PD-AAM-987 16854

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): 931-5900

6. BUREAU/OFFICE: A. SYMBOL: DSB; B. CODE: 36

7. PROJECT TITLE (Maximum 30 characters): Accelerated Delivery Sys. Support (ADSS)

8. PROJECT APPROVAL DECISION — ACTION TAKEN: A = APPROVED, D = DISAPPROVED, DE = DEAUTHORIZED

9. EST. PERIOD OF IMPLEMENTATION: YRS. 03 QTRS. 0

10. APPROVED BUDGET AID APPROPRIATED FUNDS ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE C. GRANT	PRIMARY TECH. CODE D. LOAN	E. 1ST FY 89 F. GRANT	E. 1ST FY 89 G. LOAN	H. 2ND FY 90 I. GRANT	H. 2ND FY 90 J. LOAN	K. 3RD FY 91 L. GRANT	K. 3RD FY 91 M. LOAN
(1) HEA	539	510		1,200		1,300		1,500	
(2) POP	[illegible]	[illegible]		700		800		1,000	
(3)									
(4)									
TOTALS				1,900		2,100		2,500	

A. APPROPRIATION	N. 4TH FY 92 O. GRANT	N. 4TH FY 92 P. LOAN	Q. 5TH FY ___ R. GRANT	Q. 5TH FY ___ S. LOAN	LIFE OF PROJECT T. GRANT	LIFE OF PROJECT U. LOAN
(1) HEA	1,000				5,000	
(2) POP					2,500	
(3)						
(4)						
TOTALS	1,000				7,500	

11. PROJECT FUNDING AUTHORIZED (ENTER APPROPRIATE CODE(S)) 1 = LIFE OF PROJECT, 2 = INCREMENTAL, LIFE OF PROJECT: A. GRANT 2; B. LOAN

C. PROJECT FUNDING AUTHORIZED THRU FY 81

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

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

PROJECT AUTHORIZATION AND REQUEST FOR ALLOTMENT OF FUNDS

Part II

Entity: DS/HEA

Project No.: 931-5900

Project Name: Accelerated Delivery Systems Support

I hereby authorize grant financing of one million nine hundred thousand dollars ($1,900,000) during FY 1979 for the above named project.

I approve a total level of A.I.D. appropriated funding planned for this project of seven million five hundred thousand dollars ($7,500,000) including the funding authorized above, during the period FY 1979 thru FY 1982, subject to the availability of funds in accordance with A.I.D. allotment procedures.

Attachment: Project Paper

Date: 8/17/79

Sander Levin, AA/DS

Clearances: DS/HEA, L. Howard 12 July '79
DS/POP, J. Speidel 16 July 79
DAA/DS/HRD, S. Joseph 8/13/79
OC/TFHA, A. Richstein
AFR/DR, L. Hellman 7-13-79
ASIA/TR, J. Brady 7-12-79
LAC/DR, H. Lusk 7/14/79
NE/TECH, K. McManus 7/12/79
DS/PO, B Chapnick

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

August 7, 1979

MEMORANDUM FOR: DS/HEA, Lee M. Howard
DS/POP, Joseph Speidel

FROM : GC/TFHA, Stephen Tisa

SUBJECT : Approval of Project 931-5900, Accelerated Delivery Support Systems

I have cleared the subject project for legal sufficiency with the exception of the portion of the anticipated contract with APHA* relating to short-term technical advisory services that are not identified. I believe that the project may be authorized, and the problem resolved in connection with the PIO/T in consultation with SER/CM and GC.

Briefly, I believe that the description of the short-term advisory services being procured by AID so lacks specificity that it cannot support the obligation of funds for that purpose. (I believe the other aspects of the contract are sufficiently defined.) An illustrative list of the kinds of services that can be procured does not cure this problem.

As I have indicated in the past, this problem may be resolved in a number of ways, including improving the degree of specificity, or obligating for these advisory services in increments individually, on a quarterly or seimannual basis as they are identified through requests from the field. (Obligations for the other services can proceed as planned because they are adequately defined.)

I would be happy to participate with your office and SER/CM in an effort to resolve this problem in the contracting process.

cc. G. Gold, SER/CM
B. Veret, GC/C&P

*Mr. Royer advised me that the Noncompetitive Review Board has approved a noncompetitive selection of APHA for this contract.

July 31, 1979

ACTION MEMORANDUM FOR THE ASSISTANT ADMINISTRATOR,
DEVELOPMENT SUPPORT BUREAU

FROM: DS/HEA, Lee M. Howard, M.D., Dr. P.H.
DS/POP, Joseph Speidel, M.D.

THRU: DAA/DSB, Stephen Joseph, M.D.

Problem: Approval of Project 931-5900, Accelerated Delivery System Support (ADSS),

Discussion: The PP for this project was reviewed by the DSB Project Review Committee on April 13, 1979. While the committee generally favored the concept of the project, they felt that several modifications in project design should be made before the project was approved. It was decided that committee members would work with DS/HEA and DS/POP to modify the PP to meet regional bureau requirements.

The paper has been revised and approved by all four regional bureaus.

The project activity will continue for 36 months, from October 1, 1979 thru September 30, 1982. DS/POP plans to obligate their portion of the funds in FYs 79, 80, and 81. DS/HEA will need to spread its contribution over four fiscal years with the final obligation in FY 1982.

Funds for FY 1979 and FY 1980 are currently available in the FY 1979 OYB and FY 1980 C.P. for both offices.

Recommendation: That you sign the attached PAF.

Attachments: PAF and PP

Clearances: DS/PO, R. Simpson

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AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT PAPER FACESHEET

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

PP

2. DOCUMENT CODE: 3

3. COUNTRY/ENTITY: DS/HEA RDA II

Adaptation and Application Field Service

4. DOCUMENT REVISION NUMBER

5. PROJECT NUMBER: 931-5900

6. BUREAU/OFFICE: A. SYMBOL: DSB; B. CODE: 36

7. PROJECT TITLE: Accelerated Delivery Sys. Support(ADSS)

8. ESTIMATED FY OF PROJECT COMPLETION: FY 82

9. ESTIMATED DATE OF OBLIGATION: A. INITIAL FY 79; B. QUARTER 4 (Enter 1, 2, 3, or 4); C. FINAL FY 82

10. ESTIMATED COSTS ($000 OR EQUIVALENT $1 -)

A. FUNDING SOURCE	FIRST FY B. FX	FIRST FY C. L/C	FIRST FY D. TOTAL	LIFE OF PROJECT E. FX	LIFE OF PROJECT F. L/C	LIFE OF PROJECT G. TOTAL
AID APPROPRIATED TOTAL						
(GRANT)	1,900	-	1,900	7,500	-	7,500
(LOAN)						
OTHER U.S. 1.						
OTHER U.S. 2.						
HOST COUNTRY						
OTHER DONOR(S)						
TOTALS	1,900		1,900	7,500		7,500

11. PROPOSED BUDGET APPROPRIATED FUNDS ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE C. GRANT	PRIMARY TECH. CODE D. LOAN	E. 1ST FY 79 F. GRANT	E. 1ST FY 79 G. LOAN	H. 2ND FY 80 I. GRANT	H. 2ND FY 80 J. LOAN	K. 3RD FY 81 L. GRANT	K. 3RD FY 81 M. LOAN
(1) HEA	520	510		1,200		1,300		1,500	
(2) POP	440	440		700		800		1,000	
(3)									
(4)									
TOTALS				1,900		2,100		2,500	

A. APPROPRIATION	N. 4TH FY 82 O. GRANT	N. 4TH FY 82 P. LOAN	Q. 5TH FY ___ R. GRANT	Q. 5TH FY ___ S. LOAN	T. LIFE OF PROJECT T. GRANT	T. LIFE OF PROJECT U. LOAN
(1) HEA	1,000				5,000	
(2) POP					2,500	
(3)						
(4)						
TOTALS	1,000				7,500	

12. IN-DEPTH EVALUATION SCHEDULE: MM 11 YY 81

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

1 (1 = NO, 2 = YES)

14. ORIGINATING OFFICE CLEARANCE

SIGNATURE: J.J. Speidel

TITLE: J.J. Speidel, Deputy Director, DS/POP

Lee Howard, Director, DS/HEA

DATE SIGNED: MM 8 DD 29 YY 79

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

AID 1330-4 (3-78)

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A. Background

Four-fifths of the people in the developing world have no access to meaningful health services. There is also widespread disenchantment with health care throughout the world. Unfortunately, health resources have been allocated mainly to sophisticated medical institutions in urban areas with little or no services for rural people and the urban poor. The conventional hospital-based health care system, adopted from prior patterns in industrialized developed countries has proved too costly and too complex for most developing countries. More importantly, it has not resulted in health improvements for the majority.

