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UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
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LAC REGIONAL

PROJECT PAPER

HEALTH TECHNOLOGY AND TRANSFER

Project Number: 596-0136
598-0632

AID/LAC/P-218

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AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

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6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 01 DD 31 YY 90

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)

A. Initial FY 84 B. Quarter ☐ Supp. C. Final FY 88

8. COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY 84 Supp/85 OYB B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total						
(Grant)	(2,850)	( )	(2,850)	(13,100)	( )	(13,100)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
Host Country						
Other Donor(s)						
TOTALS	2,850		2,850	13,100		13,100

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1)	500R	500				2,850		13,100	
(2)									
(3)									
(4)									
TOTALS						2,850		13,100	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 542 | 570 | 520 | 560 | 510

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	BR	BU				
B. Amount						

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To adapt and extend existing technologies and strategies which address major organizational and financial problems in delivering health services.

14. SCHEDULED EVALUATIONS

Interim MM 09 YY 86 | MM 04 YY 88 | Final MM 09 YY 89

15. SOURCE/ORIGIN OF GOODS AND SERVICES: ☒ 000 ☐ 941 ☐ Local ☐ Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a ____ page PP Amendment.)

17. APPROVED BY

Signature: [signature]

Title: Dwight B. Johnson
Director, Development Resources
Bureau for Latin America and the Caribbean

Date Signed: MM 06 DD 21 YY 85

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Summary and Recommendations

Recommendations

LAC/DR recommends the authorization of a Project to support LAC governments and indigenous health organizations in their efforts to address major administrative and financing problems which adversely effect the delivery of health services. The total AID contribution (grant) to the Project is $13.1 million from the Health account. The grant will be incrementally funded, subject to availability of funds, as follows: $2 million from FY 1984 (Supplemental); $850,000 in FY 1985; $6.0 million in FY 1986; $2.8 million in FY 1987 and $1.55 million in FY 1988.

Summary Project Description

The purpose of the Project is to adapt and extend existing technologies and strategies which address major organizational and financial problems in delivering health services. Common needs exist in the major areas of malaria control, provision of essential drugs, alternative financing of health services, and management and clinical training. Through a regional approach, to provide for better coordination and sharing of information and experiences, the Project will provide for technical assistance, training, analyses and related materials to establish or strengthen systems for meeting these needs.

The two project components for malaria and provision of essential drugs will be concentrated on Central America and Panama. The components for health services financing and training will have a LAC region-wide focus. A brief description of each component follows:

1. Malaria Control

The objectives of this component are to a) eliminate mortality and reduce morbidity caused by malaria; b) reduce transmission in epidemic areas, especially those populated by refugees and displaced persons and c) prevent malaria from spreading to areas where its transmission has been successfully interrupted. AID will fund a collaborative program with the Pan American Health Organization (PAHO) to provide technical assistance to Central American countries to design and implement malaria control programs. AID financed activities will assist malaria control organizations to improve their epidemiological surveillance and management capabilities; to develop, implement and evaluate more cost-effective control measures; to improve intercountry cooperation and information exchange and to strengthen training and applied research capabilities.

2. Provision of Essential Drugs

The primary objective of this component of the Project is to effect improvements in the supply of essential drugs to combat a variety of diseases which affect populations in Central America and Panama. The Project will support the establishment of a Central America pharmaceutical vendor/pricing information network and will fund technical assistance and training in drug selection and procurement, inventory and quality control, warehousing, distribution and dispensing and utilization.

3. Health Services Financing

This Project component will assist LAC missions and health ministries in the region to fill critical knowledge gaps which limit their ability to address financial/economic issues in the sector. Studies will be funded to examine, inter alia, costs, demand and alternative financing mechanisms and technical assistance financed for the design of studies, formulation of health financing policy dialogue agendas, economic analyses of health projects and implementation of financing related components of health projects. Resources will also be provided for promotional visits on alternative financing of health delivery systems, with particular attention to private sector options.

4. Management and Clinical Training

Activities under this component will directly support existing regional and bilateral programs by assisting AID missions with selection of participant trainees, matching participants with appropriate training institutions and providing short term TA to LAC training institutions. TA and training will be financed for assisting the aforementioned activities, staging regional workshops and establishing a pilot preceptorship program for placement of LAC medical students and junior physicians with U.S. physicians. Management training activities will be implemented through the Association of University Programs in Health Administration (AUPHA) and clinical training with the cooperation of the Inter American College of Physicians and Surgeons (ICPS).

Cost

The $13.1 million A.I.D. grant will fund all direct Project costs. In-kind contributions, primarily for staff salaries and benefits, will be provided by PAHO, AUPHA and ICPS (see Annex D.). Ten of the A.I.D. missions queried on the Project have indicated a willingness to participate by funding participants in training activities and co-financing technical assistance (see Annex I.). The nature and extent of individual mission co-funding of various project activities will be determined during the LOP, if and when individual commitments of funds are deemed appropriate. The Project Assistance Completion Date is January 31, 1990.

Conditions and Covenants

Conditions and covenants are placed on the use of assistance, and implementation of the Central America portion of the Project by the Pan American Health Organization.

I. Background

A. Health Status in Latin America and the Caribbean--Summary and Trends

The Latin America and Caribbean region has experienced a considerable improvement in health in the past 10-15 years. Infant mortality declined from 85 infant deaths per thousand births in 1965-1970 to 67 per thousand in 1975-1980. Similarly, deaths among children aged 1-4 years fell from 8.4 to 6.3 per thousand in this time period. (Annex A, Table I).

These mortality rates, however, are only statistical averages that do not differentiate changes in mortality by economic or geographical subgroups. In other words, while the health status of LAC countries is significantly better than that of other regions of the developing world: (a) nine of the seventy countries with the highest infant mortality rates in the world are in Latin America and the Caribbean*, (b) certain areas within LAC countries (Brazil, Guatemala, Peru) have mortality and morbidity rates equivalent to the poorest countries in Asia and Africa, and (c) malnutrition, parasitic, viral and other infectious diseases remain major causes of death and disability in Latin America and the Caribbean. Diarrheal and acute respiratory diseases continue to be major killers of children. Parasitic diseases, especially those that are vector borne (malaria and schistosomiasis), remain endemic particularly in Central and South America. The incidence of certain viral diseases, including dengue and yellow fever, is actually increasing. The resurgence of malaria is a particularly significant health problem due to the appearance of insecticide resistant strains of the malaria-carrying Anopheles mosquito and drug resistant strains of the malaria parasite.

The differences among the subregions of the Americas (Commonwealth Caribbean, Central America, Temperate South America, Tropical South America, etc.) with regard to health status are significant. In general, Central America has fallen behind the rest of the region in improving health status as measured by infant and child mortality. Central America is followed by Tropical South America (Panama, Colombia, Ecuador, Brazil, Peru, Bolivia) in this regard. (Annex A, Tables II-V). The poor health status in these two subregions is due, in part, to the relatively poor quality and lack of availability of health services in these countries, as well as to the continued prevalence of major endemic, communicable diseases (malaria, schistosomiasis, Chagas' disease, etc.) which have been eradicated or controlled in other areas of the hemisphere.

In addition to subregional differences in health status, it is important to note the time frame of the reductions in mortality, particularly infant mortality, in the LAC region. In general, the significant reductions in mortality occurred prior to 1975. This is due to achievements having been made in the delivery of health services (Panama, Colombia, Costa Rica) as well as economic growth in many countries (Costa Rica, Panama, Brazil, Colombia) during the 1970's. Since the late 70's some reductions in mortality have been made, but the trend is levelling off with slowed economic growth in the region and stable if not reduced public sector expenditures in health, despite significant inflation in health care costs.

* Bolivia, Haiti, Peru, Nicaragua, Ecuador, Honduras, Brazil, El Salvador, and Guatemala. UNICEF, State of the World's Children, 1985.

A particularly alarming trend in the health sector since 1975 has been the resurgence of malaria, particularly P. falciparum malaria which untreated has a high case fatality rate (see Annex A, Table VI, VII maps). While some 12 LAC countries have eradicated malaria, the number of people at current malaria risk (residing in malarious areas) has risen to an all time high of 170 million. Between 1961 and 1982 the percentage of malaria infection among individuals tested quadrupled.

The resurgence of malaria does not, however, represent a homogeneous situation throughout the Americas. Six countries (Brazil, Colombia, El Salvador, Guatemala, Honduras and Haiti) accounted for 83% of the confirmed malaria cases in 1982. Central America, containing 3.5% of the hemisphere's population, accounts for 34% of the hemisphere's malaria cases. The majority of falciparum malaria infections were detected in Brazil and Colombia, where parasite resistance to chloroquine has been confirmed (see Annex A, Map II). Most of the mosquito vectors of malaria in Central America have demonstrated resistance to virtually every form of residual insecticide to which they have been exposed (see Annex A, Map I).

B. Constraints to Improving Health Status and Health Services in LAC Countries

The constraints to improving health status which relate to the provision of health services fall into three categories:

1. Resource Allocation and Management in the Health Sector

Financial resources for health services in LAC countries are limited and will not increase in the short term. LAC countries are not likely to increase the proportion of their budgets allocated to the health sector, particularly given economic austerity programs in many countries which restrict public sector spending. In addition, existing health resources are not allocated efficiently within the public sector. The high capital and recurrent costs of the hospital based, curative system limited to urban populations consume a major part of the public sector health budget. Primary health care services, while less costly per capita, nonetheless generate recurring costs for manpower, facilities and vehicle maintenance, vaccines, drugs and transportation. Without more efficient resource allocation in the public sector, additional revenue generated by the health delivery systems, and the introduction of risk and cost sharing modes of health services, resources will remain insufficient to expand and/or improve primary health care services which directly address infant and child mortality and morbidity.

In addition, management problems continue to impede effective health delivery. Adequate systems of planning and management, transportation, logistics, drug supply, supervision, referral and data collection are frequently lacking in LAC health systems. Appropriately trained planners, managers and health care providers are scarce, unevenly distributed, and employed in the urban-based, curative health system. Thus the

productivity of existing health delivery systems is uniformly low and the quality of care generally substandard.

2. Inadequate Knowledge and Technology

Comparatively little has been done in the utilization of new medical technologies to develop drugs, vaccines or diagnostic tools for the highly prevalent diseases of the developing world, including Latin America and the Caribbean. Even effective and well established technologies (immunization and oral rehydration) are underutilized. For example, only 30-40% of the children under five years of age in Latin America and the Caribbean are immunized. In addition, for certain major diseases and health problems (e.g. acute respiratory diseases and prematurity and low birth weight) little is known regarding their causes, modes of transmission in the case of diseases, prevalence and impact on the individual and the community.

3. Detrimental Intersectoral Linkages

Certain health problems (i.e. resurgence of malaria, yellow fever) have been caused or accelerated by urbanization, migration and resettlement, and development activities in other sectors (i.e. irrigated agriculture, agricultural use of pesticides, man-made water impoundments, and road construction). This is particularly true in Central America as a result of large migrations of populations due to civil unrest, and uncontrolled use of pesticides for agricultural production, particularly cotton.

C. Problems to be Addressed

1. Malaria

a. Status of Malaria in Latin America and the Caribbean

In the countries of Latin America and the Caribbean, as in the rest of the developing nations of the world, malaria has historically been a major cause of morbidity, a less serious but nevertheless significant cause of mortality, and one of the greatest health related constraints to economic and social development.

The countries of the LAC region were among the first to accept the World Health Assembly's 1955 resolution to eradicate malaria world-wide. Between 1957 and 1982, total funds invested annually in anti-malaria programs in the Americas rose from roughly $26 million to $126.6 million, and overwhelmingly were the result of national budgetary outlays rather than of external assistance. External assistance peaked (at less than 30% of the total outlay) in 1969, and has declined in both percentage and absolute terms in nearly every succeeding year. The commitment of the governments of the region to eradication of malaria has been generally impressive if less than area-wide. Some 12 American countries or territories have been certified by the World Health Organization as having eradicated malaria. Yet the number of people at current malaria risk -- excluding those in countries where malaria has been certifiably eradicated -- has risen to an all-time high of 170 million. And malaria morbidity (measured by multiplying the percentage of malaria-positive

blood slides within the number of individuals actually tested by the population of areas at current malaria risk) is also at an all-time high of 137.7 per 100,000 population.

Beginning in the 1950's, nations throughout the LAC region implemented anti-malaria campaigns, normally through the creation of autonomous National Malaria Eradication Services (SNEMs). Early results were dramatic. Among the 1.7 million blood smears examined in 1958, 56,705 showed the presence of malaria parasites, giving a Slide Positivity Rate (SPR) of 3.3%. Applied to the entire population at malaria risk at that time, such a rate of slide positivity would indicate a malaria case burden as high as 4.5 million cases. By 1961, the SPR was down to 1.9%. But from 1961 through 1982, the SPR rose to an all-time high of 8.1%. A projection of the 8.1% SPR to the population of malarious areas -- roughly 170 million people -- indicates that as many as 13.8 million cases of malaria are theoretically possible.

Regional trends are not to be interpreted as representing a homogeneous malaria situation throughout the Americas or an even rate of decline in program effectiveness. Of the 709,255 malaria-positive slides reported in 1983 (see Table 3), six countries (Brazil, Colombia, El Salvador, Guatemala, Honduras and Haiti) accounted for 87% of all cases. The bulk of P. falciparum malaria infections were detected in Brazil and Colombia, where parasite resistance to chloroquine has been widely confirmed. Anopheline vectors in Central America have shown resistance to every form of residual insecticide to which they have been exposed. In some countries, DDT continues to be an effective insecticide after 15 to 25 years of uninterrupted use; but in most, the use of DDT is declining as the use of other more expensive and toxic insecticides is on the rise. Chloroquine remains the chemotherapeutic drug of choice, although it is no longer effective in all cases, particularly in Colombia and Brazil.

In 1982, the Central American countries and Panama registered 237,104 laboratory confirmed malaria cases, or 34% of all cases registered in the Americas. This number of cases is approximately double that registered 12 years ago (123,311 in 1970). The actual number of cases in Central America could exceed one million, if it is assumed that for each patient diagnosed in a laboratory there are four who have not had access to health services. A considerable increase in the prevalence of malaria infection has been observed in affected areas of Guatemala, Honduras and El Salvador. Costa Rica and Panama, on the other hand, have maintained low malaria morbidity rates, although the number of reported cases of malaria in Costa Rica doubled from 1982 to 1983. There is persistent transmission, albeit at a low level, of malaria in certain areas of Panama and Costa Rica. If epidemiologic surveillance is not maintained and control measures are not applied due to financial and/or technological problems, the incidence of malaria will increase. Nicaragua has managed to stop malaria outbreaks of epidemic proportion, but high endemic levels still exist, especially on the Pacific Coast. Belize experienced a 19% increase in the number of registered cases from 1982 to 1983 and a 15 % increase in malaria positive localities requiring a regression from the "control" back to the "attack" phase of malaria control programming. PAHO characterizes malaria as "the most serious health problem among existing tropical diseases in the sub-region in terms of the number of

cases registered, its potential for epidemics, and its effect on the rural population, on migrants with poor housing, and on refugees and displaced persons."

Most LAC countries continue to support malaria programs. Yet, despite many partial successes, most anti-malaria programs throughout the region are in a state of disarray. The strategy of intensive but short-term malaria eradication, of a massive investment to attain a total and sustained interruption of malaria transmission in most of the region has been maintained and nurtured, despite inadequate human and financial resources. Only with reluctance has there emerged a gradual appreciation of the impossibility of short-term eradication of malaria. The extraordinary increase in malaria incidence in the past four years has focused attention on the need to concentrate resources in areas where malaria is of critical importance; to stratify each country into epidemiologically homologous areas, and to tailor the anti-malaria efforts to the epidemiological situation, the resources available and the socio-economic significance of the disease; to concentrate on problem areas; to utilize intersectoral data sources as opposed to total reliance on the data of the National Malaria Eradication Services; to decentralize anti-malarial efforts; to take advantage of the capabilities of their general health services; in short, to restructure malaria programs from eradication to control programs. With varying degrees of alacrity, program adjustments may now be reasonably anticipated.

b. Major Constraints to Reducing Malaria Prevalence in the Region

Numerous lists of the problems facing anti-malaria programs in the region have been compiled and presented in various AID and PAHO documents. The major constraints identified by the countries of the region and by analysts of the causes of program failure may be grouped as follows: technical (vector and parasite resistance), administrative/structural (institutional redundancy, inappropriate use of costly and/or ineffective technologies), operational (weak management of programs, lack of information feedback systems to identify technical and operational problems), and financial (lack of budgetary resources).

Examination of these four classes of commonly encountered constraints indicates that most can be ameliorated and some eliminated as constraints through the adoption of an appropriate strategy of control, supported by a judicious combination of applied field research and training. Financial constraints must be resolved by the individual countries, with external support, if necessary.

2. Essential Drugs

a. Status of Essential Drug Availability in Central America and Panama

Pharmaceuticals have assumed an increasingly important role in the management of many diseases. In many cases, rational ambulatory use of medications can

obviate the need for costly hospitalization, e.g. diarrhea, tuberculosis, and pneumonia. Many diseases, especially the early diseases of childhood, can be prevented by the use of vaccines. With a population of approximately 25 million persons, and consumption of medicines valued at $13 per capita per year, the countries of Central America and Panama invest more than $300 million per year (much of it in foreign exchange) in pharmaceuticals, one third of which is purchased for public sector delivery systems.

