
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2)									
3)									
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14. ORIGINATING OFFICE CLEARANCE
 SIGNATURE: John Alden
 TITLE: Director, DS/HEA
 DATE SIGNED:

15. DATE DOCUMENT RECEIVED IN AID/W. OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

AID-CDC International Health Initiative

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1. Overall Planning and Project Development

This is an agency-wide AID initiative with prime responsibility for coordination with CDC resting in the Office of Health of the Development Support Bureau. A project manager will be appointed by DS/HEA to be the principal AID contact with CDC and the overall coordinator for AID regional bureau activities under this program. CDC will establish a unit to implement the program under the direction of the Assistant Director for International Health. A project manager within this unit will be appointed to be responsible for coordination with AID. For effective coordination, both the AID and the CDC project managers will need to be knowledgeable of activities under all other active AID-CDC RSSAs and PASAs. In order to insure adequate monitoring, coordination and equitable allocation of resources, all action requests (e.g., requests for commodities, short-term advisors, etc.) must pass through standard AID channels and no commitments to host governments may be made without concurrence of the AID mission in the concerned country and the AID and CDC project managers. This provision does not restrict communications between CDC personnel in the field and CDC headquarters for routine technical backstopping within previously agreed upon activities, but the AID mission and the project managers should receive information copies of all such correspondence to assure completeness of the official project files and an adequate global overview of project operations and problems.

An AID Coordinating Committee will be established to advise the AID project manager on policy, to review progress as projects are implemented, and to keep abreast of changing priorities, conditions, etc. in the developing countries that will impact on the overall progress and direction of the RSSA. Members of

the Committee will include health professionals from DSB, PPC, and the four regional bureaus. They will meet regularly two times a year and more frequently if circumstances require. It is expected that this mechanism will enable AID/W to closely monitor this program and to ensure that it is fully supportive of and carefully coordinated with AID priorities and programs.

Annually, CDC will prepare a budget for implementation of this agreement for review and approval by AID. CDC will provide quarterly financial reports of expenditures. Unless otherwise agreed upon procurement of equipment and supplies will be handled through AID channels. Planning cycles will be coordinated to the maximum extent possible to meet the planning and budgetary deadlines of each agency.

A three person external review group, composed of non U.S. government health experts will be established to, periodically review the progress and direction of the overall project and submit their findings and recommendations to AID and CDC. The review group may request that in depth evaluations of certain components of, or activities under the project be conducted and may recommend experts to be included on evaluation teams. All administrative arrangements for the review group will be handled by CDC under this RSSA.

In depth evaluation of the total program will be carried out at the end of 18 month and of 36 months. Members for any evaluation teams may be nominated by AID and/or CDC. The final composition of the evaluation teams and the external review group, as well as the criteria and scope of work for the evaluation will be mutually agreed upon by AID and CDC.

A. Development of Regional Strategies

A primary emphasis at the beginning of this project will be the development of strategies for each of the four AID geographic regions. Development of the strategies will be coordinated by the AID and CDC project managers with participation by AID regional bureau personnel (including mission staff where appropriate) and appropriate CDC technical and administrative personnel. The plan for each region will set the general guidelines for activities within that region. The situation within each country, including disease problems and current health programs, will be examined to determine the potential activities which might be usefully carried out under this project. An estimate of the budget requirements to implement the plans will be developed and a rough order of priorities for the country and regional activities will be established. The regional plan will also establish the methods and procedures to be used in working with the USAID's and host country governments to develop and administer projects and activities within each region. The regional strategies will be updated and priorities re-evaluated semi-annually by AID and CDC.

B. Technical Consultation

In order to implement the Regional strategies, CDC will provide short-term consultants to USAID's and LDC's to evaluate health constraints and provide technical consultation which may result in the development of specific country programs. These exploratory visits to discuss health problems and constraints of joint/mutual interest, will be channeled through the AID project manager

who will be responsible for obtaining the appropriate AID clearances.

4. Country Programs and/or Projects

Overtures to governments to ascertain the level of interest and commitment will be made by USAID mission staff with the participation of CDC as mutually agreed and appropriate. These programs will be collaborative efforts with the host governments. Following approval by AID/W and CDC, project agreements with the host governments will be negotiated by the USAIDs. USAID mission has final diplomatic and legal authority for all country projects.

The country projects will define detailed program content and the responsibilities of each of the participating parties (host governments, USAIDs, AID/W, and CDC). Each project developed under the strategies will be approved by all parties and will specify detailed plans for implementation and requirements for evaluation and periodic review.

Mode CDC health professionals will be available under this project for both short- and long-term assignments in-country to assist in carrying out country projects. All CDC staff on long-term or short-term assignment will work under the USAID director and/or his delegated representative. Since CDC staff are U.S. government employees, mode ceilings will be required from the mission prior to placement of long-term CDC advisors in the field. Assignment of CDC personnel to host governments and/or USAID's will have to be approved in advance by USAID missions, the AID project manager and the host government.