Despite the considerable achievements of certain categorical programs, such as Smallpox Eradication, Malaria Control, Population Control and Family Planning, and Measles Immunization Campaigns, the health status of the majority of the people in the developing world remains discouragingly poor. In developing Africa, infant mortality rates average about 150; and 50 percent of the children die before the age of five. Most developing countries in Asia and the Near East have infant mortality rates over 100 and the average IMR in 16 A.I.D. assisted countries of Latin America is 85. The Center for Disease Control estimates that 2.6 million children die each year from immunizable diseases. Less than 20 percent of the 80 million children born each year in the world receive immunization against preventable disease. There are 40 million blind people in the world—two thirds of these from diseases and conditions that are preventable or curable, such as onchocerciasis (river blindness), vitamin A deficiency, and trachoma. Death rates associated with child birth in poor areas of Africa are 4-5 times those in developed countries. Perhaps half of the deaths among children under 5 years are due to respiratory and diarrheal diseases superimposed on varying degrees of malnutrition to which these diseases are synergistically related. No less than 80% of people in the developing world have at least one form of intestinal parasite. According to WHO[1], 1.5 billion people (over 1 billion in Africa and Southeast Asia) in 89 countries live in areas with moderate to high risk of malaria compared with approximately 2 billion in 143 countries in 1947.

High birth rates and the resultant population growth, in many of the least developed countries, continue to compound these problems and negate much of the gains made by health programs. Low child survival

1. Malaria Control Strategy—Report by the Director-General, World Health Assembly, 31st Session, March 15, 1978

rates in turn tend to motivate towards continued higher birth rates perpetuating the typical lesser developed country pattern of high birth rates with high child death rates.

Although global information about the nutritional status of people in the developing world is very incomplete, it can be estimated that about 13 to 15 million children in the world have Kwashiorkor or marasmus at any one time and most of these children die. An additional 200 million children below the age of five have chronic malnutrition that is less dramatically apparent but often results in stunting of growth, impaired and delayed learning, reduced energy and diminished ability to withstand infections.

Seventy percent of the world's population is without safe and dependable water supplies. There are 250 million new cases of water-borne diseases a year, while 25,000 die daily from them. Based on the WHO mid-decade survey in 1975 , only 22 percent of the rural people in developing countries have access to safe water supplies and only 15 percent of people in rural areas have provision for excreta disposal.

A safe and adequate water supply is generally associated with a healthier population. When Japan installed water supplies in 30 rural areas, for example, the number of cases of intestinal diseases was reduced by 72 percent. However, the construction of water and sewage disposal systems alone, without training local people in their proper use and maintenance, will not assure health improvements. Improperly constructed water systems for irrigation purposes often promotes the spread of diseases. When irrigation water was introduced into the Kano plain in northwest Kenya, for example, the population of malaria transmitting Anopheles mosquito increased by seventy times. And in Egypt, where 20 to 30 percent of the population is infected with schistosomiasis the construction of the Aswan Dam was a potential threat to the spread of this disease. Nevertheless, the access to adequate supplies of safe water, for most rural people in developing countries, remains a question of life or death.

One of the major constraints that impedes progress in extending essential health services to peripheral areas is the lack of effective health networks that reach down to community level, particularly in rural areas. A.I.D. identified the lack of affordable, appropriate,

2. World Health Statistics Report: Vol. 29, No. 10, 1976, p. 370, WHO, Geneva

integrated health delivery systems as a major constraint as early as 1969. WHO and UNICEF have also, during the 70s, been supporting a realignment of health programs towards the provision of affordable essential health services with integrated planning, improved coverage, and increased emphasis on participation at the community level. In 1975, the World Health Assembly passed resolution 28.88 endorsing the promotion of primary health care (PHC). Government delegates from 140 countries, including most of the developing countries, at the WHO/UNICEF sponsored International Conference on Primary Health Care held at Alma Ata, USSR on September 6-12, 1978, endorsed a global commitment to the PHC concept with a clear understanding that the conference goal of "Health for all by the year 2000" implies that country health care programs be drastically reoriented to provide essential health services to the majority of the people, including the urban and rural poor. A.I.D., working with WHO and UNICEF both directly and through AID contract associates, was instrumental in developing the overall conference plan. AID also supported pre-conference activities in the WHO Regions of Southeast Asia, Western Pacific and the Americas and helped in organizing the WHO nongovernmental conference in Halifax in May, 1978 which materially influenced the subsequent declaration adopted at Alma Alta.

A.I.D. pioneered early initiatives in low cost health delivery systems and primary health care with such projects as the Lampang Province Project in Thailand (1972) and the Integrated Health Delivery System Project in Brazil (1973). As of FY 1979, A.I.D. has 243 projects in the fields of health and population, located in 65 A.I.D. assisted countries. One-hundred and sixteen of these are primarily concerned with health services and 127 are primarily population/family planning projects. Only 36 of A.I.D's ongoing projects are Category I* projects with a varying degree of nutrition, disease control and population/family planning services. These include: 16 in Africa, 5 in Asia, 11 in Latin America and 4 in the Near East. By FY 1980, Category I projects will increase to a total of 50 and A.I.D. funding will reach $100 million annually compared with only $20 million in FY 1976.

A.I.D.'s technical staff has been strengthened both in Washington and in the field to reflect new initiatives and rapidly expanding interest in affordable health and family planning delivery systems and primary health care. A.I.D. has also, in recent years, used three long term

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*Category 1 is defined as those projects with a specific end-of-project objective to test or demonstrate a nationally determined method which has the potential for delivering minimal health services in a culturally acceptable manner to a defined population majority in the location in which the population resides at a cost the population can afford.

centrally funded contracts with (a) the American Public Health Association (b) the University of Hawaii (MEDEX Program), and (c) the Boston University Center for Educational Development in Health, and has established five new indefinite quantity contracts (IQCs) in order to foster and develop the application of the principles and methods of PHC and to provide advisory services to country health system programs. AID has also had a centrally funded contract with the American Public Health Association to provide technical advisory services to POP/FP projects and activities.

A.I.D. has a long history of involvement in both rural and urban water supply and sanitation (WS&S). After a period of limited investment in the early seventies, support is trending upward again. There was a substantial increase in the number of countries with WS&S activities in FY '79 and an increase, although smaller, is projected for FY '80. A.I.D. is planning a total of $336 million for all water supply and sanitation activities in FY '80. Of this, $267 million is from Supporting Assistance for improved urban water systems in two countries (Egypt and Syria). The remaining $69 million is for rural water supplies with 30 projects in 20 countries.

In FY '79 AID/DSB, in order to increase and improve its technical resource base in support of bilateral water and sanitation projects in the field, has entered into four indefinite quantity contracts, two for rural water supply and sanitation, two for hand pump technical assistance. AID/DSB in FY '79 is also planning a new Water and Sanitation for Health (WASH) project which, through a large consortium of U.S. technical assistance organizations will provide a wide range of technical expertise to develop and promote improved intermediate level technologies and provide consultants for A.I.D. field missions.

Emphasis in the last decade has shifted from vertical programs towards a focus on essential health care and new types of multipurpose delivery systems aimed at improving the health status of people at the social periphery; A.I.D. has kept pace with these changes and has been in the forefront of those agencies (WHO, UNICEF, et al) that have spearheaded these initiatives. The climate for the acceptance and widespread application of primary health care is favorable; however, much remains to be done.

B. <u>Problem Addressed</u>

Emerging world-wide interest in primary health care and new patterns of health delivery systems are particularly timely and appropriate in view of congressional mandates that stress the extension of essential health services to the poor. AID's overall assistance strategy and AID's newer programs strongly reflect this emphasis. It is anticipated that AID will progressively expand assistance in primary health care to most of the 65 AID-assisted countries and will eventually have projects in 45 to 50 countries.

In most developing countries political commitment to support primary health care will be difficult to establish and maintain. Primary health care implies that governments will support a preferential allocation of resources to people at the social periphery in order to satisfy first and foremost their essential health needs. However, public spending for health in the developing countries has consistently received a low priority. In the time period 1960 to 1976, per capita expenditures for health care in developing countries grew only 20 per cent in constant dollar amounts. In contrast, military budgets grew 60 per cent on a per capita basis and per capita expenditures for education doubled. All governments taken together spent an estimated $225 billion on the health of their citizens in 1976 but the governments of developing countries, with three-fourths of the world's population, spent less than 10 per cent of this amount while the balance was spent by the developed industrial countries of Europe, Asia and North America .[3]

Resources for primary health care are not limited to publicly appropriated funds. Nor can health (in contrast to disease control) be attained by health programs alone; economic development, anti-poverty measures, food production and distribution, water, sanitation, housing, family planning, and education (to name a few examples) all contribute to health and have the same goal of human development. Primary health care must therefore be an integral part of the overall development of society and must involve a wide range of non-governmental organizations both national and international such as, professional societies, industrial companies, trade unions, social welfare organizations, educational institutions, religious groups, women's organizations, youth groups, family planning association, cooperatives and many more.