Although up to 40% of health care expenditures in Central America many be on drugs, the majority of the population, particularly those dependent on the public sector health delivery system, does not have access to many of the essential drugs needed to treat prevalent diseases. Frequently, the limited funds available are ill-spent on ineffective, duplicative, unacceptably dangerous drugs or wasted on nonessential drugs which are used inappropriately. Funds are also wasted due to inadequate inventory control,inadequate storage, stock mismanagement, and inappropriate prescribing and use of drugs at all health care levels. Additionally, numerous studies have demonstrated that drugs have the capacity to not only cure, but to harm as well. This paradox of drugs is acutely experienced in developing countries where quality control is absent, access to health services is limited, and consumption through commercial channels is not regulated. When drugs are not available, the patient is often given an inappropriate substitute, does not get well, and becomes disgruntled with the entire health care delivery system. On the other hand, if the drugs that are available are badly used, therapeutic failures and drug induced illness add significant burdens to the already overburdened health system.

The countries of Central America have begun to demonstrate an awareness of the need to rationalize drug use in their health care programs and have begun to implement measures aimed at increasing efficiency and effectiveness of therapy. These measures include:

(1) Development of essential drug formularies based on prevalent morbidities, utlizing criteria of efficacy, safety and costs.
(2) Development of therapeutic prescribing information and standards of care.
(3) Implementation of "level of use" standards
(4) Development of quality control procedures
(5) Improvement of inventory control systems
(6) Establishment of management information systems
(7) Improvement of procurement systems

These efforts have been undertaken with the assistance of donor agencies. PAHO and AID have been the major providers of such assistance--PAHO focusing on activities 1-4, and AID on 5-7 The Ministers of Health, and the Directors of Social Security of Central America and Panama in their last meeting in August 1984 identified the availability of essential drugs as their #1 problem and their highest priority for external support.

b. Constraints to Improving Drug Supply and Utilization

The major constraints to improving essential drug supply--exclusive of the overall availability of funding--fall into seven categories.

(1) Selection

Many countries, including those of Central America and Panama, purchase a wide variety of pharmaceutical products for their public sector health programs without regard to prevalent morbidities, drug efficacy and safety, or cost. Hence, limited resources are diluted by the purchase of low priority, high cost and potentially unsafe drugs leading to a diminished capacity to purchase essential drugs. Typically this situation exists because of the absence of a formalized drug selection committee, with objective criteria and procedures for the evaluation of drugs proposed for inclusion in an essential drugs formulary.

Compounding the constraint to rational drug selection is the paucity of unbiased drug prescribing/use information available to practitioners. Rational decisions for drug selection must be predicated on complete information regarding drug safety, appropriate indications and administration. Finally, many products are prescribed by practitioners who are not sufficiently trained to responsibly select and monitor product use. As pharmaceuticals differ widely in their relative complexity, toxicity and capacity for misuse, many LAC countries fail to assign designation of "level of use" indicators for each product.

(2) Procurement

Pharmaceutical procurement in LDCs is frequently based on estimates of drug movement (inventory control) that are not true reflections of actual drug consumption. Therefore, quantities procured are either over or under estimates with resultant overspending of funds or shortages of pharmaceuticals. Moreover, criteria for selection of supplies are not well-defined resulting in repeated purchases from vendors with poor product quality, unreasonably high cost, or undependable delivery characteristics. This is further compounded by the absence of detailed specifications of products to be procured (in terms of strength, dosage, form, color, etc.) which when not adequately defined, results in product deliveries which do not meet actual needs.

The procurement process is similarly impeded by the absence of order tracking procedures and follow-up systems (management information system). Characteristically this process, when it exists, is unsystematic and as such fails to identify situations leading to stock outages. The scheduling of call for bids for pharmaceuticals is oftentimes erratic. This is directly related to the deficiencies in quantity estimating and planning, and erratic availability of funds. Repeated smaller procurements are more costly than semi-annual or annual larger procurements. Delivery schedules which result in a spreading out of receipt of pharmaceuticals are not negotiated at the time of contracting when specific delivery dating is desirable to the country. And finally, procurement personnel do not avail themselves of "return goods" policies offered by many drug manufacturers which allow for return of damaged or expired products for exchange or credit.

(3) Inventory Control

Inadequate control of pharmaceutical inventory remains a common and serious problem throughout all of the countries in Central America and in the LAC region. This problem has led to stockpiling of drugs at some locations within a country (due to fears that an essential drug will become unavailable) while there are drastic shortages at other locations; drugs being lost through reaching their expiration dates, and inappropriate minimum quantity standards for reordering. Management information is not routinely updated so that reports describing availability of drugs are erroneous and misleading. Local practitioners responsible for inventory control at clinics and outposts lack sufficient guidelines and training to be able to properly control their pharmaceutical stocks.

(4) Quality Control

Although there has been an increased focus on procuring pharmaceuticals generically in Central America and Panama, there has not been a corresponding increase in support for quality control. Products reaching the central warehouse are not systematically tested to determine whether they meet the product specifications. Consequently, governments are often paying for drugs of inferior quality which results in practitioner reluctance to use generic products.

LAC countries have justifiably determined that performing routine quality control analyses on all products is an impossible task and thus have required very few, if any, routine analyses on products reaching the central warehouse. There has not been any systematic identification of a limited list of products whose efficacy or toxicity characteristics require strict quality control analyses. Sampling procedures to select samples for testing are not closely adhered to, if employed at all, in many government central warehouses.

In Central America and Panama, separate quality control facilities exist to serve the Ministries of Health, the Social Security Institutes, and other agencies, resulting in duplication of expensive equipment and little or no coordination or collaboration.

(5) Warehousing

Warehousing for pharmaceuticals is inadequate in all countries of Central America. In addition to physical limitations, there are significant problems in space planning and security which can be addressed independently from the remodeling or construction of warehouses.

(6) Distribution

Distribution of drugs, including transportation, storage, control and dispensing at local levels is hampered by problems of theft and pilferage, inefficient, and uninformed distribution of products. Drugs are a desirable commodity for personal use as well as for sale and hence require strict security measures. Inefficient distributiuon and deficient dispensing

procedures negate the value of approporiate drug selection, adequate procurement and warehousing. The "end point distribution" must be successful for drug therapy to be effective.

(7) Use

The inappropriate use of drugs leads to therapeutic failures and drug induced illness. These problems of inappropriate drug use can be in part attributed to the lack of availability of appropriate drugs and unbiased drug information for prescribers. Of equal importance, however, is the patients' lack of knowledge regarding how to take medication. Drugs are often prescribed in the absence of a correct diagnosis, adequate information on the drug, a complete patient medical history and appropriate procedures for monitoring therapy. The system for collecting morbidity/mortality and therapeutic statistics in most Central American countries is deficient. The information collected on morbidity is limited to gross descriptions of disease. Statistics on drug consumption are based on movement of products from the central warehouse to other storage facilities. Therefore, it is difficult to accurately assess the use and impact of drugs on health status and health services.

3. Health Services Financing

a. Current Status of Financing Constraints and Resource Allocation Problems in the Region

Financing systems and resource allocation issues pose fundamental constraints to efficient, effective delivery and expansion of health care services in the LAC region. Total health expenditures for LAC countries are estimated at between 2-6% of GNP. Social insurance and payments by individuals usually account for at least half of the total but relatively little information is available regarding the nature of these expenditures. Public sector health budgets take up the remainder. Ministry of Health systems in the region are financed almost entirely by public sector health budgets which are generated by general tax revenues derived from duties, consumption taxes, licenses, fees, and income taxes. The recurrent cost burdens of these public sector health care delivery systems already account for a relatively large share of total government recurrent expenditures, yet they experience constant shortages of funds, drugs, supplies, and other resources as well as constant management and administrative problems. In addition, government health budgets are heavily biased towards urban, hospital-based, curative services. The pressure to deliver curative services primarily free of charge overly compromises the capacity of public systems to deliver consistent high quality curative and preventive services. The gap that has developed between goals and reality in the allocation of expenditures is enormous. While public health systems have achieved effective coverage of only a limited proportion of their national populations, most Ministries of Health in the region remain committed to ambitious health goals which imply substantial increases in expenditures and/or fundamental changes in the types of services provided. Major shifts in funds toward improved rural access and more preventive care clash with priorities for established programs.

b. Major Constraints to Improving Financing Strategies and Resource Allocation

There are few guidelines at present that indicate what financing strategies and resource allocation patterns are best for any given country. The basic principles or standard rules common to all sectors call for: optimizing efficiency in resource use by allocating additional resources to a given activity as long as the extra net benefit to society exceeds the foregone benefit in the next best alternative use of the same resources; and, promoting efficiency and cost recovery through financing strategies that utilize user charges based on efficiency prices. These general principles, however, provide little in the way of concrete direction for A.I.D. health officers and host country health planners. In addition, several features of the health sector set it apart from the general case:

- Outputs are heterogeneous; financing solutions require discrimination between dissimilar activities, e.g. "public good" activities vs. curative patient care activities.

- Health providers, i.e suppliers, are heterogeneous; diverse service provider combinations co-exist within a single country and require a broader approach to health planning than Ministries of Health typically take.

- Contrasting models of service delivery and financing exist, and the appropriate role of government in the health sector is not always understood and/or a matter of consensus.

- Revenue-raising potential of user charges in public institutions is more limited in health than in most other sectors; cost recovery figures higher than 15 to 20 percent appear unrealistic.

- Revenue-raising potential of insurance-type or prepayment vehicles is substantial but requires better understanding of the conditions for success.

Financial difficulties and resource allocation problems are generic to health systems across the region and emerge as major constraints to expansion and improvement of health service delivery. At the moment, AID and LAC governments face several critical knowledge gaps which limit ability to address these issues. Improvements in knowledge at a region wide level will make a major contribution to formulating necessary guidelines for developing financing strategies and changing resource allocation patterns. The general set of issues which arise can be appropriately addressed through a regional level research agenda, and technical assistance pool.

A panel of experts identified in 2/84 several interrelated areas which require attention in order to improve health financing systems and address resource allocation problems in the region. LAC health officers at the recent regional meeting concerned with these issues strongly endorsed the need to develop a technical assistance pool to assist Missions and countries to identify

financing issues, design research activities, promote new ideas, particularly with regard to private sector alternatives, and identify strategies and issues for policy dialogue concerning the financial viability of public sector health delivery systems.

The key financing issues to be explored through technical assistance and research include:

i. Costs

In order to arrive at sensible new financing policies which will curb costs and improve resource allocation, governments need to know a good deal more about the costs of services. Relatively little effort has been focused on identifying unit costs of services. Governments do not know what services cost and consequently are unable to establish what they should cost. As a result, Ministries of Health cannot reach general conclusions on the appropriate allocation and distribution of expenditures within the health sector.

A more critical understanding of what drives costs is essential to improved health planning and management. Analytical attention should be focused on the distribution of expenditures between preventive and curative services, between personnel and other operating costs, and between hospital and primary health care services. Unit costs of services need to be determined and related to health outcomes. How costs change over time given structural changes in the age distribution of the population as well as changes in the underlying patterns of disease need to be understood.

ii. Uncertain Budgetary Support

At a time when health costs are escalating and ambitious health goals have been established, health budgets have achieved no growth in real terms or have actually declined. Adverse economic conditions and escalating health costs make it difficult for governments to maintain and/or expand the quantity and quality of health services that are necessary to maintain and improve health status. Concerns over the sensitivity of governmental budgetary support for health programs have recently gained considerable attention, and economic fluctuations which lead to uncertainty regarding resource availability are recognized as major problems. Economic stabilization policies, mandated and implemented to cope with poor economic performance and burgeoning debt, have tended to restrict government financial allocations to Ministries of Health. The erosion of health improvements which may result from declining health budgets and deteriorating international and national economic environments is of great concern. Social sectors tend to suffer the highest cuts in times of economic recession such as the region has experienced since 1980, but it remains unclear how the health sector is affected and whether the current situation might even be helpful in fostering new sector strategies. The impact of necessary cuts in health spending may also increase the sector's inefficiency in providing services. The question is how health sector spending can be made counter-cyclical so as to avoid disproportionate damage in both bad times and good.

The impact on imported factor supplies, such as medical equipment and drugs, under foreign exchange restrictions must be understood to keep from seriously interrupting essential supplies and appropriate modifications in trade and payment polices should be identified.

Private sector initiatives in developing new payment and health care delivery mechanisms, such as HMOs, also are seriously affected by foreign exchange restrictions, domestic inflation, and reductions in participants' incomes, and household income elasticities of demand for health care are unknown.

The uncertainty of budgetary support for health given a climate of poor economic performance and burgeoning national debt pressures governments to examine alternative financing mechanisms to achieve the health goals that they have established and avoid erosion of past health improvements. A research effort which will identify and assess alternative mechanisms for governments to maintain and expand health services in times of severe economic constraints is needed. The proposed research effort will assess the potential that user charges and expanded roles for private and/or semi-public providers (i.e. social security or publicly owned commercial health plans) can contribute to maintaining or expanding the quantity and quality of health services.

(1) User Charges

The main arguments advanced in support of user charges are that they promote efficiency in resource use and they generate needed revenue. However, there is little systematic analysis of user charges which supports these arguments. Research oriented to determining the circumstances and situations where user charges would be advantageous is required.

The revenue generating potential of user charges is considered to be more limited in health than in other sectors. Governments which presently utilize user charges recover less than 10 percent of the costs of public health services. The recovery rates which realistically can be expected and the costs of collection which must be anticipated are questions that require analytical attention.

User charges are believed to promote efficiency because they curb "excessive" consumption, but evidence on this issue is fragmentary. Issues related to what services should have charges and what the level of charges should be needs investigation. Whether user charges lead to too little consumption from society's perspective is unknown. Equally unknown are: whether providers ould prescribe the same types and amounts of services and whether patients would ultimately consume the prescribed amounts regardless of fee policies; and whether the services which would be prescribed by health professionals are consistent with efficiency objectives. Compared to other alternatives, user charges may be clearly regressive, i.e., they require the poor to pay a larger share of their income then the wealthy for health care and they shift the burden of payment to those who are ill. Empirical analysis of these points is needed.

(2) Expanded Roles for Private and/or Semi-public Providers

The revenue-generating potential of alternative financing/delivery mechanisms is believed to be substantial. Risk-sharing devices such as social insurance, prepayment health plans, employer-based or cooperative-based health plans, and community financing are receiving increasing interest as potential vehicles for expanding health care and improving efficiency in the health sector. However, there is little understanding of how these mechanisms work. Research attention oriented to identifying inherent advantages/disadvantages of these mechanisms, the critical elements for success or failure, and their implications for equity and efficiency is necessary. More research on how vulnerable groups fare in mixed public/semi-public/private systems would be useful.

iii. Demand Analysis

Research efforts on the economics of health care have tended to concentrate disproportionately on the problems of supplying services in resource poor economies. The factors which influence demand for and utilization of health services remain relatively unexplored. The absence of reliable information on what people are willing and able to pay for health care hinders health planning.

Studies are required which draw on household survey data to investigate ability and willingness to pay for services, to identify the significant factors influencing demand and utilization of health services, and to estimate income-class-specific income and price elasticities for health services.

iv. Supply and Cost of Physician Services

Labor costs represent 60-70 percent of total costs in the health sector of most countries in the region. At the level of primary health care services, labor costs may be as high as 80-90 percent. The health sector's labor supply is generally thought to be seriously imbalanced because there is a disproportionately large supply of medical doctors in comparison to nurses and other technical specialties. The impact on health care costs of the number of physicians produced and the ratio of physicians to other providers in the system is virtually unknown. These observations and hypotheses regarding the supply and demand for physician services require serious examination as the bases for policy dialogue with regard to medical education and employment practices of public sector health delivery systems.

4. Management Training

a. Current Status

In the past ten years, there has been a substantial increase in health administration/management training capacity in Latin America and the Caribbean. Previously, all substantial efforts were based in officially recognized schools of public health. There were also several programs sponsored by either national, regional, city or Catholic hospital associations. During the last ten years, these resources have been expanded

by the growth of programs based in a variety of other academic and non-academic institutions, and with considerably enhanced prospects for effectiveness.

The public health school based programs were modeled after the predominant pattern of programs in U.S. public health schools in the 1950's. The programs' structure and content reflected the fact that most of the schools are dependencies of Ministries of Health and/or medical schools. The schools are self contained, seldom drawing upon resources of other schools and health institutions. Management training in these programs consists of tracks in health administration and in hospital administration. The hospital based programs are generally short term and part time. Faculty consists of practicing administrators, most of whom lack formal administration or management training. The courses are highly descriptive and may focus on the procedures of a single system (personnel, financial management, purchasing, etc.). Both public health school and hospital based models began by serving only physicians, but are now open to individuals with other backgrounds.

Beginning in the early 70's, new models began to emerge under nontraditional auspices. Programs developed in management schools(Mexico, Brazil), departments of systems engineering (Colombia), departments of community medicine (Colombia, Peru), and even schools of architecture. These programs generally follow an interdisciplinary approach and serve a varied student body. These interdisciplinary programs have had precarious funding, in some cases, because they are outside of the official structure. The newer models are apparently competitive with the older models, and there are indications that in some countries public health school health administration training programs are changing as a result. These new programs evolved with considerable support from the W. K. Kellog Foundation, PAHO and the Association of University Programs in Administration (AUPHA).

b. Constraints to Improving Management Training and the Impact of Management Training on Management Systems

In a recent survey (11/83) of LAC Health officers, representatives of donor agencies and LAC management training institutions, the following major problems with present management training in the health sector were identified:

i. The design of existing programs has been unsystematic; that is, undertaken without parallel assessment of organizational and individual requirements and without attention to both the supply and demand sides of the labor force equation.

ii. The focus of existing programs has been narrow and lacks integration; that is, the content of most programs has been limited to public administration, or to business management, or to health delivery (public or private) but rarely expanded to link any or all of these, conceptually or operationally.

iii. Numbers of trainees have often been too small to generate critical masses for change, primarily because of inadequate scholarship opportunities and lack of training programs that address the key operational issues and institutional audiences.

iv. Training program target populations have mostly been from senior managerial levels. While this has been a crucial first step in creating constituencies for health management training, it has meant that mid-level administrative and functional categories have been left largely unattended. The corollary of this has been lack of attention to those substantive issues identified over and over as major management constraints: financial analysis and management, logistics, pharmaceuticals and equipment, transport and maintenance, supervision, manpower planning, facilities management, and the design, implementation and evaluation of special, vertical programs.

v. The weakness of management systems in the health ministries themselves has inhibited those ministries from adequately identifying and articulating their needs, to themselves, to cooperating international donor agencies, and to relevant national interest groups.