CDC staff will be considered an integral part of USAID missions. USAID's will provide CDC staff with similar support as for AID direct hire. CDC personnel overseas will be responsible administratively to the USAID mission and receive technical advice and support from CDC. Program implementation will be undertaken by the host government in collaboration with AID and CDC. Host governments will decide what technical inputs are necessary based on CDC and AID advice and recommendations. USAID's and CDC will also advise on the countries technical and administrative capacity to effectively implement a cooperative program.

Country programs will be developed as appropriate, taking into consideration other available donor support. These country programs will be developed with the host governments in the field and submitted to AID/W and CDC for approval. Individual projects undertaken under the terms of this initiative will be documented by a project agreement between AID and the host government that describes the scope of work including the objectives, the plan of operation, the detailed budget (with all sources specified - AID, CDC, host governments, etc.), job descriptions of expatriate personnel, criteria for evaluation, etc.

5. Availability of Reference Expertise

CDC will maintain and where appropriate, develop a core staff of technical experts to fully backstop the various project activities ~~on a long-term basis.~~ These individuals will be available as short-term consultants to provide backstop for primary health care components such as epidemiology, vector control, toxicology, parasitology, training, and environmental concerns.

In areas that are mutually agreed as being necessary to fulfill the requirements of the RSSA (i.e., schistosomiasis, health anthropology, etc.) CDC will develop staff expertise.

6. Funding Arrangements

DSB funds will be obligated under a RSSA to support all core costs of the project. This will include costs for support of the overall planning, for development of regional strategies, and for short-term country consultations. The RSSA agreement will provide technical support for the development of country projects up to the point at which a project agreement and a PASA are negotiated and signed.

The funding source for the PASAs to implement country projects which are covered by project agreements will depend on the total cost of the PASA and on the availability of funds. Approximately fifty percent of the DSB funds allocated to this project will be obligated under the RSSA. The remaining fifty percent will be available to fund PASAs for specific country projects. If the total cost over the life of the PASA is not more than \$200,000, it may be funded entirely with central funds. If the total cost of the PASA is greater than \$200,000, the funds should be provided primarily by the regional bureau or mission.

7. Staffing Requirements

During the first implementation year (FY 81) approximately 14 positions will be made available (4 from AID and 10 from CDC) to operate under CDC auspices for the initial planning and development phases, including the completion of the four regional strategies. This includes all core staff and any overseas personnel.

During the second implementation year (FY 82) an additional 16 positions (6 from AID and 10 from CDC) will be provided to implement the requirements of the RSSA. This includes core staff and all overseas personnel.

AID/CDC Health Initiative
Preliminary Budget
Fiscal Years 81, 82, 83.

	<u>FY 81</u>	<u>FY 82</u>	<u>FY 83</u>
I Personnel Costs	614,425	855,590	1,158,787
A RSSA Core Group (Roster Attached)	513,615	724,850	1,005,519
B Bureau of Tropical Diseases Composite	100,810	130,740	153,268
II Travel and Per Diem	343,080	498,367	579,218
A Domestic			
Atlanta-Washington & Return (person/trips @ \$500.00)	30,000(60)	20,125(25)	19,838(30)
Recruitment Travel	15,000	25,000	30,000
B International (person/trips @ region rate)			
Latin America Region (\$4000)	48,000(12)	69,000(15)	79,750(.5)
Near East Region (\$5000)	60,000(12)	86,250(15)	119,025(18)
Asia Region (\$6000)	72,000(12)	110,400(16)	126,960(16)
Africa Region (\$5000)	100,000(20)	143,750(25)	165,313(25)
C External Review Group (3 members)			
Domestic-semi-annual meetings 6 days x(\$130 consultant fee +50 per diem)x 2 trips x 3 travelers+6 R/T air fare @ \$600	10,080	11,592	13,331
International (3 travelers x1-trip x\$5750)		17,250	19,838
D Shipping Costs	8,000	15,000	25,000
III Other	281,200	310,800	369,600
Matrix Contracts with Other CDC Bureaus	140,000	200,000	250,000
Shared Logic/text editing system (AID/W & CDC)	70,000	-	-
Cables/telephone	10,000	15,000	25,000
Printing/reproduction	10,000	15,000	25,000
Office supplies	5,000	10,000	12,000
Lab supplies & Equipment	46,200	70,800	157,600
IV Overhead on I,II, &III (20%)	247,741	332,951	421,521
GRAND TOTALS	1,486,446	1,997,708	2,529,126

Assumptions:

1. Operations will continue beyond FY 83.
2. Annual inflation rate of 15%.
3. An increasing number of overseas assignees (not included in personnel roster) will be posted during FY 82 and 83 under bilateral or regional PASA's.
4. During start-up phase any unspent funds will be forward funded per AID fiscal procedure.