Given the many interrelated and interdependent social and economic factors and the multiplicity of agencies involved in health care, a wide reaching mechanism will be needed to systematically collect, analyze and disseminate information concerning primary health care and affordable health and family planning delivery systems. Support and commitment to the concepts, principles and methods involved must be generated and promoted through diverse development agencies - private and public, national, regional, and international. AID's centrally funded activities must aim at fostering a world-wide climate favorable to the extension of primary health care.

While the approach is universal, there is no universal recipe for primary health care programs, each one being a national endeavor specific to the country's situation. What succeeds in one country cannot

3. Sivald, R.L., World Military and Social Expenditure, 1978 (WMSE Publication: Leesburg, Virginia 1978) PP 10-17

necessarily be transplanted and have the same result elsewhere. Nevertheless, certain principles of primary health care have evolved from experience over the years. The following general approaches are applicable to most LDCS:

1. Relate closely to the life patterns and perceived needs of the community.

2. Maximize the use of local resources including those in parallel sectors of development and promote self reliance and community participation so health care remains relevant, affordable and accessible.

3. Integrate essential health services, including prevention, treatment, promotion and rehabilitation to efficiently use scarce personnel, facilities, transport and funds.

4. Undertake health interventions at the most peripheral level by a worker simply trained for this activity.

5. Redesign other health services to support the peripheral level and furnish technical help, referral facilities, supervision, and essential supplies.

Primary health care involves a major rethinking of ways of delivering health care. Although the general approaches are established the application of relevant technology will require continous critical analysis, widespread sharing of experiences and selective adaptation of techniques to ensure successful programs in countries with varying political, social, economic and cultural settings.

The total effort needed to revolutionize health planning and implementation aimed at extending essential health services to most the people of the lesser developed world is enormous. Within the context of expediting action in the time frame of this century as advocated in AID legislation, the ADSS project addresses three inter-regional aspects of this general problem, namely:

1. Promotion, information gathering and dissemination, and education to foster world-wide awareness, understanding and acceptance of the principles, concepts and methods.

2. Analysis, evaluation, tracking of progress, special studies and identification of problem oriented research.

3. Provision of rapidly responding technical advisory services drawn from expertise in diverse fields to support country and regional programs and projects.

These activities, as relevant, will be carried out in close coordination and at times association with other international, national, and regional health agencies working in the field of primary health care such as the World Health Organization and the United Nations Children's Fund. The details (including specific inputs and outputs) are summarized in the next section. It should be stressed at this point, however, that the main thrust of the ADSS project is to create and develop, an AID - associated inter-regional-mechanism to promote, foster and support the extension of essential health services to the majority of the people in the lesser developed world in ways that are feasible, affordable and acceptable. No single project can be expected to fully accomplish this overall objective within a project time frame of 3 years. However, the ADSS project should provide the foundation and momentum on which to build AID's leadership role in the newly emerging field of primary health care which undoubtedly will be a prime interest of most development agencies in the ensuing decade.

C. Description of the Project

Project Goal

The Project goal is to extend affordable essential health and family planning services to the majority of the people in the lesser developed countries.

"Essential health services" as defined at the International Conference on Primary Health Care Alma-Ata, USSR, 6-12 September 1978 jointly sponsored by WHO & UNICEF includes at least: promotion of proper nutrition and an adequate supply of safe water; basic sanitation; maternal and child care including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; education concerning prevailing health problems and the methods of preventing and controlling them; appropriate treatment for common diseases and injuries and the provision of essential drugs. 4 The degree to which these components may be included in an actual country program will depend on what is affordable and administratively feasible.

"Affordable" is defined as:

At a cost that the developing country can support without prolonged external assistance. For the purpose of analysis, "cost" includes all operating expenses such as salaries, fringe benefits, drugs, vaccines,

4 Primary Health Care - A joint report by WHO and UNICEF Geneva, 1978 page 23.

expendable supplies, maintenance and repairs, rents, transportation, travel and per diem, supervisory expenses, communications, refresher training, and amortization of major equipment vehicles and buildings; it does not include expenses associated with preparatory activities such as research and development of methodology, temporary expatriate consultant services, baseline data and other start-up assessments and surveys, special experimental studies or investigations and analysis generated by donor agency requirements or for costs associated with the initial training of core staff.

PROJECT PURPOSE

The purpose of ADSS is:

To reinforce and expand Agency capability to exert a leadership and supportive role in the promotion, planning, development and evaluation of affordable health and family planning delivery systems and primary health care in most of the developing countries.

The accomplishments of this overall purpose will be measured against the following statement of conditions which will exist at the end of the project (3 years after onset);

1. Health leaders and health related agencies and professional associations, including those in 50 or more developing countries, will regularly (at least 6 times a year) be receiving materials published and distributed through the agent or agents of this project, and these materials will be widely viewed as an important source of vital information in the field of primary health care.

2. Health-workers primarily responsible for the planning and execution of Primary Health Care Programs in 50 or more developing countries regularly received newsletters or informational materials which contained simply explained examples of actual interventions, concepts, methods or ideas related to primary health care which were subsequently successfully applied (possibly with adaptation to local settings) in the provision of essential health services in 10-12 areas where these materials were distributed.

3. Thirty-five to forty AID-assisted countries will have received demonstrable assistance from activities generated by this project in the form of on-the-scene technical advisory services, attendance at workshops or conferences or participation in special studies aimed at extending the knowledge and understanding of the principles and methods applicable to primary health care.

4. The agent or agents of this project will have well established participating relationship with the WHO, UNICEF, UNDP, UNFPA, the World Bank and other prominent international organizations and

agencies having a mutual concern with the global promotion and development of primary health care. This relationship may be evidenced through the extent of collaboration with such organizations in a variety of joint efforts aimed at extending essential health and family planning services in developing countries.

5. The instruments of this project will have substantially contributed to the pool of knowledge concerning the "state-of-the-art" of primary health care and the development of affordable health and family planning delivery systems. The evolution of the most important advancements in these fields will be summarized in project generated publications.

6. AID, and those associated with AID, will have ready access to an up-to-date register of consultants representative of the best available expertise in the various fields relevant to primary health care and population/family planning and to a well organized data bank with ready retrievable current material concerning the most important aspects of primary health care projects.

OUTPUTS

The services provided under this project are grouped into three categories: (1) Promotional Information and Education, (2) Technical Advisory Services, and (3) Evaluationand Special Studies.

1. Promotional Information and Education

There are two major components in this output: (A) informational material, and (B) conferences and workshops. Both components are discussed in detail below.

The collection, analysis, publication and dissemination of information concerning community based health delivery systems and primary health care programs including those aspects of nutrition, population and family planning, and water supply and sanitation that are important to the objective of assisting LDCs mount such programs in their respective countries will be undertaken. As part of this objective, the project contractor will periodically prepare, publish and distribute informational packets, a newsletter and other appropriate informational material.

(1) Information packets

Packets containing current and vital information or technical papers related to the fields of primary health care and affordable health delivery systems will be distributed regularly (six times per year). The principle audience that should receive these packets are AID staff and AID-funded contractor's personnel working in field missions. However, on a selected basis, information packets should also be distributed to non-AID individuals and institutions in LDCs that have a known active involvement in primary health care activities.

The intended audience for these packets are those that are actively engaged in planning, developing and evaluating primary health care delivery systems in LDCs. It is intended that the materials distributed as information packets be selected from among the best and most significant publications that emerge in the field of primary health care. These may vary from reports of special studies, monographs, expert committee reports, reports of significant conferences and workshops, et al. The target audience for these materials are health professionals who need to be kept up-to-date of significant developments, concepts and ideas in primary health care and who are not likely to receive similar information from other sources.

Since the costs associated with purchasing and distributing each packet will be significant, it is important that they only be distributed to a limited and selected number of individuals in LDCs (perhaps limited to 100 or 150), in addition to AID staff and AID contractor's personnel. One of the criteria for selecting the LDC target audience should be LDC persons who have major operational roles and responsibilities for developing or implementing primary health care programs in their respective country. AID mission health staff should be consulted in determining potential audience in LDCs.

The contractor should also establish a follow-up system which may be used to evaluate the relevance and usefulness of these materials to recipients. This activity should be coordinated with other bilateral, multi-lateral and private voluntary organizations that support primary health care both to seek input and avoid duplication of materials.

(2) Newsletter

A quarterly newsletter will be published (4 issues annually) on topics related to delivering primary health care services to poor urban or rural populations. The newsletter should disseminate

information about recent developments in primary health care as well as serve as a forum for field personnel (both AID and non-AID) to communicate information and ideas and to present relevant questions.

At least 75% of each issue should be sent to personnel residing in developing countries; the remaining 25% to personnel residing in the more developed and developed countries, but having an active role in the delivery of primary health care in LDCs. periodic, probably annual, review of the mailing should be undertaken to maintain the appropriate audience. A suggested distribution is:

(a) LDC personnel working on AID or other funded primary health care projects;

(b) LDC governmental or private public health persons;

(c) AID mission health and population staff and AID funded contractor's personnel engaged in health and population activities in the field;

(d) major governmental or private LDC training institutions responsible for providing manpower for primary health care delivery systems in the respective country;

(e) major U.S. or other more developed country training institutions providing collaborative training for LDC personnel involved in primary health care systems in their respective countries;

(f) major U.S. or other more developed country data collection centers, when such data collection is primarily concerned with primary health care delivery systems in LDCs; and

(g) appropriate representatives of bilateral, multi-lateral and private voluntary organizations engaged in the support of primary health care delivery systems in LDCs.