According to LAC health officers, it is these management training issues which constrain improved health services management, rather than issues of post training incentives, brain drain, and so forth.

5. Clinical Training

a. Current Status

Deficiencies in medical education are at the root of a number of problems in health services delivery in LAC countries. Medical curricula in LAC countries do not, in many cases, include--either as core content or electives--principles of public health and community medicine, new, cost-effective screening and diagnostic techniques, new information on the safety and efficacy of pharmaceuticals, new forms of health services organization, etc. Those LAC physicians who are trained in the U.S. often attempt to transfer costly technologies (i.e. CAT scanners) to their home countries which may not be relevant to country needs and/or sustainable with country resources. While U.S. based undergraduate, graduate and post graduate medical training is still highly desirable, it is becoming increasingly difficult for non-U.S. citizens to have access to these programs, particularly at the post graduate level. Language requirements have become more difficult. The credibility of non-U.S. undergraduate medical education has recently come into question, particularly for LAC students, due to the proliferation of "off shore" medical schools in LAC countries. U.S.

residencies and internships are diminishing in number and are more comptetitive due to increased numbers of students from the U.S. and elsewhere.

Deficiencies in medical education have been addressed in part through short term, in country training funded under bilateral projects. Post graduate medical education is also being supported under the LAC Training Initiatives Project. Training requests for medical education are numerous at Missions, and often--perhaps more often than in other sectors--politically motivated.

II. Project Rationale and LAC Bureau Strategy

A. AID Health Policy and Strategy

Agency health policy and strategy dictate that AID resources will be utilized to support health services which address the major causes of mortality and morbidity primarily in infants and children. In addition, resources may be provided to assist programs designed to control the principal communicable diseases which affect the productivity of the adult population. According to the global policy and strategy, the services provided to address both objectives should be cost effective, and to the extent possible "self financing".

Taking into account emerging disease patterns in LAC countries, Agency policy and strategy, past experience with AID-financed health projects and current economic trends, an LAC health strategy was prepared in 1982 to delineate priority countries for AID health programming, to identify appropriate bilateral and regional initiatives, and to establish trends and targets for investments by AID in the health sectors of LAC countries. The LAC strategy targets countries with infant mortality rates of more than 50/1000 as candidates for improved/expanded primary health care initiatives. In addition, malaria is highlighted as perhaps the major technological problem to be addressed, in part, through a regional initiative. Management improvement of health delivery systems and assessment of alternative financing schemes for health services are recommended interventions for countries where benefits from past investments (donor and host country financed) in the health sector are at risk of being lost and the quality of services is declining due to a lack of resources resulting from low levels of economic growth, economic austerity programs, etc.

Two additional Agency programs are being implemented by the LAC Bureau which have had and will continue to influence resource allocation to and within the health account: the Central America Initiative and the Advanced Developing Country Program. As a response to the recommendations of the National Bipartisan Commission on Central America (NBCCA), health resources for Central America doubled in 1984-1985. The Central America sub-regional components of this project are directly responsive to the recommendations of the NBCCA. New ROCAP initiatives in oral rehydration and supplementary feeding constitute part of this initiative, as well. Increased levels of resources for health projects have also been made available to Guatemala, Belize, Honduras and El Salvador.

Health has also been highlighted as a key sector for the Advanced Developing Country programs being designed for Mexico and Brazil. Support has been requested by both of these countries in the areas of oral rehydration, nutrition and biomedical and operations research. These requests have been met to date on a limited basis with resources from S & T Bureau funded projects.

B. Trends in LAC Health Programming

In the mid-to-late 1970's, AID involvement in the health sector increased, in general, as a result of the "Basic Human Needs Strategy" of the Foreign Assistance Act, the International Conference on Primary Health Care at Alma-Ata which committed governments to "Health for All by the Year 2000", and the prevailing wisdom that providing simple, community-based preventive and curative health services could significantly reduce mortality and morbidity, remove the health constraints to economic development, and improve the quality of life of large segments of the population of the developing world.

In LAC, this heightened interest in the health sector was translated into a large number of sector loans whose major impact was to develop the infrastructure (human resources, physical plant) to deliver rural, primary health care services. By 1980, it became evident that such primary health care extension programs suffered from a lack of management support systems at the central level (transport, logistics, maintenance, supervision, etc.) necessary to sustain these services. This insight stimulated the current generation of health management improvement projects which have successfully demonstrated that certain systems and functions can be substantially improved--particularly planning and training.

As gains in the extension of services and improved management of these services were being achieved, the financial underpinning of health services in the public sector began to crumble. Declining economic growth, growing external debt, and economic stabilization policies have placed enormous pressure on public sector budgets, so that Ministries of Health in LAC countries have experienced, in the last three years, no or negative program growth, despite inflationary health care costs, which in some cases, greatly exceed general inflation rates. LAC countries (and AID Missions) are now faced with the need to sustain past and current levels of effort in the health sector with a declining resource base, inappropriately allocated and inefficiently managed. Due to the pressure on the public sector health delivery system, LAC governments are increasingly looking toward alternatively financed health services which generally include risk and cost sharing mechanisms--health maintenance organizations (HMOs), cooperatives, private provider groups, etc. to relieve the public sector of its medical care burden. In addition, most LAC governments have instituted user fees for health services both to generate revenue and to rationalize utilization where it is excessive. AID has stimulated much of this interest through policy dialogue, economic analyses of health projects, and operations research.

AID resources for health projects in LAC countries have been steadily increasing--approximately 30% per year since 1981 (see Annex B). The Central America Initiative, including resources for this project, accounts for the

increase from 1984-1985. The LAC health account has also increased as a per centage of LAC development assistance from 8% in 1981 to 13% in 1985. As of 1984, the LAC health account constituted approximately 40% of the Agency's health budget, the largest of any of the regional bureaus. This increase in resources reflects not only the political priority of Latin America and the Caribbean (particularly Central America) in general, but also: (a) the financial crisis of the health sector in LAC countries, (b) the AID Administrator's promotion of key health technologies, (c) the resurgence of malaria and the need to reinvest in malaria control programs, and (d) the recognition of the need for regional programs to complement bilateral projects (particularly those in new areas) and to create mechanisms to assist countries which are no longer recipients of bilateral support in the health sector.

Three new areas for AID/LAC involvement in the health sector have emerged and will dominate LAC health programming for the next 5 years--malaria control, essential drugs, and alternative financing and organization of health delivery systems. In 1981, AID financed malaria control activities in two LAC countries, Haiti and Honduras. In 1984, AID-financed malaria control activities were undertaken in eight countries under projects and/or with local currencies (D.R., Haiti, El Salvador, Honduras, Belize, Ecuador, Peru and Bolivia). Pharmaceuticals are financed in virtually all health projects but constitute key components in the most financially troubled health sectors--Costa Rica, El Salvador, and Haiti. Essential drugs were also provided in all of the projects in 1983 and 1984 designed in response to disasters. Operations research and financing studies covering recurrent costs, resource allocation, user fees, cost containment and private sector alternatives have been undertaken in more than 10 countries. (See Annex C). These issues were virtually unexplored as of the Health Officers Conference in April 1982.

C. Rationale and Responsiveness of Project to LAC Bureau Strategy

The components of this project are intended to meet the common technical assistance, training and operations research needs in the health sector for LAC Missions, to support the new directions in health programming, particularly malaria, essential drugs, and alternative financing, and to provide a mechanism to support health activites and to respond to health requests from countries and Missions which no longer receive bilateral support in the health sector.

For each of the three new program areas (malaria, essential drugs, and alternative financing) deficiencies in the availability of technical support (technical assistance and technical information), and training opportunities have been identified by LAC Missions, PAHO and host countries as key constraints to both project design and program implementation. Operations research is a missing link in malaria programs and drug logistics components of health delivery systems. This research is needed to identify and resolve key operational problems, to test alternative technologies and approaches for cost effectiveness, and to provide feedback regarding the impact of certain key interventions. Operations research protocols should be developed to meet these common research objectives. In the area of alternative financing, key strategies will be those adopted from U.S. and LAC Advanced Developing Country

models, particularly, Brazil, Uruguay, Chile and Colombia. A technical support capability from the U.S. needs to be developed, and the opportunities for technical cooperation among LAC countries need to be expanded. Management training and clinical training in the health sector are now important elements of LAC regional and bilateral training programs and projects, i.e. LAC Training Initiatives. Resources are needed to improve the targeting of these resources to appropriate individuals in the countries and the matching of candidates with appropriate training programs in the U.S. and other LAC countries. Increased access to technical materials and expanded information exchange are also needed--particularly with regard to management training.

1. Rationale for Regional Approach

These common needs and new directions require consideration of a regional approach to problem identification and problem solving. Institutions within the region need to be tapped for their expertise, particularly those in Advanced Developing Countries. New expertise needs to be developed in certain areas (malaria, private sector). A regional project to meet common needs, promote new directions, develop new expertise and promote technical cooperation among LAC countries is a cost-effective and efficient means of achieving these objectives. In the absence of a regional project, these objectives will not be met by a series of bilateral projects.

2. LAC Malaria Control Strategy

The most recent LAC policy statement specifically covering malaria projects was issued in December 1979. Two criteria for supporting malaria control activities established in this policy served to reduce interest of LAC Missions in developing malaria control projects:

> "Malaria programs must be considered in the context of rural health delivery goals....AID assistance will normally be provided only as a component of multidonor operation. Such donors may include private, public, or international organizations. AID assistance in Latin America and the Caribbean should be as a donor of last resort when technical assistance, commodities and other forms of assistance are unavailable from multilateral or other sources."

This policy statement was based on the LAC Bureau's experience with malaria programs: their high recurrent costs, the long time frame for control programs, problems with PAHO and host countries regarding control versus eradication policies and related factors.

From 1979 to 1982 support for malaria control activities was limited to Haiti and Honduras. Due to the severe resurgence of malaria and the dual problems of insecticide and parasite resistance, the new LAC health strategy promotes increased support, both bilateral and regional for vector borne disease control. The LAC strategy foresees a 10% increase in the proportion of LAC health funds used for vector borne disease control activities in the next five years - from 5 to 15% of the LAC health account. Consistent with the severity of the problem and the "softening" of LAC policy/strategy, five missions have

requested and received technical assistance for malaria control in 1982-84: Ecuador, Peru, the Dominican Republic, El Salvador and Colombia. This is in addition to the two on-going, bilateral malaria projects in Haiti and Honduras.

Eight countries currently support malaria control activities under AID financed projects and/or with local currencies generated from P.L.480 Titles I and III. (Dominican Republic, Haiti, El Salvador, Belize, Honduras, Bolivia, Ecuador, and Peru).

The geometric increase in malaria incidence, the problems of vector and parasite resistance, and the number of mission requests for technical assistance have heightened the need - region wide - to redesign malaria activities which are tailored to the epidemiologic profiles of each country, and which are pursued, within cost parameters, to reduce malaria incidence. Existing country programs have focused on malaria eradication. Conversion from eradication to control does not represent a mere redeployment of existing tools and staff. Experience elsewhere has shown the need for training and technical assistance in the selection and implementation of appropriate control methods, for the support of applied field research to determine the most cost effective control methods, and for improved management of malaria programs.

3. LAC Health/Essential Drug Strategy

Recently, the provision of essential drugs has become a major component of bilateral programs, particularly in Central America, due to restrictions on the availability of foreign exchange and the resulting "emergency" shortages of basic, essential drugs. (Essential drugs are defined as those drugs necessary for the treatment of prevalent diseases affecting the population). To complement bilateral programs, a regional approach was mentioned as part of the LAC Health Strategy. The regional program will provide the technical assistance needed by all countries in Central America and Panama; the development of training programs, and the strengthening of indigenous institutions, particularly those with a potential for regional coverage, to perform these functions. Such institutions include ICAP (Instituto Centroamericano de Administracion Publica) in Costa Rica for supplies management training, and LUCAM in Guatemala for drug quality control.

4. LAC Strategy for Health Financing and Resource Allocation Problems

The LAC Health Strategy highlighted the need for a regional initiative to assist Missions and LAC countries in the following areas:

- Procurement and distribution of essential drugs through public and private channels;
- Private sector model health delivery systems inlcuding risk sharing schemes (HMOs, social insurance, cooperatives);
- Revenue generating activities for public sector health delivery systems;
- Hospital cost containment strategies.

As an initial step in implementing this strategy, an IPA health economist was recruited to assist Missions in the conceptualization, design and

implementaion of financing studies, including household expenditure surveys, community financing feasibility studies, private sector provider studies, etc. These activities are listed in Annex C.

In the development and implementation of these thirty plus studies, it became evident that Missions would benefit from the elaboration of standard methodologies for certain types of studies, to be adapted to individual country contexts. The LAC health officers at their recent meeting confirmed their need for "how to" information, particularly for financing studies and project design. Health officers strongly recommended the establishment of a regional technical assistance mechanism which could be jointly supported by regional and Mission funds to assist in the design and implementation of financing studies, to promote the new financing and organizational concepts at sub-regional and country meetings, and to design projects.

5. LAC Strategy for Health Management Training

Achieving the objective of improved and expanded management training in support of health delivery systems in LAC countries requires both regional and bilateral support. Virtually all bilateral health projects, as well as regional LAC training projects, have included management training in the health sector. Economies of scale, consistency, and improved quality control may be achieved if key LAC institutions can be strengthened to provide the necessary training, particularly for mid-management.

The objectives of regional support for health management training are to:

- establish a network for communication and exchange among Latin American , Caribbean, and U.S. health services management training centers,

- strengthen the centers' capabilities through faculty development, development of teaching materials, and information dissemination,

- support expansion of the centers' roles in national training initiatives,

- provide access to U.S. training centers and a locus for cooperative facilities,

- assist USAIDs in matching health management training needs with appropriate LAC and US universities and non-academic training programs, and to draw upon appropriate technical assistance sources.

6. LAC Health Strategy for Clinical Training

In order to meet the existing need to improve LAC medical education, to focus on skills-development in U.S. based medical training, to provide Missions an alternative to expensive, long term academic medical participant training, and to respond to Mission requests for short term technical assistance for continuing medical education trainers, LAC strategy calls for utilization of regional funds to provide a mechanism to access the over 30,000 Spanish speaking physicians who teach and or practice medicine in the U.S.

D. Other Donor Activities

Other than in Brazil and Colombia, AID is the principal donor in the health sector in most LAC countries. PAHO is represented in all of its member countries, and provides technical assistance in a wide variety of areas and finances short and long term training. The InterAmerican Development Bank (IDB) has been involved with the financing of hospital construction for many years. Recently the Government of Japan has become active in the health sector in several LAC countries through the provision of pesticide for malaria control and hospital equipment.

The activities proposed in this project complement on-going donor activities and will serve to increase donor coordination in the countries. The malaria and essential drugs components are entirely consistent with requests of the Central American countries elaborated in a sub regional health sector program called the "Puente De Paz" program. This program, which includes over 200 projects in health elaborated by all of the Central American countries, has been approved by the Contadora Group and has been approved by the PAHO Directing Council. The U.S. Government, as a member of PAHO, has endorsed this project. PAHO has received the approval of the Central American countries to present the Puente de Paz program to European donors and to the Japanese. This process began in November of 1984.

In FY 1985, PAHO itself anticipates, and has budgeted $1.2 million in Central America for malaria control and essential drugs out of PAHO core funds . This is in addition to a 25% in-kind contribution of salaries, benefits, equipment and supplies made for this project. The IDB is considering financing feasibility studies ($600,000.) for a Central American regional health investment program ($30 million for five years) which includes a revolving fund for pharmaceuticals and pesticides. OPEC, and the Governments of France and Holland have also indicated willingness in supporting disease control and essential drugs programs in Central America. These activities will be coordinated by PAHO.

The malaria and essential drugs components of this project are entirely consistent with the sub-regional malaria control projects (# RE-TD-03,04,and 05, and RE-ED-01,02,and 03) in the Puente de Paz plan. Moreover, the operational research component of the malaria control program, which will cover appropriate utilization of pesticides, is consistent with recent Government of Japan recommendations regarding its future participation in the provision of pesticides. The essential drugs component of the project is consistent with projects proposed under the Puente de Paz plan and also the Regional Essential Drugs Program for the Western Hemisphere, which is a joint WHO/PAHO initiative.

The proposed financing studies and technical assistance will assist Missions to have the necessary information to assist host countries determine the long term impacts of investment decisions in the health sector e.g. investments in hospital construction, including impacts on counterpart availability for AID health projects. AID in Peru is already working closely with the World Bank on such issues, in a series of national surveys and studies, and the World

Bank will participate on the advisory committee for this project activity. The availability of such information has influenced the design of a proposed amendment to an IDB hospital construction loan in Honduras. A regional effort in health financing will establish common approaches and methodologies, thereby reducing lead time to implement such studies (and their costs), will foster inter-country technical cooperation, and will stimulate the development of a new pool of financing technical assistance focusing on private sector alternatives.

The proposed management training component evolved from a PAHO/Kellogg Foundation/AUPHA program. The clinical training portion of the project is consistent with PAHO clinical training programs but focuses on U.S. based training which PAHO does not.

The activities proposed in this project are also consistent with certain centrally funded projects. S & T Health funds a malaria vaccine development project. Operations research regarding the testing of this vaccine and other technological byproducts of this project, including a new screening technique for malaria, may be included in the LAC regional project. To date, S & T has not developed a vector control project, but may be in the process of doing so. The S & T project will not have as its objective and output, however, long term support for the development of regional institutions to carry out vector control activities. All effort will be made to assure that any S & T project can be utilized to enhance and expand the impact of the Central America regional project and to provide assistance to LAC countries outside of Central America and Panama. There are also two S & T financed operations research projects one in health and one in population. Neither of these projects focus on operations research in the areas proposed in this project -- malaria, essential drugs and financing. There are no centrally financed projects which support activities in essential drugs or clinical training. Centrally financed health management training is provided only to the University of the West Indies.