AID-CDC International Health Initiative

Budget Schedule

	<u>Total AID Obligation</u>	<u>For Country PASAS</u>	<u>For Core RSSA</u>	<u>For Services from - thru</u>
FY 80	\$ 500,000	. \$ -0-	\$ 500,000	10/1/80 - 1/31/81 (4 mos)
FY 81	2,700,000	712,000	1,988,000	2/1/81 - 3/31/82 (14 mos)
FY 82	3,000,000	1,370,000	1,630,000	4/1/82 - 12/31/82 (9 mos)
FY 83	<u>5,000,000</u>	<u>3,104,720</u>	<u>1,895,280</u>	1/1/83 - 9/30/83 (9 mos)
TOTALS	\$11,200,000	\$5,186,720	\$6,013,280	(36 mos)

	GRADE	FY 81 SALARY P/A BASE	FY 81 AID/CDC RSSA %	FY 81 SALARY CHARGED TO RSSA	FY 82 AID/CDC RSSA %	FY 82 SALARY CHARGED TO RSSA	FY 83 AID/CDC RSSA %	FY 83 SALARY CHARGED TO RSSA
FRONT OFFICE								
1.	Project Manager	13/10		60112	30	18034		
2.	Program Management Officer	14/4		41659	39	16247		33454
3.	Administrative Officer	12/8		33236	39	12962		28085
4.	*Project Design Officer	12/8		33236	100	24927		29875
5.	*Fiscal Accounting Assistant	9/5		21064	80	16831	100	37344
6.	Staff Assistant	11/9		28433	27	7690	80	18934
7.	Travel Clerk	7/2		15698	44	6907	60	19201
8.	Travel Assistant	5/6		14312	50	7156	50	8819
9.	Secretary	6/7		16408	60	9845	50	8040
10.	Administrative Clerk	6/7		16408	60	9845	80	14748
11.	**Travel Assistant	5/6		14312	60	9845	80	14748
12.	**Fiscal Accounting Assistant	6/7		16408	100	15171	100	16081
13.	**Clerk Typist	4/7		13156	100	17392	100	18436
14.	**Secretary	5/6		14312	100	13945	100	14782
15.	*Training Specialist	12/8		33236	100	15171	100	16081
16.	*Schistosomologist	04		47019	100	24927	100	37343
17.	Medical Epidemiologist (Malaria)	05		55704	100	35264	100	52630
18.	*Health Anthropologist	13/6		37389	100	55704	100	62589
19.	*Health Economist	13/6		37389	60	11216	60	25206
20.	Nurse Educator	12/8		33236	60	19941	60	25206
21.	Medical Epidemiologist	05		55704	60	19941	60	22406
22.	Medical Epidemiologist	06		58737	60	33422	60	37554
23.	*Health Information Specialist Demo.	13/6		37389	60	35242	60	39598
24.	Secretary	6/7		16408	60	9845	60	25206
					60	10435	60	11061
AFRICA								
25.	Senior Public Health Advisor	14/3		40396	25	10099		36311
26.	Public Health Advisor	13/6		37389	4	1496	80	25206
27.	*Public Health Advisor	13/6		37389	42	7851	60	33608
28.	Medical Epidemiologist	05		59034	27	13509	80	44975
29.	*Shared Logic Technician	6/7		16408	11	1354	80	11061
30.	**Secretary	6/7		16408	11	1354	60	16897
							100	
ASIA								
31.	Public Health Advisor	13/6		37389	30	11217		14938
32.	Medical Epidemiologist	05		48074	30	14428	40	22359
33.	Secretary	5/6		14311	22	3148	40	6437
MIDDLE EAST								
34.	*Public Health Advisor	12/8		33236	60	9971		22406
LATIN AMERICA								
35.	Medical Epidemiologist	05		51975	60	31185		35038
36.	*Secretary	5/6		14311	60	4293	60	9648
SUBTOTAL						464576		649777
BENEFITS						24582		40557
5 PERCENT (PROMOTIONS & WCI)						24457		34516
GRAND TOTAL						513615		724850
								897506
								60156
								47857
								1005519

* Phased in First Year

ACTION MEMORANDUM FOR THE ADMINISTRATOR

July 14, 1980

THRU: ES *pl*

THRU: AA/DS, Sander Levin *Sander*

FROM: DAA/DS/HRD, Stephen C. Joseph, *SCJ*

ES Note: Pls call Ms. Wills, X22564 to establish due dates for items 1 and 2 below.

Problem: Need to determine whether the Agency will proceed with the AID/CDC project.

Discussion: As of Friday, July 11, we had received 38 replies to your cable asking for Missions' comments on the proposal.