French and Spanish translations will be provided and distributed as appropriate.

Issues of the newsletter might contain: (1) brief reviews of primary health care developments, particularly those related to projects included in the state-of-the-art; (2) a feature article on a project or components of a larger project having significant interest and relevance to the development of primary health care programs in LDCs; (3) a feature article reviewing

activities in selected topical areas such as training manuals, simple evaluation techniques, basic interventions appropriate for introduction to ongoing PHC programs, etc.; (4) synopsis of important publications and how they can be obtained; (5) information concerning up coming meetings, conferences or other events relevant to furthering PHC with persons to contact in order to participate; (6) a brief question and answer column.

An illustrative list of some of the issues of concern to primary health care program personnel is provided below. It is anticipated that some coverage will be given to most of these issues over the life of the project. However, innovative developments and significant technologies which address the affordability, accessibility and appropriateness of services should be the rule governing published articles. An illustrative list might be:

(a) simple health care interventions for field health workers, including such items as oral rehydration, use of height/weight charts, treatment of simple eye diseases and injuries infant feeding with home-grown foods and early introduction of weaning foods and maintenance of breast feeding;

(b) essential drugs and formularies suitable for use by community based health workers and proper use of these drugs;

(c) ways of gaining and maintaining community participation and involvement to effect self-sufficiency of program;

(d) methods of improving supervision, motivation and continuing education of peripheral field staff;

(e) patterns of financing health services and ways of attaining auto-financement with participation of community; and

(f) ideas and techniques to improve support and communications from intermediate levels out to peripheral units including such factors as supply and resupply, consultation and referral services, cold chain maintenance, simplified information systems;

(g) simple and reliable methods for assessing progress in PHC programs.

A number of newsletters are currently being published for the international health community on health, nutrition, population, communication and water activities. The contractor should survey the field and keep up to date on audience and topics in these other newsletters. Every effort should be made to compliment and not duplicate other available information.

The contractor should develop a brief questionnaire for newsletter readers to determine the usefulness of content and solicit recommendations for improvement which might effect wider distribution. An annual assessment of newsletter recipients should be conducted, with a report submitted to AID which addresses how the contractor sees the effectiveness of the newsletter and what steps might be taken to improve its content.

Quantified indicators of informational materials are:

(a) 12 issues of newsletters; 4 per year; circulation 12,000 each; 3 languages

(b) 18 information packets; 6 per year; circulation 300 each

Conferences and workshops on subjects vital to the promotion, development, operations and better understanding of primary health care and affordable health and family planning delivery systems will be undertaken. The project contractor will plan, convene and conduct these conferences and workshops in collaboration with AID or as co-sponsor with international health organizations (e.g., the WHO, UNICEF, the World Federation of Public Health Associations), multidonor agencies (e.g., OECD), international development agencies (e.g., the World Bank), bilateral and voluntary donor agencies (e.g., IDRC, OXFAM, CRS, World Council of Churches) or other appropriate organizations including those within or among LDCs which are vitally concerned with the extension of essential health and family planning services.

(1) The contractor will plan, organize and conduct one conference a year (for a total of three during the life of the project) in collaboration with AID. These conferences will be designed primarily to keep AID and AID contractor's field staff and LDC participants up to date on current developments in the field of primary health care and affordable health delivery systems and to provide for exchange of information about lessons learned from AID-assisted country programs and activities. A collateral purpose of these conferences is to acquaint AID's field staff with the types of technical advisory services and other resources that are available to AID-assisted country programs from AID/W through centrally funded contracts, IQCs, RSSAs, PASAs, and other mechanisms, and to clarify any questions or uncertainties in the minds of AID's field staff about procedures in procuring and properly utilizing these services. These conferences may also provide a unique opportunity for feed-back from the field staff about the quality and relevance of the services provided under the ADSS contract

arrangements. However, this should not be a preoccupation of the conference. Perhaps a single well designed questionnaire with some open ended questions concerning special problems and suggestions for improvements distributed early and collected at the end of the conference would suffice. The primary thrust of the conference should focus on technical exchange. AID internal management or administrative matters should not be the dominant theme of these conferences.

Each conference will be organized on a regional basis; one in Asia, one combining Africa and the Near East and one in Latin America.

Participation should be limited to AID mission health and relevant AID contractor's staff, a representative from the Office of Health of DSB Washington, and, at most, two representatives from the technical support staff of the relevant regional bureau. Additionally, LDC participants should be primarily health officials having an operational responsibility in the design, development, planning, and evaluation of primary health care programs in their respective countries. Emphasis should be on obtaining technical persons with managerial or supervisory responsibilities in the implementation of PHC programs. Some of the suggested topics on pages 16 and 17 will also be appropriate for these conferences, if target audience is kept in mind and topic is adjusted accordingly.

(2) The contractor will organize and conduct two workshops a year (a total of six workshops during the project) in collaboration with, or as co-sponsors with, other international, multidonor, bilateral, voluntary or other appropriate organization. These workshops will focus on the interests, problems and needs of LDC health personnel at the intermediate level who have operational responsibility for the planning, execution and supervision of primary health care programs which extend out to the peripheral areas, particularly to the urban and rural poor.

Suggested topics for these workshops are listed below, however, they are only illustrative. Definitive workshop themes must be carefully developed and worked out in order to compliment and not duplicate similar activities being conducted by other organizations.

Workshop examples:

(a) motivation of health workers assigned to rural outposts;

(b) approaches to maintaining the cold chain;

(c) community/user financing of health services;

(d) PHC interventions for field workers (including oral rehydration, eye treatment, personal hygiene);

(e) maternal health: role of nutrition and child spacing;

(f) day care and its relation to child health;

(g) supervision—roles and training;

(h) cost effectiveness: cost benefits;

(i) dynamics of community participation;

(j) outreach health work;

(k) issues in non-physician HMD programs.

(3) In addition, the contractor, in collaboration with or as co-sponsor with other international, multidonor, bilateral, voluntary or other appropriate organization will organize and conduct one conference a year (a total of three during the life of the project). These conferences are designed to help the health leadership in LDCs to plan and extend country primary health care programs. These conferences should be organized on a regional basis similar to the regional breakdown for workshops and should be carefully coordinated with the WHO, UNICEF, UNDP, the World Bank and other international organizations that are active in this field in order to compliment, not duplicate, other conferences planned by these organizations. Invitees should be primarily the principle health officials in their respective country. Other invitees should include limited representation from AID, DSB, and the relevant regional bureaus. Also, top level representatives of other development organizations working in LDCs in the region and relevant resource personnel should be invited.

The conference subjects and agenda items for each conference should be developed in close coordination with the Program Committee of the Executive Board of the WHO, Geneva, who are and will continue to be developing the strategies for country programs in primary health care. The general concern of these conferences should focus on "health for all by the year 2000". The following list is illustrative of subjects which might be included in such conferences:

(a) national health policies and strategies;

(b) generating political commitment to the concept of PHC;

(c) social and economic considerations, including measures for attaining more equitable distribution of services and resources;

(d) community participation;

(e) administrative and management reforms to provide the population with essential health services;

(f) resources and financial implications associated with reallocation of essential services;

(g) enabling legislation;

(h) country primary health program and national health plans of action, methods and principles involved;

(i) health delivery systems design;

(j) monitoring supervision and evaluation in PHC programs;

(k) national health information systems;

(l) training and manpower development;

(m) the role of national health councils and other coordinating bodies;

(n) appropriate technology for health;

(o) referral systems and referral processes, organization and mechanisms;

(p) logistic support to health units including essential drug formularies and their proper use;

(q) reorientation of existing health systems;

(r) research requirements; and

(s) quantified indicators: conferences and workshops.

TYPE	SPONSORSHIP	PRINCIPLE PARTICIPANTS	PER YEAR	#LO
Conference	with AID	AID field staff and LDC participant	1	3
Conference	with WHO other development agency	LDC health leaders	1	3
Workshop	with WHO UNICEF, UNDP, other agency	Intermediate level health staff in LDC (Operational)	2	6
TOTALS	-	-	4	12

2. Technical Advisory Services

The contractor will provide short-term, rapidly responding technical advisory services to AID missions, AID regional programs, government and non-government organizations in developing countries as requested through the Regional Bureaus and the technical offices of AID in a wide range of activities aimed at the extension of essential health and family planning services as previously defined under "Project Goal". These technical advisory services will be used to: (a) assist AID missions in assessing the opportunity, advisability and feasibility of initiating new HDS, PHC, POP/FP, or water supply and sanitation (WS&S) assistance projects (b) help governments of LDCs assess its existing health and family planning delivery systems and provide guidance towards restructuring the existing systems aimed at the extension PHC to unserved areas (c) evaluate ongoing AID supported projects and activities related to HDS, POP/FP, WS&S and PHC (d) provide expertise in specialized aspects of PHC, HDS, POP/FP and WS&S development and implementation activities (e) provide guidance in solving unanticipated problems that emerge during the implementation phase of PHC, HDS, POP/FP and WS&S projects.