III. Project Description

A. Project Goal and Purpose

The goal of this project is to improve health status in LAC countries, particularly Central America and Panama. The project purpose is to adapt and extend existing technologies and strategies which address major organizational and financial problems in delivering health services. Project inputs--technical assistance, training and operations research--will respond to common Mission needs in the areas of malaria control, essential drugs, alternative financing of health services and management and clinical training. Two project components - malaria and essential drugs - will focus on Central America and Panama. The two remaining components - health services financing and training - will be region-wide, including countries which do not have active, bilateral AID-financed health projects, e.g. Advanced Developing Countries. Missions outside of Central America will be able to participate in the Malaria Control and Essential Drugs components of this project as indicated below. Such participation for Advanced Developing Countries may be supported by the LAC regional Inter-Country Technology Transfer project.

B. Project Components--Central America

1. Malaria Control

Regional activities funded under this project will focus on Central America due to: (a) the relative severity of the problem in this sub-region, (b) the potential of the economic and political crises in this sub-region to greatly exacerbate the malaria problem, reintroducing malaria into areas where it had been eradicated, (c) the presence of institutions to provide the necessary technical support services for malaria programs, and (d) the recommendations of the NBCAA to improve/expand malaria control programs in the sub-region.

Other LAC countries may participate in these activities, particularly training, but all regionally-financed technical assistance and operations research will be undertaken in Central America.

The Central America regional malaria program will have as its goals to: (a) eliminate mortality and reduce morbidity caused by malaria, (b) reduce transmission in epidemic areas, especially those populated by refugees and displaced persons, and (c) prevent malaria from spreading to areas where its transmission has been successfully interrupted. AID-financed inputs will be used to assist malaria control organizations to improve their epidemiological surveillance and management capabilities, to develop, implement and evaluate more cost-effective control measures, to improve intercountry cooperation and information exchange, and to strengthen training and applied research capabilities.

Specifically, AID/LAC will fund a collaborative AID-PAHO program to provide technical assistance to Central American countries to design and implement malaria control programs. Regional short term training courses will be designed to meet needs of country programs in epidemiology, entomology, management of malaria control programs, pesticide handling and safety, applied research methodology. (Missions will contribute to the travel and per diem of participants). An institution(s) will be selected to become the regional base for such training, technical assistance and research. The institution will meet criteria of accessibiliity, institutional capability and interest, laboratory facilities, etc. In addition, PAHO is placing a core staff of malaria advisors in Panama who will have regional responsibilities. Funds from this project will also be used to develop an AID-PAHO task force on malaria to: prepare terms of reference for assessing country technical assistance requirements, establish the organizational mandate and structure of the proposed training and research center, review research protocols, advise Center on training needs, etc. The task force would be authorized to retain consultants as needed including representatives from other donor agencies (Government of Japan, World Bank, Inter-American Development Bank).

Illustrative Budget -- Central America Malaria Control
(000)

Activity	Year 1	Year 2	Year 3	Year 4	TOTAL
Applied Field Research	-	450	400	200	1050
Research and Training Center	500	400	250	150	1300
Short Term Training	100	200	100	100	500
Short Term TA	150	100	100	100	450
Task Force	50	50	50	50	200
TOTAL	800	1200	900	600	3500

Malaria control activities funded under this project component will be implemented through an agreement with PAHO. Certain management responsibilities, curriculum design functions and short term technical assistance will be sub-obligated by PAHO in contracts and/or grants to U.S. Universities, particularly for training (institutions with appropriate capabilities include Tulane University and the University of South Carolina), U.S. consulting firms and the Centers for Disease Control (CDC). A project manager and short term management technical assistance will be recruited by PAHO. CDC will be involved in providing technical assistance and short term training, particularly for pesticide safety and handling, determination of pesticide effectiveness, drug resistance studies, and epidemiological surveillance. Missions and host countries will support the in country training costs of participants.

PAHO will be the major source of technical assistance for country program design and evaluation; PAHO will assist in curriculum design, particularly for in-country training activities; and, PAHO will design and implement regional technical meetings, and organize the AID/PAHO task force. PAHO was selected as the principal actor for this component due to its technical credibility with Central American governments, its ability to draw technical experts from all countries in the hemisphere, and its own prior commitment to the objectives and activities of this component of the project.

2. Essential Drugs

In order to affect short term and medium term improvements in the supply of essential drugs in Central America and Panama, through this project LAC will fund in-country technical assistance activities for, among others, the following tasks:

* Analysis of existing essential drug formularies
* Development of criteria and procedures for the selection of drugs for the formulary
* Establishment of "level of use" standards for each drug
* Development of unbiased drug information for the essential drug formulary
* Design of methodology to calculate actual drug consumption statistics
* Development of procurement criteria and detailed product specifications
* Development of drug supplier performance incentives
* Development of an order tracking system
* Identification of reasonable procurement scheduling
* Design of manual or computerized inventory management system
* Design of system for locating and transfering critical supplies
* Development of minimum quantity standards for reordering drugs
* Development of sampling procedures for quality control to be carried out at the central warehouse down to the primary health care level
* Identification of the list of drugs that require strict quality control
* Coordination of resources for quality control among all health institutions to minimize duplication
* Organization of warehouses
* Design of a product tracking system
* Improvement of accuracy and efficiency of filling orders
* Establishment of efficient delivery routes and scheduling
* Improvement of security of drugs during transport
* Development of dispensing procedures and standards for packaging
* Development of system for collecting patient specific information on drugs and morbidities
* Develop patient drug monitoring program and prescriber notification/education program
* Design a pharmacist drug counseling program
* Design patient drug information posters and brochures.

Country technical assistance plans will be developed by Central America Missions, PAHO, local Ministries of Health and Social Security Institutes. The regional project will support approximately 40 months of technical assistance for Central American Missions, including Panama.

Regional training programs will be developed and implemented, to the extent possible, at Central American institutions. Training will be provided in: (1) drug selection, (2) drug procurement, (3) inventory control, (4) quality control, (5) warehousing, (6) distribution and dispensing, and (7) utilization. These courses will be provided on a space available basis to candidates from countries outside of Central America and Panama, to be supported by Mission, countries, etc. outside of the sub-region. The target group of trainees will be technicians and managers (generally mid-to low

level) with direct line responsibilites for the topics presented in the courses. An illustrative list of courses is presented below.

Essential Drugs Training Program for Central America and Panama

SELECTION	2 weeks
PROCUREMENT	
Projecting Requirements	1 week
Procurement Process	1 week
Order Tracking	1 week
Negotiations with Suppliers	1 week
INVENTORY CONTROL/WAREHOUSING	
Management of Central Facility	2 weeks
Management of Local Facilities	2 weeks
Design of Utilization-Driven System	2 weeks
QUALITY CONTROL	
Laboratory Planning	1 week
Testing Basic Drugs	2 weeks
Advanced Principles for Drug Assaying	2 weeks
DISTRIBUTION	
Developing Delivery Schedules	1 week
Pharmaceutical Security	1 week
Dispensing Principles	1 week
USE	
Drug Use Data Collection	1 week
Drug Monitoring Programs	1 week
Adverse Drug Reporting Programs	1 week
Principles in Drug Epidemiology	1 week

The regional project will also support the establishment of a Central America pharmaceutical vendor/pricing information network which will provide current data on procurements and suppliers within the sub-region and would create a more informed procurement process. Participating procurement offices will provide copies of successfully negotiated vendor contracts to a central coding and data entry facility (possibly PAHO). Quarterly, this information would be added to the network data base, copied and forwarded back to each participating prosurement office. If microcomputers are available in the countries, this would permit the data base to be stored locally and classified on the basis of a number of variables (product name, therapeutic class, vendor, price, return goods policy, dating, etc.) Although pharmaceutical manufacturers and suppliers assume a "what the market will bear" attitude with respect to product availability and pricing, armed with current procurement data from recently awarded contracts within the region, negotiators can secure lower prices and better terms for their pharmaceutical procurements.

To: (a) assist in the development and on-going awareness of the requirements for rational drug use, (b) maintain an adequate consciousness relative to adverse effects of drugs; and, ultimately, to reduce drug induced illness, LAC will provide funding for the purchase of unbiased drug therapy information resources for several sites within each participating country. This support would be in three major categories: reference textbooks, journals and newsletters and, where appropriate, microfiche libraries. Although the reference textbooks provide a useful theoretical foundation, monthly journals, newsletters and microfiche libraries represent current therapeutic knowledge and relevancy to the clinical issues confronting the health practitioner. The need, feasibility and cost of translating such materials into Spanish will be determined prior to dissemination of the materials. If necessary and feasible, resources from this project will be provided for translation of the materials.

LAC will also fund the development of two prototypes which involve skills apart from traditional expertise available in Central America and Panama--a prototype drug quality control laboratory, and a prototype warehouse. These prototypes will establish for health planners and managers the minimum space, equipment, staffing requirements, etc. for facilities at various levels in the health delivery system. These prototypes may then be adapted to individual country settings.

Finally, LAC will support an analysis of drug utilization, where the technology available through microcomputers exists, to link patient specific pharmaceutical use, to morbidity outcomes to drug supply. Existing U.S. drug monitoring software packages will be utilized/adapted for this purpose.

Illustrative Budget--Central America Essential Drugs

	YR1	YR2	YR3	YR4	TOTAL
TA	100	300	200	100	700
Training	230	450	450	200	1330
Reference Materials	15	15	15	15	60
Pricing Network	50	20	20	20	110
Prototypes	250	150	---	---	400
Drug Utilization Software & Studies	100	200	100	---	400
TOTAL	745	1135	785	335	3000

Primary responsibility for implementation of this component will rest with PAHO. Essential drugs activities will be the second component of the agreement to be signed with PAHO for malaria. The activities described above were identified by the Central American countries with the assistance of PAHO, as part of the "Puente de Paz" health assistance package for Central America

which has now been presented to the donor countries of Western Europe, the Contadora Group, and the U.S. In addition, these activities are consistent with the Western Hemisphere Essential Drugs Program developed by PAHO in conjunction with WHO. Certain discrete activities--development of prototypes, development of software, provision of information, etc.--may be sub-obligated to U.S. firms, and appropriate 8a firms. In addition, U.S. institutions, when appropriate, will be utilized when appropriate in the areas of training methodology for supplies management and quality control.

PAHO was selected to implement this project component due to its capability to draw experts from all countries in the hemisphere, its relationships with existing training institutions in the region and its ability and willingness to subobligate project components to organizations with predominant capability/comparative advantage in providing these services.

C. Project Components--LAC Regional

1. Health Services Financing

Through this Project LAC regional funds will be used to support a synthesis of existing health financing studies in Latin America and the Caribeean, and 3 financing studies per year for the first three years, in 3 different countries each year for a total of nine country studies. The studies will fall into the following categories:

(1) Cost studies will assemble and assess health sector cost data and estimate unit costs for public, semi-public and private systems (i.e. cost per unit of input, cost per unit of intermediate output, cost per unit of change in incidence or prevalence, cost per unit of mortality reduction). Estimation procedures for costs at different levels of facilities will also be established. The countries selected for cost studies will be representative of regional diversities as these features may have an important bearing on cost relationships. The countries selected will represent the diversity in the region as to physical size, population size, GNP/per capita, infant mortality rates, organizational structure of the health delivery system.

(2) Demand studies which draw on household survey evidence are needed to shed light on the issues of willingness and ability to pay for health care services. While the optimum approach would rely on collection and analysis of new primary data, new surveys are very expensive undertakings. A more cost-effective approach is to rely on new analysis of existing and available household expenditure data sets. While this approach will not be able to resolve specific issues related to price, more general analytical results from a greater range of country situations will significantly strengthen the base information on demand for health care services. Data sets are known to exist for Ecuador, Honduras, Panama, and four of the Eastern Caribbean LDCs, a new primary data collection effort is currently underway in Peru, and data sets are potentailly available for Colombia, Brazil, and Haiti. These data sets need to be scrutinized and the highest quality data sets accepted for analysis. Most of the analytical work on the new primary data base for Peru will be conducted by the World Bank. When this work is sufficiently underway (mid-1985), analysis of existing data sets can build on the relationships and results identified in this work.

(3) Two types of studies covering alternative financing mechanisms will be including user fees and risk sharing models of health delivery.

A great deal of uncertainty exists regarding household willingness and ability to pay for health care. These issues can be partially addressed within the demand studies. Other uncertainties related to changes in utilization as a consequence of introducing (or increasing) user charges within the public system and the actual potential of user fees to increase revenue and improve efficiency need to be investigated separately. The project will identify countries where user charges are already in place or where policy changes regarding user charges have been adopted. Peru, Honduras, Haiti and Jamaica unofficailly utilize user charges in many MOH facilities. Dominica is considering implementation of an official user fee schedule. Brazil charges user fees in some of its public facilities. The project will analyze these "natural experiments" with respect to the issues identified above.

The project will identify and investigate several variations on the fundamental concept that health services can be funded entirely, or in part, through payments made by or on behalf of the individual into a common pool without respect to individual utilization of services. These variations include prepayment systems such as health maintenance organizations or social insurance mechanisms through employers or cooperatives. Brazil, Chile, and Uruguay make extensive use of health maintenance organizations for financing and delivering health services. Government involvement is through regulation. Ecuador, Peru, Bolivia and Colombia report extensive provision of health care through cooperatives with a wide variety of financing arrangements. In addition, a variety of employer health plans exist throughout the region. Studies financed under this project component will examine on an in-depth case study basis the practical operation of these schemes and their implications for efficiency and equity and contrast the experience of the group of countries. The studies will be selected to reflect both a range of countries and types of schemes.

(4) Other studies will be funded e.g. labor market analyses of physicians, HMO feasibility studies, etc., based on a peer review of outside experts and subject to the availability of funds.

Approximately nine studies will be funded during the life of project. Actual numbers will depend on the level of Mission participation in funding. In addition, approximately 40 person months of technical assistance will be provided during the life of the project to assist Missions with: the design of financing studies, the formulation of appropriate health financing policy dialogue agendas, economic analyses of health projects, and the implementation of financing related components of health projects, e.g., establishing appropriate fees schedules or revenue generating schemes for public sector programs, developing hospital cost containment programs, public/private sector cost sharing schemes, etc. It is not anticipated that general management technical assistance will be funded under this project. Finally resources will be provided for sub-regional meetings (promotional visits) on alternative financing of health delivery systems, with special reference to private sector options. Individuals responsible for innovative, private sector models from

the U.S., Brazil, Uruguay, Colombia and Chile, among others, will discuss the economic, financial and technical rationales for these approaches to both public and private sector audiences.

Illustrative Budget--LAC Regional Health Financing

	YR1	YR2	YR3	YR4	TOTAL
Technical Assistance	180	150	100	100	530
Studies	450	300	300	150	1200
Promotion Visits	120	--	100	50	270
TOTAL	750	450	500	300	2000

A contract for the technical services, including research related technical assistance, will be awarded based on an open competition. LAC/DR/HN is exploring with SER/CM the possibility of authorizing a higher level of services than LAC regional resources can finance, to allow for Mission "buy-ins" (financing technical services above the level which can be supported by Regional funds). There is precedence for this mode of contracting with centrally funded health and education projects. The contractor will also be responsible for forming an expert advisory committee composed of individuals from the private sector, the World Bank and AID whose function will be to provide guidance on research methodology and review specific research proposals. Preference will be given in reviewing responses to the RFP to firms with 8A subobligation plans.

2. Training

The training of health professionals--both clinical and managerial--has become an important element in bilateral programs in the health sector, and in LAC regional training programs. The activities proposed in this component will directly support those activities by assisting USAIDs with selection of appropriate individuals to be trained, and matching them with institutions in the U.S. and in other LAC countries. In addition, translation and dissemination of key training information will be supported.

a. Management Training

Through the Project LAC regional funds will be utilized to develop a network for LAC health management training programs. Such a network would involve strengthening of faculty through short term technical assistance, faculty exchanges, information dissemination, seminars, etc. In addition, resources would be utilized to assist LAC Missions in the identification of appropriate short term and long term management training programs in the U.S. and other LAC countries. Candidates will be supported with Mission funds. Missions will benefit then, not only from the improved targeting of candidates to programs, but also the improvement in the quality of programs available--particularly in LAC countries. A data base will be assembled, including information on the training programs, faculty members, student

characteristics, etc. Once key LAC training institutions are identified, reference materials will be provided to them, in addition to technical assistance. Technical assistance will be solicited from key U.S. health management experts and institutions in the private sector and from U.S. universities.

It is envisaged that the project will fund approximately two person months per year of short term technical assistance to USAIDs and LAC management training institutions. The participating management training programs will not be limited to countries with AID bilateral health projects. Five regional workshops will also be implemented during the life of the project, focusing on the management issues and skills needed for new approaches to the organization and financing of health services, e.g. HMOs, hospital cost containment programs. Should Central America resources become available in 1986 or later, consideration will be given to providing focused support to a management training center in Central America, namely ICAP or INCAE to improve national health management training programs in the public sector, and to develop its own management training capability in the area of private sector oriented health management training.