Attached as Tab A is a schematic analysis of the responses. Attached as Tab B are copies of the individual cables, arranged by region.

In my view, there are already clearly enough positive Mission responses (16) to proceed with this project - providing enough country sites for development at the program levels previously proposed. Undoubtedly, other Missions listed as "favorably inclined", clarification or changes of mind in others, and other USAID's not yet heard from will add to the total.

I find the high level of field support from Africa, Asia, and Near East particularly interesting in light of our prior discussions.

If you agree and desire to proceed, the following next steps are suggested:

1. Memo from you to Regional Assistant Administrators stating your decision to proceed, starting with FY 80 monies if possible. *Program, send later*
2. DS Bureau to develop an Action Memorandum for the Administrator to approve project with PAF Parts I and II with attached scope of work and budget. *FINAL*
3. DS Bureau to develop a PIO/T with scope of work and budget, to also be cleared by the Regional Bureaus.
4. Contract Office to negotiate a RSSA with CDC.

If you wish us to draft the memo from yourself to the Assistant Administrators, please let me know.

Recommendation: That development of the AID/CDC RSSA proceed as per the above-described steps.

Approved: _____

Disapproved: _____

Date: _____

like to review #2

*Send memo to AAs
Send memo to PAF's
Once action memo done*

- Attachments: *once action memo done*
- A - Summary of Mission Responses
 - B - Cable Responses.

MEMORANDUM

TO: DAA/DS, Stephen Joseph, M.D.
FROM: DS/HEA, Clifford A. Pease, M.D.
SUBJECT: AID/CDC Initiative

DATE: July 11, 1980

As of July 11, 1980, the replies to the Administrator's cable on the AID/CDC initiative can be summarized as follows.

- I. Estimated number of missions from which responses were expected - 56
- II. Actual number of replies received as of 7-11-80 38 (68%)
 - Latin America 6 out of 12 (50%)
 - Near East 7 out of 7 (100%)
 - Asia 9 out of 10 (90%)
 - Africa 16 out of 27 (60%)

II. Responses were categorized as follows:

A. Favorable - 16 (43%)

- LAC 1 (Panama)
- NE 3 (Jordan, Morocco, Yemen)
- ASIA 4 (Fiji, Burma, India, Thailand)
- Africa 8 (Liberia, Ghana, Cameroon, Togo, Rwanda, Burundi, Guinea, Ivory Coast)

B. Favorably inclined but with major conditions or reservations - 5 (14%)

- LAC 1 (Guatemala/ROCAP)
- NE 0
- ASIA 1 (Philippines)
- Africa 3 (BLS, Mali, Niger)

C. Unfavorable responses - 12 (32%)

- LAC 4 (Guyana, Dominican Republic, Jamaica, Barbados)
- NE 4 (Lebanon, Egypt, Tunisia, Syria)
- ASIA 3 (Indonesia, Nepal, Sri Lanka)
- Africa 1 (Kenya)

D. Other responses that did not fit the above categories (Example - no health staff, referral to other USAID, no firm position, etc.) 5 (14%)

- LAC 0
- NE 0
- ASIA 1 (Bangladesh)
- Africa 4 (Botswana, Sierre Leone, Chad, Upper Volta)

IV. Comments: The major considerations or reservations mentioned under IIIB were as follows:

- 1) project should not be duplication of other efforts.
- 2) standard AID program procedures should be used.
- 3) a task ordering agreement should be used.
- 4) USAID was interested in proposal but did not anticipate use of the CDC RSSA as it was not involved in the type health program to use it.
- 5) proposal should include family planning and nutrition.
- 6) proposal did not address major disease problems of area.
- 7) program should be implemented on regional basis.
- 8) questions raised regarding CDC's ability to produce.

The main reasons for unfavorable responses mentioned in IIIC were as follows:

- 1) objection to proliferation of centrally funded projects requiring ceilings and money in competition with field needs.
- 2) downgrades mission responsibilities and staff.
- 3) mechanisms already existed for this type of activity thru PAHO, CDC, or a national program.
- 4) proposal did not respond to host country priorities.
- 5) should not be USG but a private contractor.
- 6) multiple issues of implementation.

MEMORANDUM

Date: July 14, 1980

TO: : DAA/DS, Stephen Joseph, M.D.
 FROM : DS/HEA, Clifford A. Pease, M.D.
 SUBJECT : AID/CDC Initiative (Addendum to 7/11/80 Pease Memo)

Please add the following as III E to the 7/11/80 memo.

E. Summary of responses by region

	Total	Favorable	Favorable with Conditions	Not Favorable	Other
LAC	7 6 *	1	1	4*	0
NE	7	3	0	4	0
ASIA	9	4	1	3	1
AFRICA	16	8	3	1	4
TOTAL	38*	16	5	12*	5

*An additional Not Favorable reply has been received from Peru