Note: Under the terms of this project technical assistance for WS&S is specifically oriented to the integrated cross-sectoral approach in include environmental health activities which are within the resource limits of primary health care.

Quantified indicators are:

- Total of 360 person months of technical advisory services (20 work days per month); for POP/FP and essential health services;
- Up-to-date register of 3000 qualified consultants representing major cross section expertise related to POP/FP and those aspects of health, nutrition, water supply and sanitation concerned with PHC and HDS
- Evidence that, in developing a consultant register, contractor has made a positive effort to maximize the inclusion and utilization of consultants who are members of minority groups, including women.
- A written statement indicating what affirmative steps will be taken to seek to include a significant number of American minority group members and women (see FPR 1-1.1310-2 for the definition of a minority group) among the personnel the contractor will provide in the performance of this contract. Such a statement will be provided for each team of three or more persons the contractor proposes to support to effect this output.

3. Evaluation and Special Studies

The contractor will provide overall tracking of the progress being made towards improving and extending HDS and PHC programs in AID-assisted countries and will report on methods and approaches that are succeeding in the field; he will also identify constraints and problems, suggest possible solutions and/or alternative approaches and point out and define opportunities for problem oriented research. While carrying out these analytical functions related to AID-assisted countries and projects, the contractor, from a broader perspective will also track, analyze and synthesize the global progress being made in extending essential health services throughout the developing world.

The contractor will establish and maintain a data bank concerning primary health care programs in LDCs. In doing so, emphasis should be given to non-AID supported projects and programs.

In 1976, the APHA, under contract with AID under the DEIDS (Development and Evaluations of Integrated Delivery Systems) Project, compiled the essential data on 180 health projects (75 in Asia, 56 in Africa, 44 in Latin America, and 5 in the Near East) focusing on those in rural areas that were delivering more than a single service, with particular emphasis on those with innovative activities often implemented through non-conventional health delivery system structures.

The contractor will extend this information to include, during the life of the project, a total of at least 350 projects. The contractor will maintain up-to-date information for each project, including description of components and evaluation results. The contractor will also disseminate information and descriptions of those projects or project elements that, in the contractor's opinion, are innovative, successful, and/or instructive. This dissemination of information will be in the form of brief capsules and in-depth studies.

By March 1 of each contract year, the contractor will write and publish an annual review of the global "state-of-the-art" applicable to primary health care and affordable health delivery systems. This annual review will synthesize the major developments, progress, and findings that occurred in these fields during the prior calender year. In anticipation of this requirement, the contractor will, soon after the onset of the contract, submit to AID/DS/HEA/HDS a format which will outline the organization of this annual review, setting forth the major headings and sub-headings of the subject areas which will be covered. Although the final format is subject to the approval of AID, that agency has among others a special interest in progress being made in the following areas:

1. Emerging patterns of health services and delivery systems which extend essential health services into rural unserved areas.

2. Newer findings about costs and affordability of essential health services in diverse settings - ways of financing local services, including contribution for services by the community served.

3. Experience in community participation in primary health care activities.

4. Training and use of simply trained health workers, especially newer and non-conventional types, and ways in which they are used and supervised.

5. Advancement in appropriate technology applicable to essential community level health and related services.

6. Newer approaches and methods to improve and extend village water supplies and waste disposal.

7. Experience with community-based programs aimed at preventing and managing malnutrition in young children.

8. Prevention and managing diarrhea, particularly in children - including experiences with oral electrolytes.

9. Ways of improving the health and well being of pregnant women, including the nutritional aspects.

10. Progress towards integrating categorized health and disease control programs at the community level. Successful patterns and ways of coordinating these programs at national, intermediate, and local levels.

11. The role of community-based health services in the control of vector bo rne diseases.

12. Simplified effective health information systems and how they are used in planning and evaluating health programs and activities.

13. Immunization programs - progress in executing single and multi-antigen programs. Newer vaccines, particularly improvements in heat stability and ways of solving cold chain problems. Improved ways of monitoring and evaluating immunization programs, particularly during maintenance phase.

14. Basic community level medical care activities, including such factors as formulas for essential drugs, experience with treatment of common illnesses by simply trained health workers, and organization of and experience with referral systems.

15. Supply and resupply of peripheral health activities in rural areas.

16. Ways of coordinating health and other related services at the community level. Organizaitonal patterns - schemes that enhance impact by multisectoral efforts.

17. Simplified methods of measuring impact of health and health related activities.

The above are illustrative of some of the subject areas that should be considered in the Annual Review. They should be considered only as a guide in designing a format for the Annual Review.

In the process of tracking progress in these and other aspects of primary health care, the contractor will need from time to time to convene small groups of subject area specialists and will have to conduct special studies focused on particular vital subjects and problems. The contractor is therefore authorized to engage up to 18 person-months of short-term consultants per year for a total of 54 person-months during the three year life of contract. The findings of such studies and expert committees will be published and distributed to the relevant technical staff of AID/W, to AID health staff at field missions, to the technical staff of other health development agencies and to the principle health officials and institutions in LDCs involved in primary health care programs.

Since the Office of Population of AID/DSB has other mechanisms for tracking the state-of-the-art in Pop/Family Planning programs, activities concerning these fields will not be a primary emphasis of evaluation and special studies under this contract. However, consideration should be given to those programs or activities that combine family planning and other health services within joint delivery systems.

The contractor will give special emphasis to on-site in depth assessment and evaluation of AID-supported primary health care projects in LDCs. In addition to the technical advisory services furnished under Section 2 above, the contractor will, in consultation with AID/W and the relevant AID mission, furnish consultants to assess special aspects of these projects with emphasis on such factors as population coverage, types of services available, costs per capita, and health impact. In addition to field trip reports resulting from consultation visits, the contractor will furnish AID an annual report that will analyze and summarize the progress (or lack of progress) being made in AID-assisted projects in primary health care and affordable health delivery systems.

Quantified indicators are:

3 Annual reviews of the global "state-of-the-art". English language only. Circ. 3000 each.

6. Technical reports summarizing results of special studies, expert committee meetings etc. - English only - Circ. 2000 each.

3 Annual reports summarizing porgress, constraints, suggested changes and need for problem-solving research in AID-assisted countries English only - 100 copies furnished to AID only. These annual reports should specifically summarize each AID-assisted project, and others to the extent knowledge permits, as to the percent of population coverage measured by convenient availability of services, costs per capita, and health impact.

- Workshops (2 per year) sponsored by the contractor, focused on the most vital aspects of PHC & HDS with participation of highly qualified experts representing a variety of disciplines related to the topic. Participants will be limited in number (as opposed to the workshops noted on p. 17). The intent of these workshops is to focus on a specific concern in PHC, and identify appropriate responses in minimal time.

- Extend data band from existing 180 PHC/HDS Projects to 350 projects.

Inputs

The contractor will provide a full-time core staff of 12 professionals and 10 support personnel for the duration of the contract (36 months).

The inter-relationshops of services furnished under this project are such that it is unlikely that any one activity can be carried out exclusively by one or two individuals. Rather, a cooperative effort by a number of staff members with a wide range of skills and experience will be needed. This is particularly true in fulfilling contract requirements pertaining to those aspects of the contract related to the tracking, analysis, and synthesis of global progress being made in the "state-of-the-art" of primary health care and health delivery systems.

The contractor's staff collectively should represent experience and expertise in the following fields; general public health administration and management, maternal and child health, nutrition, health education and community organization, environmental health including water and sanitation, health planning and financing, population and family planning, health evaluation techniques, health training and manpower development essential health care, immunization and communicable disease control. In addition, the contractor's core staff should also represent experience and expertise in the development of health and family planning services in the lesser developed areas of the world.

An illustrative professional staff would be as follows:

One Director GS-16 Equivalent

Duties:

1. Provides overall responsibility for execution of all services under the contract.

2. Provides supervision and guidance of professional staff, including selection and replacement, if necessary.

3. Serves as principal liaison with AID on overall policy and decisions concerning implementation of scope of work under the contract.

4. Serves as principal liaison and coordinating professional with multilateral agencies such as WHO, UNICEF, UNFDA, UNDP.

5. Provides technical expertise in general public health administration and management, health planning and financing, community organization, health evaluation techniques, and maternal child health including family planning as those apply to primary health care. Employs these skills, knowledge, and expertise in assisting the Special Studies Chief in carrying out the contract requirements set forth in the section on Evaluation and Special Studies and in helping with technical aspects in the planning , organization, and conduct of the various conferences and workshops required in the contract.