Illustrative Budget--LAC Regional Management Training

	YR1	YR2	YR3	YR4	Total
Project Staff & Support	125	150	175	140	590
Information Dissemination	25	25	25	25	100
Short Term TA	25	50	25	25	125
Workshops	25	60	50	50	185
TOTAL	200	285	275	240	1,000

The activities funded in this project sub-component will be implemented under a cooperative agreement with the Association of University Programs in Health Administration (AUPHA). This organization currently maintains a network of over 450 universities and institutions, including 22 in LAC countries. The network includes almost 300 U.S. hospitals, HMO's, health centers and other delivery organizations. AUPHA works closely with the American Hospital Association and other national organizations. It has a full-time staff of educators and maintains the only comprehensive data base on U.S. health managment training programs and a comprehensive health management faculty and consultant skills index. AUPHA maintains a resource center of health management training materials, and is a publisher of training materials. AUPHA is supported by its member institutions, foundations, corporate participants (approximately 30) and the USG. AUPHA works closely with the private sector through its private sector members, including CITICORP/CITIBANK, American Hospital Supply, Peat, Marwick and Mitchell, DuPont, etc. AUPHA has also been the primary source of technical assistance for PAHO and the Kellogg Foundation in the implementation of their interdisciplinary management training programs in LAC countries.

b. Clinical Training

Resources provided under this project sub-component will be utilized to provide assistance to Missions with regard to selection and placement of clinical training candidates in short and/or long term academic training programs in the U.S. In addition, technical assistance will be provided by Spanish speaking physicians to participate in short term continuing medical education programs in LAC countries. AID/W has received many such requests in the last two years. Finally, resources will be provided for a limited number of candidates to participate in a short term (1-6 month) "preceptorship" program. That is, candidates will be placed with Spanish speaking physicians in the U.S.--in rural and urban underserved areas to observe and participate, to the extent possible, in the practices of these physicians. In addition, informal structured training programs (seminars, etc.) will be provided by the supervisors for their trainees. No English language requirement is anticipated. This will be a non-degree program. Both clinical and non-clinical skills will be incorporated in the preceptorship program, including, pediatrics, obstetrics and gynecology,family practice, emergency medical services, ophthamology, rehabilitation medicine, hospital administration, and public health. To the extent possible, placement in new/innovative service delivery environments will be emphasized. LAC regional resources will fund approximately 5-10 participants in the preceptorship program per year. Missions will finance additional candidates.

Illustrative Budget--LAC Regional Clinical Training

	YR1	YR2	YR3	YR4	Total
Project Staff & Support	100	110	125	140	475
Project Staff Travel (U.S. & LAC)	85	50	50	50	235
Short Term TA	40	40	40	40	160
Participant Training	125	125	75	75	400
Information Dissemination	25	25	25	25	100
TOTAL	375	350	315	330	1370

The activities funded under this component will be implemented under a cooperative agreement with the Interamerican College of Physicians and Surgeons (ICPS), a non-profit, Hispanic organization comprised of 24,000 Hispanic physicians practicing in the U.S. ICPS is affiliated with the American College of Physicians and Surgeons. Informally, the members of ICPS return frequently to their home countries to teach and practice medicine on a short term basis. In addition, many of the members are involved in training

in the U.S., interns and residents from LAC countries. ICPS currently maintains a skills register of their members and publishes a technical, monthly magazine, Medico Interamericano, the first medical journal published in the U.S. in Spanish. The cooperative agreement will formalize their in-country (LAC) training activities, and focus their effort on high priority areas consistent with AID primary health care objectives; will improve targeting of AID funded medical participant training; and will provide a lower cost, alternative to academic medical training which also removes the English language constraint.

IV. Project Feasibility

A. Technical Analysis

The interventions proposed in this project are based on a synthesis of past and current program and project experience in the health sector in LAC countries. Project components were selected on the basis of technical priority, opportunities for cost effective regional approaches to complement Mission initiatives, and consistency with bureau strategy and special initiatives.

1. Malaria Control

The need for technical assistance, training and operations research to reorient malaria control organizations away from inappropriate, costly, and often times non-effective eradication programs to control programs has often been mentioned in PAHO and AID evaluations of ongoing programs. This need is reinforced in the PAHO annual report, Status of Malaria in the Americas, drawing upon hemisphere-wide experience. Recently, a meeting held in Lima of the Andean country malaria experts reaffirmed the need for technical assistance and, particularly, training. The Central America Ministries of Health have also identified these interventions together with financial inputs, as critical to controling malaria in the subregion and preventing its spread to areas where malaria has been previously eradicated. Localizing these services in one country is the approach which has been followed elsewhere with some degree of success--for example, in Asia, where a malaria training and technical assistance center has been established, in part with AID support, in Kuala Lumpur, Malaysia. Finally, technical direction of the project will be supported by the technical advisory group, made up of AID and PAHO, other USG institutions, and technical experts. This group will establish operational research priorities and protocols, review courses developed under the project, assist in establishing evaluation indicators for the project, and advise AID and PAHO on future directions in malaria control in Central America and Panama.

2. Essential Drugs

This project component evolved as a result of AID's experience with Management Improvement projects, in general, and specifically with "pharmaceuticals" projects most recently designed and implemented in Central America. The proposed project component is also consistent with the Latin American Essential Drugs Program, a worldwide WHO initiative, in this hemisphere

co-designed by PAHO/WHO and implemented by PAHO. Training methodologies and course materials developed under bilateral programs will be used to the maximum extent possible. Existing U.S. technologies for drug quality control and inventory and assessment of drug utilization patterns (computer software) will be adapted to Central America drug logistics/management information systems, some of which are being supported through bilateral projects (Costa Rica, El Salvador, Honduras).

3. Financing

The financing issues to be studied were identified by a group of health economists convened in February 1984, based upon a canvassing of more than 30 financing specialists and health economists in the US and LAC countries, and an extensive literature search. The need for technical assistance, and promotional visits for private sector health initiatives was identified by AID health offices at a regional technical meeting held in November 1984.

Because the proposed studies constitute a new type of operations research for AID, other donor agencies and host countries, the research protocols will be reviewed by a technical advisory committee formed by the Contractor as apart of the project implementation. This advisory committee will be made up of representatives of AID, the World Bank, U.S. universities, private sector health enterprises and LAC individuals/institutions involved in innovative health service delivery programs. Such individuals/institutions exist in Brazil, Uruguay, Colombia and Chile, among others.

4. Training

Management training is included in virtually every bilateral health project in LAC. Health officers were canvassed in 1983 to ascertain the strengths and weaknesses of existing management training approaches. The regional approach proposed in this project evolved as a result of this survey, together with an assessment of the PAHO, Kellogg Foundation management training program, and the existing institutional network established by AUPHA and Kellogg as part of this program. The interventions proposed in this project will serve Mission needs by identifying appropriate training sites for participants and will take the AUPHA/PAHO/Kellogg interdisciplinary management training program one step further by focusing on those management skills needed to design and implement new types of health services organizations (HMO's) and to implement "private sector"-like management principles to public sector programs.

The clinical training component responds to the countless Mission requests received by LAC/DR/HN for experts to participate in continuing medical education programs in-country, and to provide clinical training experiences in the U.S. which would not require English language training and extensive pre-entry testing (FLEX, ECFMG). The proposed "preceptorship" training is the first of its kind and will be closely evaluated as a pilot effort.

B. Economic Analysis

1. Application of Standard Benefit-Cost Criteria to Project

a. Application of Criteria

For most development projects economic evaluation involves the application of standard benefit-cost methods. The costs of the project are calculated and adjusted for distortions in prices ("shadow pricing"). Similarly, the benefits to flow from the project are calculated and shadow priced. Then the streams of adjusted project costs and benefits over time are compared by calculations of the present value of net benefits or the internal rate of return. Ideally, these methods would be applied to the economic analysis of this project. However, such analyses are at least partly inappropriate here for two reasons.

(1) Capacity Building rather than Direct Intervention

This project is aimed at improving the capacity of regional and national institutions by meeting the common technical assistance, training, and operations research needs in the the areas of malaria, essential drugs, health financing, and management training. This project will not undertake or finance any direct interventions or investments in these areas. Therefore, the economic benefits from project activities will be indirect and will accrue only after interventions generated from improved national and institutional capacity to design, implement, and manage programs in these areas. An economic evaluation of the direct benefits of this project would correctly measure the value of all the benefits of all the interventions that this project makes possible. This project's costs would necessarily include the costs of all those interventions as well. However, the timing and scope of the interventions which will be made possible cannot be defined at present, and therefore full costs and benefits cannot be estimated.

(2) Calculating Benefits of Better Health

The theory of benefit-cost analysis is difficult to apply to some important aspects of health-sector interventions. While interventions have well-defined costs, the benefits derive indirectly from averting illness and death. When illnesses are averted, the savings from the eliminated costs of treatment can be quantified, but the value of lives saved, the pure-utility values of reduced morbidity and mortality, and the value of improved performance in school or on the job are very difficult to estimate. Current methods fall short of the ideal from the standpoint of making investment decisions. While a full-blown benefit-cost analysis is not possible, a limited analysis of benefits may be done and nonquantifiable benefits can be identified and described. Policy makers, therefore, can weigh quantitative and qualitative benefits against costs.

b. Impact of Interventions

This project will make possible a package of interventions which will directly reduce mortality, morbidity, and debility. This project will also

make it possible to design interventions or investments which will contain or reduce the cost of operating the public sector health system and increase its output. These impacts will produce quantifiable benefits in the form of avoided days of work loss and averted costs of treatment. The treatment costs include hospitalizations and drug costs.

c. Analyses to be Completed

An approximation of some of the benefits which result from the interventions which this project will make possible can be made by using illustrative calculations. Costs of the interventions cannot be identified. In addition, least-cost calculations are made with regard to the choice of making this project a regional capacity-building effort rather than a set of bilateral efforts.

2. Illustrative Calculations of Benefits

a. Quantifiable Benefits

Malaria and essential drug interventions which this project will make possible can be related directly to impacts. These benefits, in principle, are quantifiable in monetary terms. Measurable benefits from malaria control interventions include averted mortality and morbidity, work loss, and avoided drug therapy costs. Measurable benefits from essential drug interventions include averted deaths, reductions in hospitalizations, and reduced lengths of stay when hospitalization is necessary.

(1) Malaria Control

In 1982, the Central America countries and Panama registered 237,104 confirmed malaria cases which accounted for 34% of all cases registered in the Americas. Based on 1982 Slide Positivity Rates, experts conservatively estimated the actual caseload for malarious regions of the Americas at 5 million. If Central America were to account for 34% of these cases as well, the malaria case burden for these countries would be 1.7 million.

Vector control practices have been demonstrated to be effective in reducing the malaria caseload. SPRs declined by 57% between 1958 and 1961, a period of intensive control and eradication activities. Data from a 1972 PAHO study in Paraguay indicates that worktime lost from malaria was reduced by half after spraying practices were initiated. We infer from these studies that malaria related morbidity can be reduced by at least 50% with effective intervention practices: reductions of 118,550 laboratory cases or 850,000 SPRs.

A more stringent assumption would be that a laboratory confirmed case (rather than an SPR) is a reasonable indicator of malaria morbidity which results in absence from work. Because we have no information on either age or employment status of the 237,104 confirmed malaria cases, we make an assumption that only 30% of these cases are attributable to the working population (i.e. 71,131 cases). We make a further assumption that the average number of days lost from work per case is 5; 10 lost work days were assumed

for Belize but this number is extaordinarily high for the rest of Central America. Using these conservative assumptions, 355,655 annual workdays are lost due to malaria morbidity. This number could be reduced by half witheffective vector control methods thereby providing the economic benefit of the additional marginal product of these work days.

A course of chloroquine therapy is the standard drug treatment for malaria. If we use a conservative estimate of two courses of chloroquine therapy per SPR or per confirmed laboratory case (12 tablets at a cost of $15/1000), the annual drug treatment costs would be between $85,360 and $306,000. If we assume that at least half of the malaria cases would be averted with an appropriate control program, treatment costs will be reduced by $42,700-$153,000.

(2) Essential Drugs

Experts who have studied drug prescribing and utilization practices among US Medicaid and Medicare populations have estimated that 10 to 20% of mortality in these groups is directly attributable to inappropriate and improper drug therapy practices. A conservative estimate for the Central American population would assume that drug-induced mortality is at least that large because: (1) physicians are less well trained in pharmacology; (2) up-to-date literature on recommended drug use is far less accessible to the physician; and, (3) prescription drugs are widely available to the consumer without a physician's prescription. Essential drug interventions as a result of this project could expect to reduce mortality by half.

In the US, 7% of all hospitalizations are drug induced. Studies have demonstrated that 52% of these hospitalizations can be prevented with proper drug therapies; for those who are hospitalized, the average length of stay has been reduced from 7 to 3 days. We assume that drug-induced hospitalizations are at least as large in Central America and could be reduced by half. The average length of hospital stay in Central America is above 10 days. We assume that an appropriate intervention could reduce it by half.

Technical assistance and training aimed at improving operational and allocational efficiencies in drug selection, procurement, inventory and quality control, distribution and use have achieved cost savings of 12% in the Dominica MOH drug system and 30% in Barbados.

b. Nonquantifiable Benefits

The economic benefits which will accrue directly as a result of (1) research efforts which address health financing constraints and resource allocation problems, and (2) management and clinical training efforts, cannot be quantitatively ascertained given present knowledge and techniques. Benefits from health financing research efforts are expected to accrue indirectly. Research efforts will identify techniques, technologies, and policy instruments which, when implemented in the health system, are output increasing/cost saving. Benefits from managerial and clinical training will also accrue indirectly. Improved human resources will be able to implement

techniques and technologies which will improve the operational efficiency and the quality of service of the health system. Reductions in mortality and morbidity will result when the system can: (1) increase its capacity to expand preventive and curative services; and (2) improve its ability to redirect resources into their most cost-effective use.

3. Regional Approach as Least Cost

This project will build the capacity of regional institutions and national governments in Central America to implement effective malaria control and essential drug programs, to undertake operational and allocative efficiencies with better trained managers and clinicians, and to identify and implement policies, new technologies and techniques which will effectively contain costs and increase output of the health care delivery system. It will build this capacity by providing US technical assistance, support for regional institutional personnel, and financial support for training, research, and dissemination of technical information.

Three alternative approaches are considered for the malaria and essential drug components: a PAHO regional, a US institution regional, and a series of bilateral approaches. The same benefits are assumed to result from each of the alternatives, and only US inputs are used. The calculations are presented in Tables 2 and 3.

A bilateral approach is considered unfeasible for the health financing research component. A small number of health financing studies conducted in several countries would provide the technical information which would assist all countries in cost containment/cost saving and productivity improvement efforts. A sufficient number of studies in any one country to achieve the same result would be more costly than a regional effort. A contract mechanism will produce the least cost method for this component.

Similarly, a bilateral effort is not feasible for the training component due to economies of scale. The institutions identified for implementation of the training component represent a least-cost approach. These institutions have an installed network in Latin America for carrying out this effort which other US institutions do not have. If other US institutions were to be used, AID would have to undertake the cost of building this network.

TABLE 1
Summary of Benefits

Malaria Control	
averted deaths	no data
averted morbidity/debility	118,550-850,000 cases/yr
averted days of work loss	177,827 workdays/yr
reduction in treatment costs	
drug costs	$42,700-$153,000
prevention of transmission	no data
Essential Drugs	
averted deaths	5% reduction in total mortality (healthy days of lives saved)
averted morbidity/debility	no data
reduced costs of treatment	3% reduction in total hospitalizations 50% reduction in average length of hospital stay
reduced ineffective consumer expenditures	no data
increased cost savings	12-30% savings in government drug system

C. Beneficiaries

This project is intended to benefit AID Missions primarily, particularly those in Central America, and Ministries of Health, including quasi independent malaria control organizations. Missions will be able to draw upon pools of technical assistance not currently available to them--and Mission management oversight will be negligible. Access to appropriate training programs will be improved and quality control maintained.

Ministries and SNEMs will benefit from the increased training provided and the operations research undertaken to improve cost effectiveness of key health interventions including management training. Ultimately, consumers of health services will benefit from improved access to cost effective health services provided by the public and/or private sectors.

D. Environmental Analysis

The purpose of this project is to develop and extend health technologies and strategies which address major organizational, financial and technical problems in delivering health services. The operations research component for malaria ($1,050,000 LOP) will include the investigation of the cost-effectiveness of various mosquito control interventions, including those which affect the environment--pesticides, larvicides, introduction of new species (e.g. fish) into an ecosystem, etc. This is the only activity of the project with potential for environmental impact. Operations research activities to be undertaken in Honduras, Belize and El Salvador will be

reviewed by the Regional Environmental Officer (in AID/W or ROCAP) to assure its consistence with existing IEE's or Environmental Assessments for malaria control activities in those countries. For such activities in Panama, Costa Rica or Guatemala, PAHO will undertake an IEE (and an assessment if deemed necessary) which will also be reviewed and approved by the Regional Environmental Officer.

All other elements of the project will result in negligible positive or negative environmental consequences and further environmental examination is not warranted.

V. Financial Plan and Budget

Total AID Financing

The total AID/Washington regional financing for this project is $13.1 million, in Health grant funds. In-kind contributions will be provided to fund staff salaries, benefits and other administrative costs by the three implementing institutions, PAHO, AUPHA, and ICPS. Individual budgets from these organizations are presented in Annex D. Further, ten of the thirteen AID missions queried on the Project have responded positively, and in some cases have indicated a desire to "buy-in". The nature and extent of their individual contributions will be determined during the LOP.

The anticipated life of project is four years. A breakdown of expected annual costs is provided in Tables One and Two on the following pages. As Table One shows, the two components receiving the largest amount of AID/W assistance are the Central America and Panama Malaria Control effort at 26.9% of total AID/W funding and the Central America and Panama Essential Drugs activity at 22.9%. Overall, nearly half of the AID/W assistance could be categorized as technical assistance. The remainder of AID/W funding is split between research and training activities.

Costs of Project Inputs

An illustrative budget showing the costs of the three main project activities (technical assistance, training, and research) is presented in Table Three on the following pages.