6. Counsels AID on such matters as the selection of subjects for conferences and special workshops, recommendations regarding studies undertaken and the final format of the State of the Art Reviews.

Qualifications

M.D. with masters degree in public health-at least five year prior experience in a supervisory position with major coordination role in a developmental health program, at least two years of which was in a lesser developed country. Established competency in general public health administration with expertise in at least one other relevant field, e.g. maternal and child health, population/family planning, health planning and evaluation of essential health services. Competency in French and/or Spanish as a second language desirable.

One Deputy Director GS-15 Equivalent

Duties:

1. Assists Director in carrying out duties outlined above and serves as Acting Director in absence of the Director.

2. Subject to general policy and guidance from the Director, supervises and coordinates all activities related to the provision of technical advisory services.

3. Supervises and evaluates the work of the two technical assistance managers, the logistics coordinator and the registry - documentation coordinator described below and the support staff related to these activities.

4. Reviews and approves all written products and assures they are of the highest possible quality, including the reports of the technical consultants.

5. Provides technical expertise in general public health administration, nutrition, health manpower development and utilization, essential health care, immunization and communicable disease control as these apply to primary health care. Employs these skills, knowledge, and expertise in assisting the Special Studies Chief in carrying out contract requirements set forth in the section on

Evaluation and Special Studies and in helping with the technical aspects in the planning, organization, and conduct of the various conferences and workshops required in the contract.

Qualifications

M.D. with MPH and at least five years prior experience in a health development program with major responsibility for overall planning, executing, and evaluating the program - preferably in a lesser developed country. Experience and expertise in general public health administration, applied nutrition, health manpower development and utilization, essential health care, immunization and communicable disease control as these apply to primary health care. Background in rural health or in deprived areas highly desirable. Competancy in French and/or Spanish as a second language desirable.

One Technical Assistance Manager (Population/family planning) GS-14 Equivalent

Duties:

1. Serves as the principal contract back-stopping professional in handling technical advisory services related to the fields of population and family planning programs and activities.

2. Serves as the principal contract liaison person with AID, DS/POP/FP and the technical support staff of the Regional Offices of AID/W in developing and executing technical advisory services furnished to POP/FP field projects. These activities include, but are not limited to, review of scopes of work, identification of appropriate consultants, briefing and debriefing consultants, monitoring of support services for consultancies, assuring that proper mission and country clearances are obtained prior to departure of consultants, and guidance in and review of the preparation of final consultancy reports.

3. Coordinates closely with the contract's Technical Assistance Manager for Health Services (described Below) with AID Project Manager in DS/POP and DS/HEA and with technical support staff of AID's Regional Offices, to assure that technical advisory services for POP/FP and Health Services are correlated and that duplication of consultant services are avoided.

4. Maintains close liaison with AID/DS/POP and the technical support staff of AID's Regional Offices in anticipating AID's projected requirements for technical advisory services in the field of POP/FP.

5. Works closely with the Contract Logistics Coordinator (see below) in order, with adequate lead time, to provide him/her all the information required to make the necessary arrangements regarding the recruitment, briefing, deployment, and debriefing of all con-consultations and field project evaluations pertaining to POP/FP

6. Advises and assists the Contractor's Registry-Documentation Coordinator (see below) in the development, extension, and updating of the registry of consultants and the data bank information pool, including the systematic feed-back and analysis of reports of consultations and field project evaluaitons pertaining to POP/FP.

Qualifications

1. B.S. or A.B. with graduate degree in field related to POP/FP. At least 5 years prior experience with development programs related to POP/FP preferably at least 2 years of which was in a lesser developed country. MPH or similar graduate degree in general public health acceptable provided graduate study included formal training in POP/FP and experience in this field is particularly extensive and relevant - Prior experience regardless of academic training should have included all aspects of program planning, development and implementation as well as evaluation methodology in the field of POP/FP. Must have broad contacts and extensive familiarity with consultants particularly in the fields of POP/FP but also in the other disciplines related to health development.

One Technical Assistance Manager (Health Services) — GS-14 Equivalent

Duties

Essentially the same as described above for the Technical Assistance Manager (POP/FP) except that these duties are related to all other technical advisory services not directly concerned with population and family planning projects and for ease in description are grouped as "health services."

In carrying out these duties the Technical Assistance Manager (Health Services) will be back-stopped by the co-project manager from DS/POP who is responsible on the part of AID for monitoring all technical advisory services furnished under the project contract. (See Section on Project Implementation Arrangements.)

In addition to the primary duties associated with back stopping technical advisory services related to health and other technical services other than POP/FP, he/she will also provide expertise in his/her fields of technical competency related to evaluation and special studies and contribute inputs related to the conduct of workshops and conferences. In this respect he/she should play a major role in identifying appropriate short term consultants for expert committees and resource people for conferences and workshops.

Qualifications

BS or AB with major in health related sciences - MPH or equivalent graduate level training - at least 5 years experience with development programs and expertise and experience in all aspects of program planning, development, implementation and evaluation of developmental health programs.

Preferably at least 2 years experience in health programs in lesser developed countries. Must have broad contacts and extensive familiarity with experts in all fields related to health services development.

One Technical Specialist (Environmental Health Engineering and Environmental Science Officer) GS-14 Equivalent

Duties:

1. Serves as the contractor's chief resource person on all aspects of environmental health engineering and environmental science especially relating to all aspects of rural and urban fringe community WS&S activities.

2. Assists the Conference Manager (see below) in the planning and organization of those aspects of conferences and workshops related to the above listed fields and participates, as appropriate, in the actual conduct of such conferences and workshops.

3. Has primary responsibility for the preparation and/or review of technical papers and other materials required for dissemination of information related to environmental health including water supply and sanitation.

4. Contributes relevant sections to the state-of-the-art reviews.

Qualifications

A.B.S. degree from an accredited college or university in Civil Engineering or Chemical Engineering and an M.S. degree in Environmental Engineering, Sanitary Engineering, Environmental Health Engineering, or Public Health Engineering. Incumbent must have significant progressive professional experience in the development of rural and urban water supply, water treatment, wastewater treatment, excreta disposal, process evaluation and assessment of projects in the LDC's. Career development through professional engineering registration in at least one state and professional sanitarian registration in at least one state is highly desirable. Other experience in the related field of preventive medicine is also highly desirable.

One Special Studies Chief GS-14 Equivalent

Duties:

1. Serves as chief of the special studies section and has overall supervisory and coordinating responsibility for the execution of those outputs described under the section on "Evaluation and Special Studies," page 12.

2. Drawing on the collective expertise of the contractor's core professional staff prepares the Annual Reports to AID that summarize progress, constraints, suggested changes and need for problem-solving research in AID - assisted countries.

3. Based on the format developed by the Contract Director which has evolved from consultations which AID/DS/HEA, prepares and publishes the annual State of the Art Reviews. In doing so, he/she will draw on the expertise and inputs from diverse members of the contractor's staff.

4. In coordination with the technical specialists conducts small workshops (2 per year) on vital aspects of FHC & HDS and prepares, publishes and distributes the resultant reports.

5. Plans and executes special studies and prepares and distributes the resultant reports.

6. Provides guidance for those aspects of the work of the Registry-Documentation Coordinator pertaining to the maintenance and extension of the State-of-the-Art data bank information system.

7. Supervises the work of the Research Assistant.

Qualifications — GS-14 Equivalent

B.S. or A.B. with major in health related sciences - M.P.H. or equivalent graduate study in public health. At least 5 years prior experience in health development programs preferably 2 years of which was in a lesser developed country. He/she must have special skills in data analysis, extensive background in broad-range public health services and the ability to analyze and sythesize major happenings in primary health care. He/she must also possess the personal traits needed to work effectively with a multidisciplinary team and draw on their collective expertise.

Adjunct Professional Contract Staff

The above staff of 6 professionals constitutes the nucleus of subject area expertise and experience needed to carry out the various health and population/family planning outputs specified in the project contract. In addition, 6 adjunct professional positions will be required to complement and supplement the work of the nuclear health related professionals. These are listed and described with less detail below:

Conference Manager

This individual will have the major responsibility for organizing and coordinating the conferences and workshops to be carried out under the Project. He/she will need to be skilled in the logistics of conference management as well as be able to draw upon the contributions and skills of a large number of other individuals on the staff and from other organizations.

Logistics/Finance Coordinator

This individual will be required to make all necessary arrangements regarding the deployment of consultants and staff including making all travel arrangements, processing pay and expense vouchers, obtaining required commodities and supplies. He/she also is responsible for maintaining contract financial documents and monitoring the fiscal affairs of the contract.

Registry-Documentation Coordinator

This individual will be responsible for overseeing the Consultant Registry and for maintaining, in an easily retrieval form, documentation for staff and consultants, such as periodicals, reports, documents from other agencies, etc. This individual should have experience in the development and maintenance of information systems.