TABLE ONE
BREAKDOWN OF AID/W FINANCING
(U.S. $000s)

A. Project Components	Year 1	Year 2	Year 3	Year 4	Total	% of Total
1. CAP Malaria Control	800	1,200	900	600	3,500	26.7%
2. CAP Essential Drugs	745	1,135	785	335	3,000	22.9%
3. LAC Regional Health Financing	750	450	500	300	2,000	15.3%
4. LAC Regional Training	600	660	540	570	2,370	18.1%
B. Evaluation	--	150	--	200	350	2.7%
TOTAL	2,895	3,595	2,725	2,005	11,220	85.7%
C. Contingency & Inflation	290	540	545	505	1,880	14.3%
GRAND TOTAL	3,185	4,135	3,270	2,510	13,100	100.0%

TABLE TWO
BREAKDOWN OF AID/W FINANCING BY COMPONENT
(%)

A. Project Components	Year 1	Year 2	Year 3	Year 4
1. CAP Malaria Control	25.1%	29.0%	27.5%	23.9%
2. CAP Essential Drugs	23.4%	27.5%	24.0%	13.3%
3. LAC Regional Health Financing	23.6%	10.9%	15.3%	12.0%
4. LAC Regional Training	18.8%	15.9%	16.5%	22.7%
B. Evaluation	--	3.6%	--	8.0%
C. Contingency & Inflation	9.1%	13.1%	16.7%	20.1%
TOTAL AID/W FINANCING	100.0%	100.0%	100.0%	100.0%

TABLE THREE

BREAKDOWN OF AID/W FINANCING BY TYPE OF ACTIVITY

(U.S. $000s & by % of each Project Component)

Project Component	Technical Assistance $	Technical Assistance % of Component	Research $	Research % Component	Training $	Training % Component	Total $
1. CAP Malaria Control	650	(19%)	1,700	(49%)	1,150	(32%)	3,500 (100%)
2. CAP Essential Drugs	1,670	(56%)	--		1,330	(44%)	3,000 (100%)
3. LAC Regional Health Financing	800	(40%)	1,200	(60%)	--		2,000 (100%)
4. LAC Regional Training	1,970	(83%)	--		400	(17%)	2,370 (100%)
TOTAL	5,090	(47%)	2,900	(27%)	2,880	(26%)	10,870 (100%)

VI. Implementation and Evaluation Plan

A. Project Management

The five subcomponents of this project (malaria, essential drugs, financing, management and clinical training) will be implemented by four organizations--the Pan American Health Organization (PAHO), the Association of University Programs in Health Administration (AUPHA), the Interamerican College of Physicians and Surgeons (ICPS), and a contractor yet to be determined.

PAHO will implement the malaria and essential drugs components under a grant to be awarded by March 31, 1985. The grant agreement will specify that PAHO will assign a project manager, project administrative officer and two part time technical coordinators to implement the project. (See Annex G for scopes of work.) Existing PAHO technical staff--both regional and country level advisors in Central America--will be tapped when appropriate for identification of country priorities, short term technical assistance, design and implementation of training courses, etc. The grant agreement with PAHO will also specify that sub-contracting and subgranting mechanisms will be utilized by PAHO for individuals, firms, universities in the U.S. and other LAC countries to implement elements of the two project sub components for which PAHO is responsible, e.g. for malaria--the Centers for Disease Control, the University of South Carolina, Tulane University; for essential drugs--the Food and Drug Administration, etc. The grant agreement will also specify specific outputs/reports required by PAHO and that project staff must be mutually agreed upon by AID and PAHO.

AUPHA is a not-for-profit professional association of academic training programs in health administration. AUPHA has maintained a large network of such programs including 22 in Latin America. AUPHA has also been involved for a number of years in several AID bilateral and S & T funded health management projects. The health management training component will be implemented by AUPHA under a cooperative agreement where staffing requirments, workplans, etc. will be mutually agreed upon. AUPHA will assign a minimum of 1.5 FTEs to implement this project.

ICPS is a hispanic, not-for-profit professional association of 24,000 Latin American physicians practicing in the United States. It maintains a skills registry of these individuals and publishes a national medical journal in Spanish. The clinical training element of this project will be implemented under a cooperative agreement with ICPS, where staffing and workplans will be mutually agreed upon.

The health financing component will be contracted in an open competition among firms, universities, etc. Preference will be awarded in review of reponses to the RFP to firms with subcontracting plans for minority firms and organizations.

The Chief of LAC/DR/HN will be the overall AID project coordinator for this project and will be directly responsible for management of the PAHO-implemented components. Management responsibility for the training and

financing components will be divided between the two other staff members of LAC/DR/HN--one managing the two training cooperative agreements, one managing the financing contract. The LAC/DR/HN Administrative Assistant will maintain the financial records of the project with assistance from LAC/CONT.

B. Contracting, Audit and Disbursement

The following plan for procuring services and assistance will be subject to approval of the AID Contract Officer. As indicated, the contracting methods under the Project are as follows: (1) Malaria Control and Essential Drugs - Grant to PAHO; (2) Health Services Financing - Contract to a U.S. firm selected through open competition; (3) Management Training - Cooperative Agreement with AUPHA; and (4) Clinical Training - Cooperative Agreement with ICPS. PAHO and AUPHA are well-established organizations, both of which have received AID grants and have otherwise collaborated with AID projects in the past. Each has automated financial accounting systems. PAHO as international organization cannot be audited by AID, however as is already standard procedure, they will be audited by a private accounting firm under the Project. ICPS will be receiving its first AID grant, and will require a pre-award audit. The three grantees will have Federal Reserve Letters of Credit opened in their names at the banks of their choice (see Annex J) and the participating firm will be contracted under a cost reimbursement (cost-plus-fixed-fee) contract.

C. Implementation Schedule

The first year implementation schedule is presented below. As the initial funding for the grant to PAHO is from the 1984 Central America Supplemental Appropriation, it will be signed by March 31, 1985. Detailed implementation schedules for future years are included in Annex E.

IMPLEMENTATION PLAN -- SUMMARY

Year 1 Plan:

ACTIVITY	DATE
Project approved	Feb 1985
Cooperative Agreement signed - PAHO	Mar 1985
First year PAHO workplan - submitted and approved	Jun 1985
PAHO staff recruited/hired	May 1985
Cooperative Agreements with AUPHA, ICPS - signed	May 1985
AUPHA, ICPS workplans - submitted and signed	Jun 1985
RFP issued for financing component	May 1985
Award for financing component	Jul 1985
First year financing workplans - submitted and approved	Sep 1985

C. Evaluation Plan/Reporting Requirements

Each implementing organization will be required to submit a quarterly status report which will include progress to date on output targets established in the workplan, financial management information (obligations, earmarkings, expenditures) and proposed activities for the next quarter. For the malaria and financing components of the project, these reports, as well as other technical reports generated by the project will be reviewed by the technical advisory groups established for these components. The technical advisory groups will also review the annual workplans submitted for these components.

All project components will include a mid term and final evaluation. The mid term evaluation will focus on process indicators and management performance. For the training components--management and clinical--LAC missions will be requested to participate in the assessment of the performance of the grantees on recruitment, selection and placement of candidates and on in-country, in-service training provided by the two grantees (AUPHA and ICPS).

The mid term evaluation for the PAHO-implemented Central America component will include an assessment by USAIDs and host country organizations of performance, and a self evaluation by the AID/PAHO technical advisory group. Baseline information on country programs in malaria and essential drugs exists and need not be collected as part of project implementation.
The mid term evaluation for the financing component will be undertaken by an independent organization, and will focus on process indicators as well. The technical advisory groups will undertake an assessment of the technical quality of the work performed which will include an assessment by participating missions of the contractor's performance.

Final evaluations will focus, on a selective basis, on impact of the technical assistance, training and operations research on the quality of health programs. All such evaluations will include Mission participation and be conducted by independent organizations. Funding for mid term and final evaluations will be contracted separately with LAC Regional health and evaluation resources.

VII. Conditions and Covenants

Conditions to disbursement of funds, and covenants under the Project pertain to the Central America components being implemented by PAHO. These conditions and covenants are as follows:

A. Conditions Precedent

1. Prior to commitment of A.I.D. funds for malaria control and essential drug activities being implemented by PAHO under the Project, the terms of reference for key PAHO staff assigned to the Project and the AID/PAHO task force for malaria must be mutually agreed upon by AID and PAHO.

2. Prior to disbursement of A.I.D. funds to PAHO under the Project, PAHO will submit an annual workplan, including a budget, which will be mutually agreed upon by both agencies. New activities proposed will not be implemented until the workplan has been approved.

B. Covenants

1. PAHO agrees that AID resources provided in the Project will be additive to on-going PAHO-financed technical assistance, training and operations research programs in malaria and essential drugs.

2. PAHO covenants that it will comply with the environmental regulations of AID by assuring proposed operations research in malaria in Honduras, El Salvador and Belize is consistent with existing environmental assessments, and by undertaking, with the collaboration of AID, an environmental assessment in Guatemala, if research is proposed for Guatemala.

3. PAHO agrees that no AID resources will be utilized for technical assistance, training or operations research in or for Nicaragua.

ANNEX A

Table I

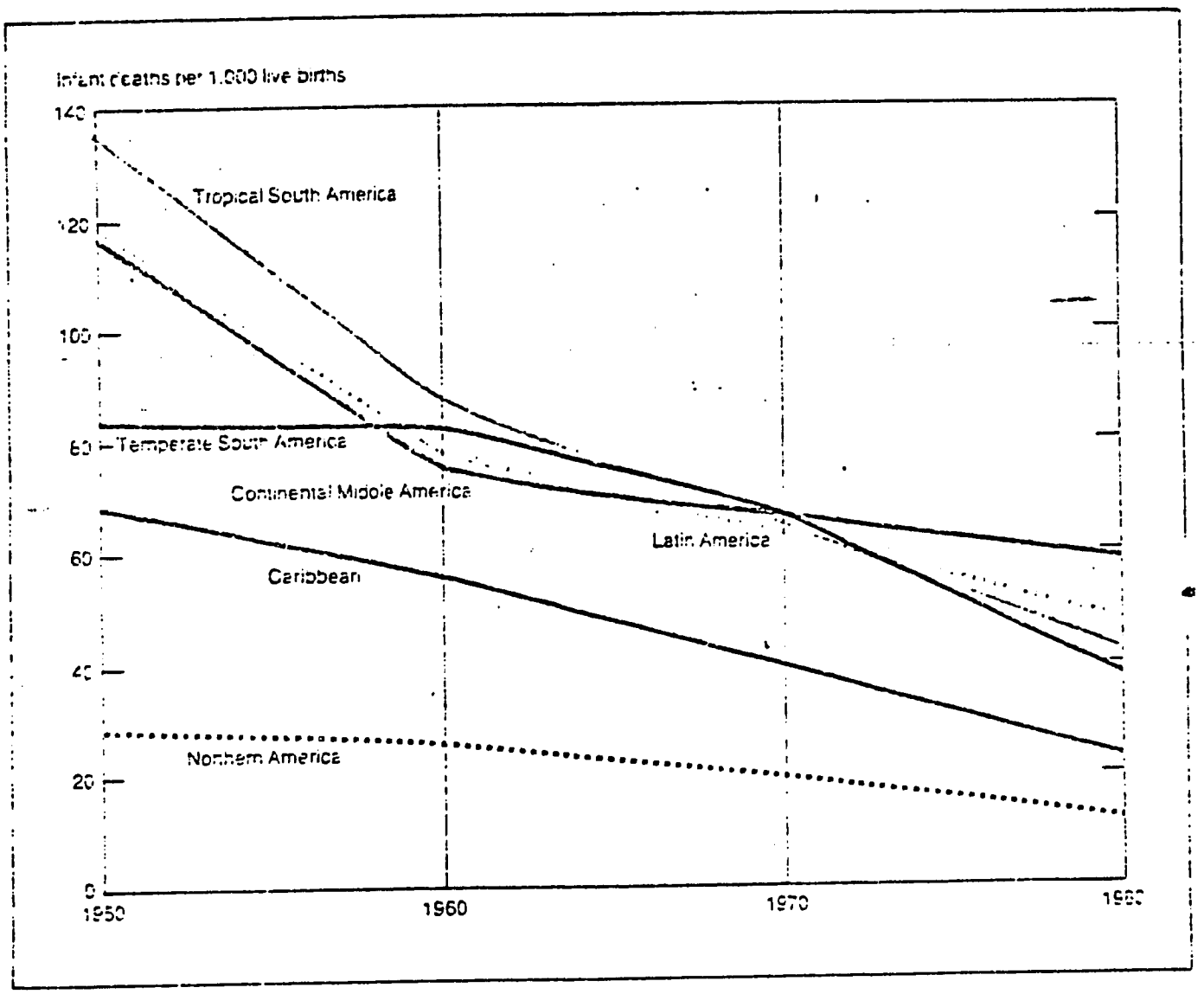
TRENDS IN HEALTH STATUS

	Infant Mortality Rate		1-4 Mortality	
	1965-70	1975-80	1965-70	1965-80
LAC Region	85.2	66.8	8.4	6.3
Andean Region	105.5	75.9	10.4	7.6
Southern Cone	49.6	36.8	5.1	3.6
Brazil	87.3	66.8	8.6	6.2
Central America	125.3	90.0	12.8	8.9
Mexico	78.5	49.6	7.8	5.1
Non-English Caribbean	73.9	57.7	7.4	5.9
Caribbean	43.0	28.4	4.3	2.4

Source: Health For All By the Year 2000: Strategies
PAHO, 1980

FIGURE I

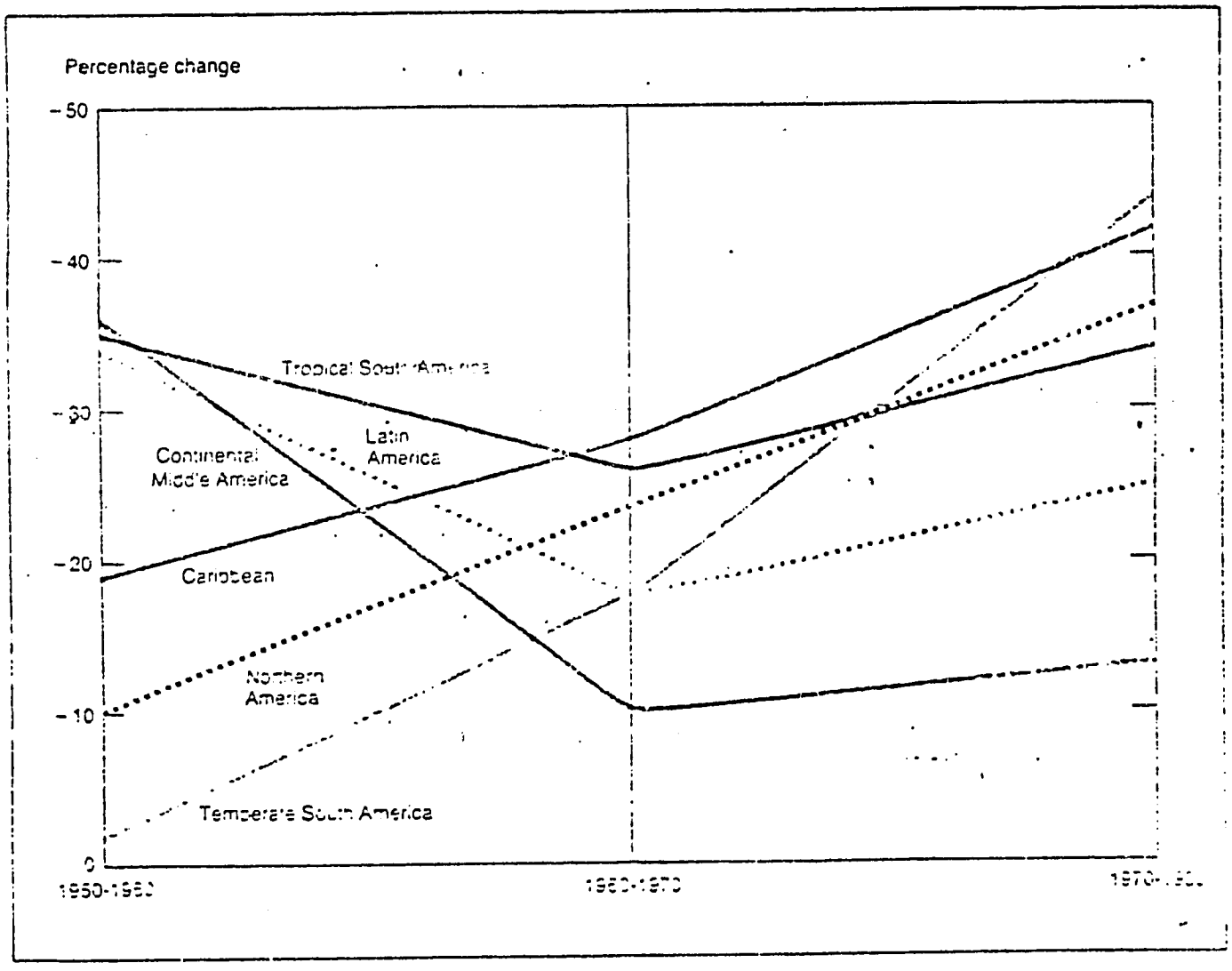
Trends in infant mortality in the Americas, by subregion, around 1950, 1960, 1970, and 1980



Source: Health Conditions in the Americas, 1980. PAHO

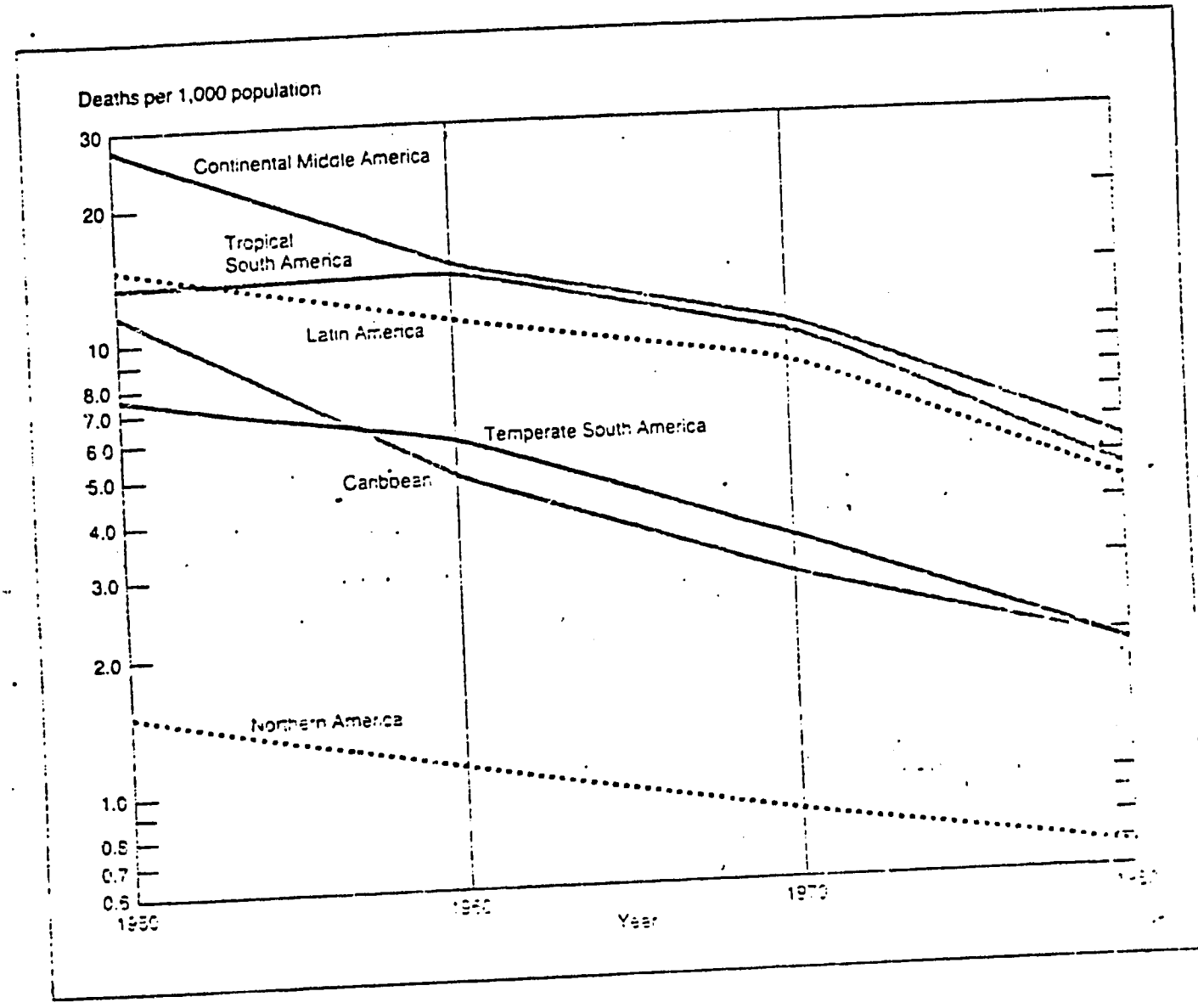
FIGURE II

Percentage change in infant mortality in the Americas, by subregion, 1950-1960, 1960-1970, and 1970-1980



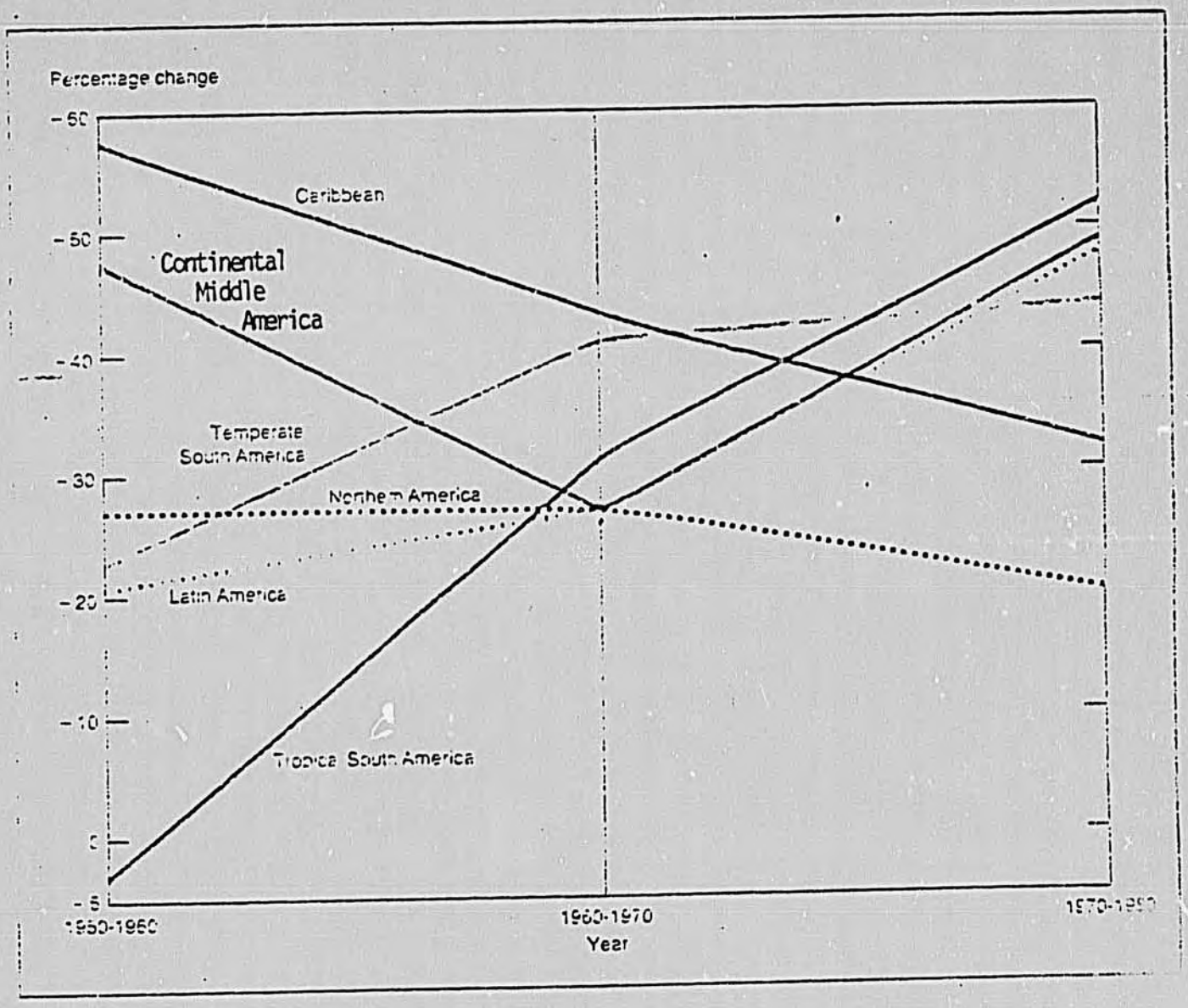
Source: Health Conditions in the Americas, 1980. PAHO

Mortality trends in children 1-4 years of age in the Americas, by subregion, around 1950, 1960, 1970, and 1980



Source: Health Conditions in the Americas, 1980. PAHO

Percentage change in mortality in children 1-4 years of age in the Americas, by subregion, 1950-1960



Source: Health Conditions in the Americas, 1980. PAHO

MAP 1

DISTRIBUTION OF A. (N) albimanus AND RESISTANCE TO DDT AND PROPOXUR (DECEMBER 1982)

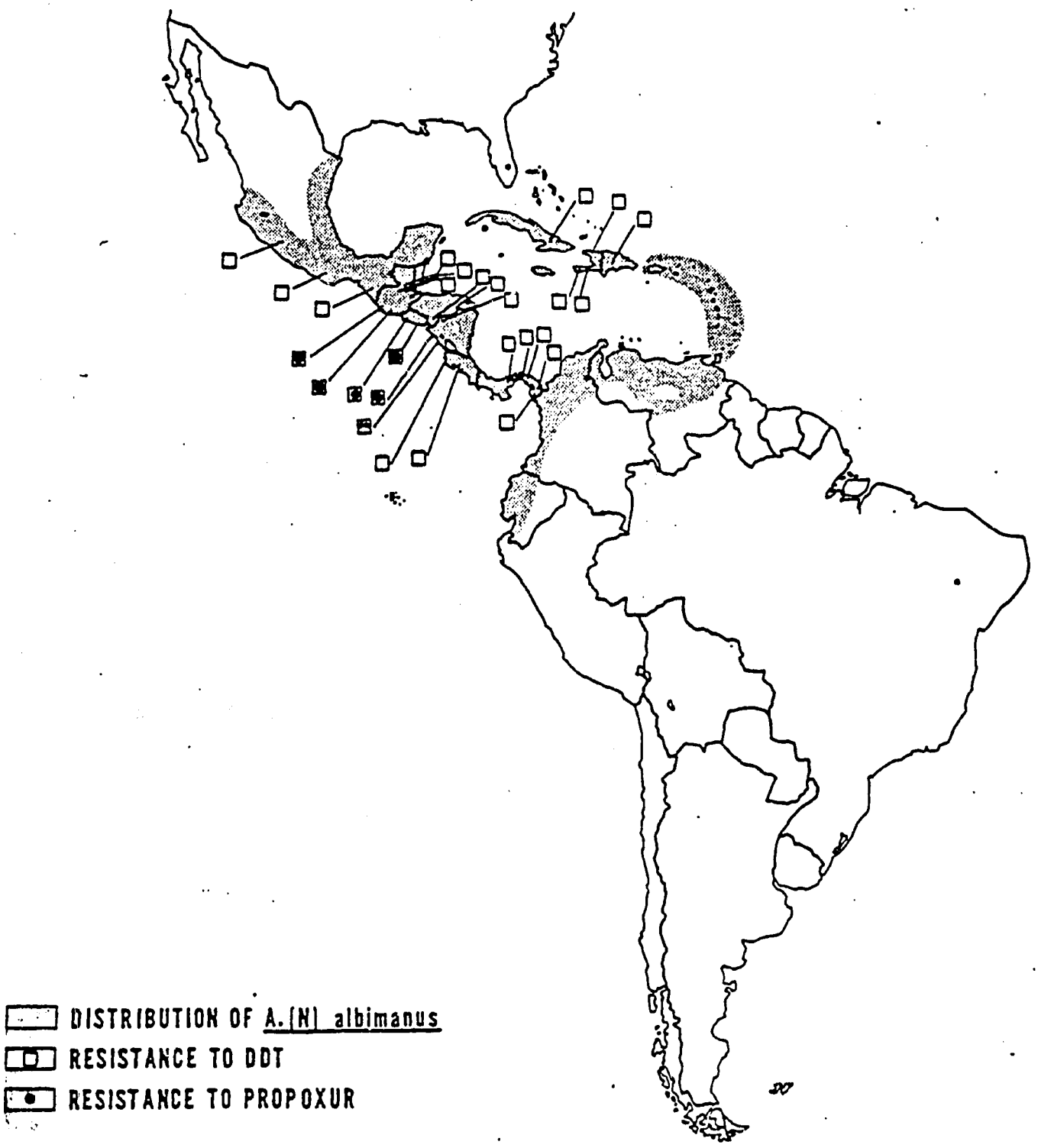


Table 3

MALARIA CASES REGISTERED: 1979-1982

Country or Territory	1982 population in originally malarious areas (thousands)	Cases Registered			
		1979	1980	1981	1982
12 in which malaria eradication has been certified	75,829	1,162	2,249	1,599	972
Argentina	3,584	936	341	323	567
Belize	163	1,391	1,529	2,041	3,868
Bolivia	2,087	14,712	16,619	9,774	6,699
Brazil	53,483	144215	169,871	197,149	221,939
Colombia	17,590	60,957	57,346	60,972	78,601
Costa Rica	677	307	376	168	110
Dominican Republic	5,610	3,080	4,780	3,596	4,654
Ecuador	5,331	8,207	8,748	12,745	14,633
El Salvador	4,558	75,657	95,835	93,187	86,202
Fr. Guiana	73	604	831	769	1,143
Guatemala	2,905	69,039	62,657	67,994	77,375
Guyana	825	2,294	3,202	2,065	1,700
Haiti	4,642	41,252	53,478	46,703	65,354
Honduras	3,628	25,297	43,009	49,377	57,482
Mexico	39,352	20,983	25,734	42,104	49,993
Nicaragua	2,852	18,418	25,465	17,434	15,601
Panama	1,882	316	310	340	334
Paraguay	2,824	116	140	73	66
Peru	6,176	17,127	14,982	14,812	14,613
Surinam	218	903	4,445	2,479	2,805
Venezuela	10,956	4,705	3,901	3,37	4,217
TOTALS	245,307	511,678	595,848	629,081	709,255

ANNEX B

LAC HEALTH ACCOUNT - TRENDS

Table I

LAC Health Account Levels 1981-1985: CP Levels
($000)

1981		1982		1983		1984		1985
19,419	(+39%)	27,177	(+31.5%)	35,733	(+26%)	45,072	(+30%)	58,550

Table II

LAC Health Account as a Percentage of
LAC Development Assistance
($000)

	1981	1982	1983	1984	1985
LAC Health	19,419	27,177	35,733	45,072	58,550
LAC DA	233,339	280,857	328,941	361,889	450,300
Percentage	8	10	11	12.5	13

Table III

LAC Health Account as a Percentage of
Total Agency Health Account
($000)

	1981	1982	1983	1984	1985
LAC	19,419	27,177	35,733	45,072	58,550
Total Aid	143,336	134,431	139,536	143,635	158,138
Percentage	13.5	20	26	31	37

LAC HEALTH ACCOUNT LOAN/GRANT RATIO

	1980 *	1981 *	1982 **	1983 ***	1984 +	1985
Loan	28,000	15,000	15,546	25,408	10,055	12,142
Grant	7,262	4,669	11,631	10,325	13,417	46,408
Ratio L/G	3.8/1	3.2/1	1.3/1	2.5/1	.75/1	.26/1

* Source = 1982 CP

** Source = 1983 CP

*** Source 1983-1985 = 1985 CP

\+ 1984 Data does not include Central America Supplemental

ANNEX C

LAC Activities Addressing Alternative Financing/Delivery of Health Services, Cost Recovery, and Private Sector Health Initiatives

The following is a list of studies, project development activities, and projects currently underway in the LAC region that are intended to address problems of health care financing and private sector involvement in health care. The activities are quite diverse, but they tend to fall within three broad categorical areas.

DEMAND FOR HEALTH CARE SERVICES/PUBLIC SECTOR COST RECOVERY THRU USER FEES

Dominica

Drug Revolving Fund.....Study/PRICOR

Study addresses how to develop a DRF and solve operational problems associated with its implementation..

Eastern Caribbean

Household Health Surveys.....Study/RDO/C with PAHO

National surveys of household health expenditures are completed for Antigua, Dominica, St. Kitts, and St. Lucia. Analysis of the data will be carried out in conjunction with PP development this spring.

Health Sector Resource Management.....PP Development/RDO/C

PP team will assess and make recommendations for implementation of a user fee system in up to three E. Caribbean countries

Ecuador

Analysis of Household Health Expenditures.... Study/USAID/Ecuador with AID/W PPC/E

Data from two previous national surveys--one rural, one urban--have been organized into computer files for data analysis. Data analysis will determine health expenditures for distinct socioeconomic groups and generate income and price elasticities.

Haiti

Drug Revolving Fund.....USAID/Haiti Bilateral Project

A drug revolving fund is being implemented as part of the Rural Health Project.

Honduras

Community Financing of PHC.....Feasibility Study/PRIC

A household survey was carried out in selected rural areas to determine factors affecting demand for health services. The study also identified case studies of existing financing schemes. Analysis of data will be completed this spring.

Jamaica

National Household Survey.....Study/GOJ/MOH
A household health service utilization and expenditure survey was piggybacked onto a routine government labor force participation survey. Data has not yet been analyzed.

Peru

National Household Survey.....Study/USAID/Peru with World Bank and PAHO
National household survey is being carried out this spring and will include collection of data on utilization and expenditures for health services. Data analyses will include an analysis of the demand for and willingness to pay for health care services.

RISK SHARING DEVICES/ALTERNATIVE MECHANISMS FOR FINANCING AND DELIVERY OF HEALTH SERVICES

Bolivia

Self Financing Primary Health Care.....PP Approved
Project will establish self financing primary health care delivery systems to serve the target population of 3 agricultural cooperatives.

Community Financing of PHC Through Cooperatives...Feasibility Study/PRICOR
Study will develop and test self financing schemes to be operated by rural and urban cooperatives in Santa Cruz including selection of packages of services and the means by which the population can pay for them (part of above PP).

Brazil

Community Financing of PHC Services (Rio).....Feasibility Study/PRICOR
Study will identify feasible financing schemes by which marginal urban communities can help finance PHC.

Financing of Community Water Supply.....Study/PRICOR
Study will retorspectively identify factors that account for success or failure of financing schemes and their cost-effectiveness.

Colombia

Health Program of the Comite de Cafeteros.....Case Study/LAC/DR/HN
The Comite de Cafeteros and the GOC jointly finance and deliver health care services in coffee growing regions of Colombia. A case study of this effort is being prepared.

Dominican Republic

Rural PHC.....Study/USAID/DR
Design of comprehensive PHC to be implemented in 3 of SESPAS's rural health clinics by Universidad Nacional Pedro Henriquez Urena and will include alternative health financing and health services delivery.

Health Insurance Scheme.....Feasibility Study/USAID/DR

Preliminary study for introduction of primary health care insurance scheme targeted for rural areas.