Editor

This individual will devote approximately 30% of his/her time to the editorial supervision of the quarterly Newsletters. His/her responsibilities also will involve editing all project documents: conference reports, Annual Review of the State of the Arts, research papers, research recommendations, and consultant reports. The Editor's task will be to assure that this information is in the most appropriate form for dissemination.

Production Coordinator/Writer

This individual will have major responsibility for coordinating the content of and managing the production aspects for the newsletters. Contributions for the newsletters will be solicited both from contract staff members and from outside individuals. The Production Coordinator/Writer will adapt and coalesce the contributions.

Research Assistant

This individual will be required to assist in the expansion of the State of the Art Data Bank, in carrying out the needed research for the State of the Art review, research papers, conferences and workshops.

The support staff of 10 individuals include:

1 Executive Assistant
1 accounting clerk
1 courier/mail clerk
and
7 secretaries

Inputs in addition to those for salaries and fringe benefits for contractor's staff include:

1. Funds for consultants services fees

   a. for technical advisory services for field projects about 120 pm/year at average cost of $3000 per month based on average fee of $150 per day x 24 work days per p.m.

   b. for special studies about 18 pm/year at average cost of $3600 per month based on average fee of $150 per day x 24 work days per p.m.

   c. for Conferences and other about 4.5 pm/year at average cost of $3600 per month based on average fee of $150 per day x 24 work days per p.m.

2. Funds for travel, perdiem and other expenses related to travel.

3. Funds for Contractor's overhead which includes such items as office rent, utilities, furnishings equipment, as specified in the contract.

4. Funds for supplies which includes such items as paper and other office supplies, folders, binders, and misc. small items of equipment et al.

5. Funds for other direct costs which includes such items as publishing and printing, mailing and other costs of dissemination of information and reports, telephone and communication et al.

Budget and Financial Plan

The project budget and financial plan for the first year by object class and output purposes is shown in the table below.

ADSS BUDGET - FIRST YEAR.

	MGMT	TA	Special Studies	Info Dissem	Conf	Year I Subtotal
SALARIES	138,500	145,000	114,000	44,000	68,500	510,000
FRINGES	27,700	29,000	22,800	8,800	13,700	102,000
CONSULTANTS		360,000	64,800		16,200	441,000
TRAVEL	15,000	420,000	47,200	6,000	60,4000	548,600
SUPPLIES	5,320	10,640	5,320	2,660	2,660	26,600
ODCS	9,600	87,400	56,850	69,920	13,500	232,270
OVERHEAD	111,340	116,570	91,650	35,370	55,070	410,000
TOTAL	307,460	1,168,610	397,620	166,750	230,030	2,270,470

NOTES "FRINGES" ARE BASED ON 20% OF SALARIES.

"OVERHEAD" IS BASED ON 67% OF SALARIES PLUS FRINGES.

ODCS is: other direct costs.

BUDGET AND FINANCIAL PLAN

Year 01

I.	Salaries	Total	$ 510,000
	A. Professional Staff Technical		
	Director	$ 47,500	
	Deputy Director	45,000	
	Special Studies Chief	37,000	
	TA Manager Pop.	34,000	
	TA Manager Health	34,000	
	Technical Spec. Environmental Health	34,000	
	B. Adjunct Professional Staff		
	Conference Manager	26,000	
	Logistics Coordinator	22,000	
	Registry-Documentation Coordinator	22,000	
	Editor	26,000	
	Production Coordinator/Write	22,000	
	Research Associate	21,000	
	Professional Staff (A + B)	Sub-total ($ 370,000)	
	C. Support Staff		
	Executive Assistant	18,000	
	Secretaries, 7 @ 14,000 each	98,000	
	Accounting Clerk	12,000	
	Courier/Mail Clerk	12,000	
	Support Staff	Sub-total ($ 140,000)	
II.	Fringe Benefits (20% of total salaries)		$ 102,000
III.	Overhead (67% of salaries plus fringes)		$ 410,000
IV.	Consultant Service Fees	Total	$ 441,000
	A. Technical Advisory Services for Country programs 120 PM/yr. @ $3000 per month	360,000	
	B. Special Studies and Expert Committee 18 PM/yr. @ $3600 per month	64,800	

C. Conferences and Workshops 4.5 PM/yr. @ $3600 per month	16,200	
V. **Travel**		$ 548,600
Transportation Sub-total ($	393,200)	
A. TA Services, country programs 150 round trips @ ave. $2000 each	300,000	
B. Special Studies and Expert Committee		
12 round trips, domestic @ ave. $300 ea.	3,600	
6 round trips, international @ ave. $2000 each	12,000	
C. Conferences and Workshops		
25 round trips international @ ave. $2000 each	50,000	
D. Other (Staff liaison with other agencies) Estimated at 7 PM		
12 round trip domestic @ $300 each	3,600	
12 round trip international @ $2000 Each	24,000	
Per Diem and other Travel Costs Sub-total ($	155,400)	
A. TA Services, country programs 120 PM @ $1000/PM	120,000	
B. Special Studies and Expert Committee 18 PM @ $1200/PM	21,600	
C. Conferences and Workshops 4.5 PM @ $1200/PM	5,400	
D. Other (Staff liaison) 7 PM @ $1200/PM	8,400	
VI. **Supplies**		$ 26,600
VII. Other Direct Costs (OCDS)		$ 232,270
TOTAL		$2,270,470

ADSS Budget, LIFE OF PROJECT*

		Year 1	Year 2	Year 3	All Years
I.	SALARIES	510,000	550,800	594,864	1,655,664
II.	FRINGES	102,000	110,160	118,972	331,132
III.	OVERHEAD	410,000	442,800	478,224	1,331,024
IV.	CONSULTANTS	441,000	476,280	514,382	1,431,662
V.	TRAVEL	548,600	631,368	681,877	1,861,845
VI.	SUPPLIES	26,600	28,728	31,026	86,354
VII.	ODCS	232,270	250,852	270,920	754,042
	TOTAL	2,270,470	2,490,988	2,690,265	7,451,723

*An 8% inflation factor has been applied for years 2 and 3.

E. Project Implementation Arrangements

The services under this project will be executed through a centrally funded contract between AID/W and an appropriate contractor. The duration of the contract will be three years funded in annual increments but the total scope of work for the life of the project will be set forth at the onset.

The implementing contractor must have the capability to:

1. Readily relate to and effectively participate and coordinate with diverse development agencies private and public, national, regional and international that are in the forefront of global efforts in the promotion and development of population, nutrition and primary health care programs including such agencies as WHO, UNICEF, UNDP, The World Bank and the major professional associations in the health related fields.

2. Have or develop ready and easy access to top qualified consultants in the various disciplines related to primary health care and family planning in order to solicit their participation in expert committee meetings, conferences, special study groups and evaluation/analysis activities.

3. Mobilize and energize the efforts of non-governmental agencies in the United States and in and among lesser developed countries in support of essential health and family planning services including corporations, labor unions, universities, professional associations, women's groups, foundations, religious organizations and other such agencies.

4. Have or develop a comprehensive register of consultants representative of all the major fields relevant to primary health care, health systems development, population and family planning, nutrition, water supply and sanitation, and the other activities related to the provision of essential health services in order to rapidly respond to AID field mission requests for advisory services at the rate of approximately 100 person months per year.

5. Have or develop a core of in-house staff qualified to track overall developments in the fields of primary health care, Pop/FP and affordable health and family planning delivery systems, to identify major advancements, constraints and needs for problem-solving research, to analyze trends and methodologies and to clearly and eruditely summarize their findings in reviews and other reports which have high impact and decision guidance value in establishing policy, strategy and development methodology for PHC & HDS programs.

The Project will be backstopped, on the part of AID/W, by a system of dual project managers. Those contractural services pertaining to the provision of technical advisory services to AID missions will be backstopped by the Family Planning Services Division of the Office of Population of the Development Support Bureau, DS/POP/FPSD. Those contractual services pertaining to other outputs of the project will be backstopped by the Health Systems Development Division of the Office of Health of the Development Support Bureau, DS/HEA/HSD. The latter outputs include all services required for promotion information and education and those for evaluation and special studies previously described in the section on project outputs.

Since the activities concerned under the provision of technical advisory services and those associated with other outputs of the project are often interrelated, there must be close liaison and coordination between DS/POP/FPSD and DS/HEA/HSD. This is particularly important in respect to those aspects of technical advisory services that concern evaluation of field projects, to assure that the results of such consultancies are uniformly fed into the pool of information needed for tracking and analyzing progress and constraints occurring in AID-assisted countries with PHC and HDS projects. Much of AID's backstopping expertise related to activities such as health care, water supply and sanitation, malaria, tropical medicine and disease control, immunization, maternal and child health, and the provision of essential drugs are staffed in the Health Division. There will be, therefore, continuous need for DS/POP to consult with specialized staff members of DS/HEA in developing the scope of work and selection of short-term consultants in these fields. On the other hand, DS/HEA will have to frequently draw on the repository of expertise in DS/POP for guidance in developing conferences and workshops and in tracking and analyzing progress and constraints related to population/family planning programs. The dual manager arrangements for AID backstopping of this project, therefore, can only succeed if harmonious and mutually supportive relationships exist between the staff of the Office of Health and that of the Office of Population.

In order to facilitate coordination between technical advisory services and other outputs on the part of the implementing contractor, the contractor's deputy director will be assigned direct responsibility for the overall direction and coordination of the provision of technical advisory services. The deputy director also serves as the acting contract director in the absence of the director and therefore must be cognizant of, and involved with the totality of activities executed under the contract.

An AID project Advisory/Coordination Committee will be established which will meet semi-annually; the first meeting will be held approximately 6 months after the signing of the project contract.

Regular members of this Committee are:

Project Manager Representative,	DS/POP/FPSD
Project Manager " ,	DS/HEA/ESD
Chief Health/Nutrition Div.,	AFR/DR
Chief Population Division,	AFR/DR
Chief Population, Health & Nutrition Division	ASIA/TR
Chief Health and Nutrition Div.	LAC/DR
Chief Population Division,	LAC/DR
Chief Health, Population & Nutrition	NE/TECH
Chief, Health Planning Div.,	DS/HEA
Chief, Environmental Health Division	DS/HEA
Representative of the Office of Women in Development	
Chief Human Resources Division	PPC/PDPR
Director, DSB Office of Nutrition	

The AID project manager representative from DS/POP and DS/HEA will share the role of chairman of the committee. The representative from DS/HEA will be responsible for scheduling meetings and for distributing notices to members at least 10 days in advance.

The project manager representative from DS/POP will chair those portions of meetings concerning technical advisory services and will distribute to members in advance a summary of the utilization of TA services by countries and purposes during the prior six months together with a summary of the total use of TA services to date under the contract. TA service utilization should be broken down by geographic region and country showing services primarily utilized by POP/FP and Health Services separately with a brief notation identifying the purpose of each TA.

The Project Manager representative from DS/HEA will chair those portions of meetings concerning other outputs of the project. He/she will distribute in advance a summary of all activities carried out by the contractor during the prior six months that pertain to promotion information and education and evaluation and special studies and should distribute copies of each product published and distributed during the period.

Each co-project manager for his/her respective back-stopping activities should present at the meeting an estimated projection of services and outputs that will be performed in the following six months.

The functions of the advisory/coordinating committee are to:

1. Review the work accomplished during each 6 months period as to its quantity, quality, relevance, and usefulness.

2. Review projected work plans for the following 6 months and assure that projected services are in keeping with AID's requirements in the field.

3. Provide feed-back from the field as to problems and gap in communication or coordination.

4. Provide information and exchange of information about the progress of the work under the contract.

5. Identify specific subject areas for future conferences, workshops and/or topics for special studies.

6. Provide a scheduled structured in-house evaluation of progress under the contract.

Major discussions and conclusions will be summarized in the minutes of each meeting. The co-chairman from DS/HEA will be responsible for preparing and clearing the minutes and maintaining the committee meeting report file.

F. Evaluation Plan

The semi-annual meetings of the project advisory/coordination committee provides a mechanism for in-house periodic evaluation of ADSS progress and the means for timely redirection of the work executed under the project's contract.

In addition, an independent evaluation of the project will be made, employing outside consultants, after completion of 18 and 30 months work. The scope of work for this evaluation will be developed by DSB and submitted for review and approval by the co-project managers at the third regular meeting of the Project's Advisory/Coordination Committee.

UTPUTS		
romotion, Information, & ducation	(a) Publication and dissemination of information concerning health, family planning, and primary health care services. (b) Sponsor conferences and workshops in vital aspects of PHC, POP/FP. (c) Extend commitment and role of LDC professional or government and U.S. Private sector in support of essential health and family planning services.	(a) 12 issues of newsletters, 4/year, circulate 12,000 each; Information packets, 6/year, circ. 300 each. (b) Conference: 1) with AID - 1/year = 3; 2) with WHO or other development agency - 1/year = 3 (c) Workshop: With WHO, UNICEF, UNDP, or other organization - 1/year = 3
Technical Advisory Service	(a) Assist AID missions in assessing the opportunity, advisability, and feasibility of initiating new HDC, PHC, POP/FP or WS&S projects. (b) Help LDC governments restructure existing health and family planning delivery systems. (c) Evaluate AID supported projects. (d) Provide Specialized expertise in PHC, HDS, POP/FP, and WS&S (e) Provide guidance in problem solving.	- Total of 360 person months of consultant services - Register of 3,000 qualified consultants representing major cross section of expertise in HDS, PHC, and POP/FP. - Evidence that in developing consultant register, contractor has made a positive effort to maximize inclusion and utilization of members of minority groups including women.
Evaluation & Special Studies	(a) Provide overall tracking of progress in extending HDS and PHC in AID-assisted countries, identify constraints, possible alternatives and applied research. (b) Track, analyze, and synthesize global progress in PHC. (c) Extend data bank of HDS, PHC, POP/FP, and WS&S projects.	(a) 3 annual reports to AID summarizing AID-assisted projects as to percent of population coverage, costs per capita, health and fertility impact. (b) 3 annual reviews of global "state-of-the-art", 6 reports of special studies, and 6 expert committee reports. (c) Extend data bank from 180/PHC/HDS projects to 350 projects. (d) 2 workshops per year focused on most vital aspects of PHC and HDS with participation of qualified experts.

LOGICAL FRAMEWORK MATRIX

	NARRATIVE	VERIFIABLE INDICATORS
GOAL	To extend affordable, essential health and family planning services to the majority of the people in the lesser developed countries.	45-50 among the 70 AID assisted LDCs will have country-wide systems for the equitable provision of essential health services at a cost that can be supported from resources within the country.
PURPOSE	To reinforce and expand Agency capability to exert a leadership and supportive role in the promotion, planning, development, and evaluation of affordable health and family planning delivery systems and primary health care in most of the developing countries.	1. Health leaders and health agencies including those in 50 or more LDCs receiving materials at least four times per year and view them as vital source of PHC information. 2. 35-40 AID assisted countries have received assistance in form of TA services, attendance at workshops and/or conferences or participation in special studies. 3. Evidence of collaboration with WHO, UNICEF, and other int'l health organizations in sponsoring workshops, conferences, expert committees, and special studies. 4. Evaluation of most important advancements in "state-of-the-art" of PHC, health and family planning delivery systems summarized in publications 5. Assessment of AID's progress in HDS and POP/FP and identification of constraints, problems and needed applied research.

[illegible] on [illegible] documentation, and requests for additional copies of materials.

b) Reports of conferences.

c) Consultant's reports and contractor's records. Inspection of catalogue at contractor's office.

d) On-site visit by DSB project officer or other AID representative.

e) Reports from other International organizations re: conferences and workshops.

Contractor's semi-annual reports on utilization of technical advisory services.
Semi-annual reports of proceeding of project advisory/coordination committee.
Inspection of consultant register at contractor's office.
Review of recruitment procedures and personnel practices of contractor.
Utilization of minority groups and women as consultants.
Reports from AID missions on services provided.

a) Review of reports received by AID.

b) Review of actual materials.

c) Inspection and analysis of data bank at contractor's office.

d) Reports of workshops utilizing experts as participants.

1. AID missions will require and utilize the technical advisory services being made available to them.

2. Relevant expertise and skills as requested by AID missions will be available in adequate numbers among minorities and women to provide appropriate services.

1. Contractor's annual reports of progress in primary health care, including POP/FP activities in AID-assisted countries. 2. Special cost-coverage-impact studies. 3. Data bank information.	1. Governments, professional power groups, and other special interest groups will support the concepts and practice of primar health care with equitable distribution of health resources in LDCs.
1. Feed-back from reports of consultancies, and project evaluation reports. 2. Contractor's semi-annual reports on usage of technical advisory services, reports of conferences, workshops, and special studies. 3. Reports of AIDs advisory coordination committee. 4. Reports of conferences, workshops, expert committees, and special studies. 5. State-of-the-art annuals and reports of special studies. 6. Contractor's semi-annual report. 7. Contractor's annual report on progress in AID-assisted countries.	Congress and AID will continue to give high priority in support of programs aimed at th development and extension of essential health and family planning services.

INPUTS

A. Contract Services:

1. Salaries and other personnel costs for core staff (36 person months each)
   6 professional staff (technical)
   6 adjunct professionals
   10 support personnel

2. Funds for short-term consultant services including fees, travel per diem, and other expenses.

3. Supplies including such items as paper, office supplies, folders, binders, and misc. small items and equipment.

4. Contractor's overhead which includes such items as office rent, utilities, major furnishings, and equipment.

5. Other direct costs which includes such items as publishing and printing, mailing and other cost of dissemination of information and reports, telephone and communication, insurance, conference expenses, etc.

B. Funds for external evaluation

SEE BUDGET TABLES

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