Eastern Caribbean

Health Sector Resource Mangement.....PP Development

Project development will include identification of opportunities for implementation or expansion of prepayment capitation programs in up to three E. Carribbean countries.

Ecuador

Private Sector Health Initiatives.....Study/USAID/Ecuador

Study to inventory non-government potential private sector health initiatives - Health Insurance.

Guatemala

Community Financing.....Feasibility Study#4/ USAID/Guatemala

Study will assess incentives for attracting and retaining promotors for a self financing curative primary health care program targeted to agricultural workers.

Guyana

Community Financing.....Study/Bilateral Project

Study of community financing of health services

Jamaica

Jamaica Health Initiatives Study.....Bilateral Project.

Study inventories private provider and asseses the role of insurance.

Hospital Conversion Project.....Study/USAID/Jamaica

Study will assess the feasibility of converting a GOJ/MOH hospital to a private service delivery model.

Mexico

Marketing and Distribution of ORS.....Marketing Study/ PRICOR

Market research of quantitative and qualitative aspects of marketing and distribution of ORS in Mexico.

Peru

Private Sector Health Initiatives.....Study/USAID/Peru/ Bilateral Project

Study identified and assessed delivery of primary health care services by cooperatives, PVOS, and local pharmacies. Results of study were used to develop a private sector health strategy for the CDSS and to focus future project development work.

LAC Regional

Social Insurance Review.....Study/LAC/DR/HN
Study provided an overview of health care delivery within Social Security systems in the LA region

HMO Review.....Proposed Study
Proposed study will review the development and operation of Health Maintenance Organizations with the LA region and will develop a protocol for assessing feasibility of prepayment systems.

Regional Project.....LAC/DR/HN
A component of the Regional will provide funds for addressing regional issues in health care financing.

Market research.....Study/LAC/DR/HN LAC/DR/P
A market research is looking at the feasibility of establishing ambulatory surgical centers in conjuction with family planning services for several LAC large cities.

REDUCTION IN PUBLIC SECTOR EXPENDITURE

Costa Rica

Policy Planning and Administrative Improvement..Bilateral Project
Project will introduce financial management procedures which will improve collection of revenues from employers and reduce inefficiencies.

Haiti

Hospital Cost Containment.....PL480 Title III Proposal

Honduras.....Feasibility Study/USAID/Honduras
Study will assess the potential for increased private sector participation in MOH's maintenance program.

LAC/DR/HN:COverholt 08/16/83 doc. #0173H

DETAILED BUDGETS

SUMMARY BUDGET--ALL COMPONENTS

	YR1	YR2	YR3	YR4	TOTAL
Malaria	800	1200	900	600	3500
Essential Drugs	745	1135	785	335	3000
Financing	750	450	500	300	2000
Training	600	660	540	570	2370
Evaluation		150		200	350
TOTAL	2895	3595	2725	2005	11200
Contingency + Inflation*	290	540	545	505	1880
GRAND TOTAL	3185	4135	3270	2510	13100

AUPHA
LATIN AMERICAN -- HEALTH ADMINISTRATION
PROGRAM RESOURCE ENHANCEMENT INITIATIVE

		YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5
PERSONNEL EXPENSE						
Senior Staff Director	Part Time	17,300	18,165	19,073	20,027	21,028
Project Director,bilingual	Full Time	40,000	42,000	44,100	46,305	48,620
Reference Librarian,bilingual	Full Time	25,000	26,250	27,563	28,941	30,388
Assistant	Full Time	20,000	21,000	22,050	23,153	25,310
Production Clerk	Full Time	7,000	14,000	14,700	15,435	16,207
Secretary	Full Time	22,000	23,100	24,255	25,468	26,741
Fringe Benefits	20%	26,260	27,573	28,952	30,399	31,919
TOTAL PERSONNEL EXPENSES		157,560	172,088	180,692	189,727	199,213
OFFICE EXPENSES						
Materials for filing and retrieval		4,000	4,000	4,500	3,000	3,000
Acquisition of educational materials		6,000	4,500	5,000	5,500	6,000
Maining and reproduction		11,000	16,500	20,000	22,000	25,000
Equipment	Initial Expense	25,000	0	0	0	0
Equipment	Annual Expenses	5,500	6,050	6,655	7,321	8,053
Office Supplies		7,200	7,920	8,712	9,583	10,542
Office and secretarial space	970 sq feet	16,005	16,490	16,975	17,460	17,945
Telephone and telex		7,000	9,500	10,500	11,750	13,000
TOTAL OFFICE EXPENSES		77,705	60,960	67,842	73,614	80,539
STAFF TRAVEL		20,000	8,800	15,000	12,000	15,000
TASK FORCES						
3 task forces of 6 members each (4 Latin and 2 U.S. faculty) @ 3 years, meeting 5 times		16,000	52,800	96,800	85,184	46,851
TOTAL EXPENSES		271,265	294,648	360,334	360,525	341,603

ESSENTIAL DRUGS COMPONENT
TECHNICAL ASSISTANCE BUDGET
(Budget Period 4 years)
In-Country

DIRECT LABOR

Professional Consultants	80 wks x 4 countries x $1,000 wk	
Secretarial Support	4 wks x 4 countries x $400 wk	$326,400

TRAVEL/PER DIEM

Airfare	160 trips x $700 trip	$112,000	
Ground Transportation	320 wks x $50 day	$ 16,000	
Food/Lodging	320 wks x $500 wk	$160,000	$288,000

OTHER DIRECT COSTS

Phones	320 wks x $50 wk	$ 16,000	
Postage/Freight	320 wks x $20 wk	$ 6,400	$ 22,400

TOTAL TA Budget $636,800

($39,800 per country year)

Assumptions

- 20 weeks TA per year per country
- Average stay per TA assignment: 2 weeks
- Four (4) countries requesting TA

ESSENTIAL DRUGS COMPONENT
TRAINING BUDGET
(Budget Period: 4 years)
Regional Centers

DIRECT LABOR

Professional Consultants	148 wks x $1000/wk x 2 Faculty	$280,000	
Graphic Support	38 programs x $2000/program	$ 76,000	
Audio/Visual Support	38 programs x $1000/program	$ 38,000	
Secretarial Support	28 wks x $400/wk	$ 11,200	$405,200

TRAVEL/PER DIEM

Faculty

Travel	114 trips x 2 Faculty x $700	$159,600	
Per Diem	144 wks x 2 Faculty x $500	$ 72,000	
Ground Transportation	144 wks x 2 Faculty x $50	$ 14,400	

Trainees

Travel	114 trips x 5 Trainee/class x $500	$285,000	
Per Diem	144 wks x 5 Trainee/class x $500	$360,000	$891,000

OTHER DIRECT COSTS

Materials/Printing	114 courses x $200 course	$22,800	
Postage/Freight	114 courses x $100 course	$14,400	
Audio/Visual Rental	114 courses x $100 course	$14,400	$ 51,600

TOTAL TRAINING Budget $1,347,800

Assumptions

- 19 basic courses and 19 follow-up advanced courses (Total 38 training programs)
- 72 weeks of actual training
- 76 weeks (38 courses x 2 week/course) faculty preparation

64

ESSENTIAL DRUGS COMPONENT
OPTIONAL PHARMACEUTICAL LOGISTICS PROGRAM ENHANCEMENTS
(Budget Period: 4 years)

OPTION A -	Feasibility Study for the Transfer of Public Pharmaceutical Transportation to the Private Sector	$ 80,000
OPTION B -	Feasibility Study for the Transfer of Public Pharmaceutical Dispensing Functions to the Private Sector	$ 100,000
OPTION C -	Enhance the Equipment and Reagent Stocks of the Existing Food/Drug Quality Control Laboratories	$1,000,000
OPTION D -	Design and Structural Modifications to Existing Pharmaceutical Warehousing Facilities	$ 200,000
OPTION E -	Equipment Acquisition (Mini-computer) and Software Development to Support a Computerized Pharmaceutical Logistics and Monitoring System	$ 800,000
	TOTAL OPTIONAL PROGRAM ENHANCEMENTS	$2,180,000

ESSENTIAL DRUGS COMPONENT
REGIONAL PHARMACEUTICAL VENDOR/PRICING INFORMATION NETWORK
Budget Period: 4 years
(Five Countries)

DIRECT LABOR (burdened by contractor overhead/fringe)

Systems Analyst	200 hrs x $50/hr	$10,000	
Programmer	100 hrs x $50/hr	$ 4,000	
Data Entry	100 hrs x $20/hr	$ 8,000	
Computer Operator	50 hrs x $20/hr	$ 4,000	$ 26,000

COMPUTER COSTS

Host Computer Processing	100 hrs @ $100 x 4 yrs	$40,000	
Micro-Computer (1 per country)	$10,000 x 5 countries	$50,000	
Maintenance	$1,000 yr x 5 countries x 4	$20,000	$110,000

OTHER DIRECT COSTS

Diskettes	$4 diskette x 40 disk/yr x 5 countries x 4 yrs	$800	
Postage/Freight	$25 shipping x 4 shippings/yr x 4 yr	$400	$ 1,200

TOTAL, Pharmaceutical Vendor/Drug Information Network $137,200

$6,860 per country per year

ESSENTIAL DRUGS COMPONENT
PHARMACEUTICAL INFORMATION SUPPORT BUDGET
(Budget Period: 4 year)
Four Sites in Each of Five Countries

REFERENCE MATERIALS - TEXT

Martindales Extrapharmacopia	$80 x 20 sites	$1,600	
AMA Drug Evaluations	$60 x 20	$1,200	
United States Pharmacopia	$50 x 20	$1,000	
Pharmacologic Basis of Therapeutics	$50 x 20	$1,000	
USP Drug Information	$50 x 20	$1,000	$ 5,8[illegible]

REFERENCE MATERIALS - JOURNALS

American Hospital Formulary Service	$120 x 20 x 4 yr	$9,600	
Medical Letter	$70 x 20 x 4	$5,600	
Clinalert	$70 x 20 x 4	$5,600	
Hospital Formulary	$50 x 20 x 4	$4,000	
Facts & Comparisons	$70 x 20 x 4	$5,600	$ 30,4[illegible]

REFERENCE MATERIALS - MICROFICHE

Adverse Drug Reaction Index	$100 x 20 x 4 yr	$8,000	
Microfiche Reader	$500 x 20	$1,000	$ 9,0[illegible]

TOTAL Reference Material Budget $2,260 per site

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ILLUSTRATIVE BUDGET FOR ESSENTIAL DRUGS PROGRAM

	YEAR 1	YEAR 2		YEAR 3	YEAR 4 TOTAL
Technical Assistance	100,000	218,400	218,400	100,000	$636,800
Training	225,000	472,800	425,000	225,000	$1,347,800
Pharmaceutical Information	13,400	10,600	10,600	10,600	45,200
Vendor/Pricing Information Network	82,450	18,250	18,250	18,250	137,200
TOTAL	420,850	720,050	672,250	353,850	$2,167,000

MALARIA

IV. Illustrative Budget for Regional Initiative

A.	Malaria Research Symposium (one time only)	$100,000
B.	Research and Training Center: Three senior positions plus clerical and administrative positions; logistic support; necessary equipment.	$1,000,000 for the first year; thereafter $500,000 annually
C.	Research and Training Coordinating Secretariat: Two senior positions, clerical support.	$350,000 annually
D.	Training Fellowships[1] Long-term $50,000 Short-term $50,000	$100,000 annually
E.	Support of Applied Field Research	$450,000 annually
F.	Support of National Training Programs: Curriculum development; Organization courses at the Regional Research and Training Center; Provision of temporary staff	$250,000 annually
G.	Technical Assistance: Short-term consultants for evaluation, planning or problem-solving teams. 300 man-days plus travel and per diem.	$100,000 annually
Totals:	First year	$2,350,000
	Succeeding years	$1,750,000

1. This figure would not cover training grants covered under PAHO or AID country programs.

INTERAMERICAN COLLEGE OF PHYSICIANS AND SURGEONS (ICPS)
ILLUSTRATIVE BUDGET

"Apreton De Manos Curativas"

Building an Interamerican Community of Physicians

I. Project Staff

A. Personnel

1. Project Director
$3,750 per month X 8 months.....$30,000

2. Administrative Assistant
$2,083 per month X 6 months..... 12,498

3. Clerical
$1,500 per month X 2 months..... 5,000

4. Consultants
$2,000 per country (5)..... 10,000

SOC/SEC, Workmans Comp. Hosp. Ins. (20%)..... 11,499

SUB-TOTAL $69,997

II. Project Communications

A. ICPS Field Communications with LAC/participants
B. ICPS U.S. Communication with Physician Trainers
C. Project Newsletter
D. Printing, duplication
E. Conference materials
F. Dissemination costs
G. Telephone, est..... 30,000

III. Staff Travel

A. Project Staff Travel

1. To LAC/AID Missions participating in the project.
Washington, D.C. to 5 countries and return, est.
travel..... 5,000
Est. per diem, 15 X $75.00..... 1,125

SUB-TOTAL $6,125

2. U.S. Travel to Training Sites

Est..... 7,500
Est. per diem, 15 X $130..... 1,950

SUB-TOTAL $9,450

B. ICPS Physician Trainer Travel

1. To Aid/WASH for Project Orientation, 30 X $800 est... 24,000

2. Physician Trainer per diem, 5 days X $130 X 30, est.. 19,500

SUB-TOTAL $43,500

3. U.S. ICPS Field Meetings
(2) Mid-Term Meeting sponsored by ICPS Members (Travel 1/per diem), 2 day meeting in rural/urban setting (Eastern/Western Region of U.S.), 30 physicians

- Travel and return $1,000 X 30, est..... 30,000
- Per diem 130 X 2 X 30, est..... 7,800
- Conference Fee Lunch/Dinner, est..... 1,200
- Conference Materials, est..... 5,000

SUB-TOTAL $44,000

C. ICPS Physician Exchange to LAC/Countries

1. 15 U.S. Physicians for 21 days
(a) Est. Travel $1,000 per participant X 15..... 15,000
(b) Est. per diem $75.00 per day X 15 X 21..... 23,625

2. ICPS Project Conferences in LAC/Countries
(a) Est. costs for 5 meetings to communicate project objectives and share medical information, $5,000 per conference X 5 (250 participants per meeting)..... 25,000
(b) Est. cost for Field Consultants for Conference coordination..... 5,000

SUB-TOTAL $68,625

IV. Training Costs

A. LAC Physician Training Costs
Living/Maintenance Allowance

1. 1st 30-day maintenance advance, $50.00 per day X 30 X 30..... 45,000
2. 5 months X $850 per month X 30.....127,500

SUB-TOTAL $68,625

B. LAC/Physician Continuing Medical Education Cost

1. Est. 1 CME course per month, $800 per course, X 6 X 30.....144,000

C. Materials

1. Books, $35.00 per month X 6 X 30..... 6,300
2. Book shipment allowance, $60.00 X 30..... 1,800

SUB-TOTAL $8,100

V. Non-Transferable Costs

A. HAC Fees, $25.00 per Physician per month, 6 months X $25.00 X 30, est..... 4,500

B. Washington, D.C. Orientation
1. ICPS orientation for Exchange Physicians est. costs based on Washington, D.C. International Training Center Orientation (1 week), $325.00 per Participant X 30..... 9,750

C. ICPS Orientation for U.S. Physician Trainers who will travel to LAC countries est. $325 per physician (15)..... 4,875

VI. Project Budget Totals

A. Est. Direct Costs.....$615,422

B. Est. Admin Costs (40%).....246,168

C. Est. Contingency Costs (10%)..... 86,159

TOTAL $947,749.00

ANNEX E:

IMPLEMENTATION PLAN / YEAP / COMPONENT

MALARIA & ESSENTIAL DRUGS

	Year 1												Year 2												Year 3												Year 4											
	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
Cooperative Agreement Signed			X																																													
First Workplan Completed			X	X	X	X																																										
Staffing Completed			X	X	X	X																																										
Formation of Malaria Advisory Committee and Subsequent Meetings				X	X	X	X																																									
Training Needs Assessment - Malaria						X	X	X																																								
Training Needs Assessment - Essential Drugs						X	X	X																																								
TA (Malaria & Essential Drugs)						X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Identification/Implementation of Operations Research Projects - Malaria													X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Development of Vendor Pricing Network									X	X	X	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Development of Warehouse and Laboratory Prototypes															X	X	X	X	X	X	X																											
Purchase and Distribution of Pharmaceutical Reference Material													X	X	X	X	X	X							X	X	X	X	X	X							X	X	X	X	X	X						
Design and Implementation of Short Term Traning Courses - Malaria									X	X	X	X	X	X	X	X	X	X	X	X	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Design and Implementation of Short Term Training Courses - Essential Drugs									X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Annual Workplans Completed and Approved																			X	X	X	X									X	X	X	X											X	X	X	X		
Evaluation																					X	X	X	X																								

IMPLEMENTATION PLAN / YEAR / COMPONENT

HEALTH SERVICES FINANCING

	Year 1												Year 2												Year 3												Year 4											
	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
RFP					X																																											
Contract Award					X	X	X																																										
Formation of Advisory Committee/ Subsequent Meetings							X	X	X																																								
Identification of Country Studies										X	X		X	X							X	X	X											X	X	X													
Implementation of Country Studies										X	X		X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Annual Workplans Completed and Approved								X												X												X												X						
Promotion Visits													X	X	X	X									X	X	X	X									X	X	X	X										
Evaluation																										X	X	X																						

IMPLEMENTATION PLAN / YEAR / COMPONENT

MANAGEMENT TRAINING

	Year 1												Year 2												Year 3												Year 4											
	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
Cooperative Agreement Signed					X																																											
First Workplan Completed and Approved					X	X	X																																									
TA to Missions/Training Institutions																						UPON REQUEST																										
Dissemination of Information																																																
Workshop /Seminars																																																
Annual Workplans																																																
Evaluations																																																

IMPLEMENTATION PLAN / YEAR / COMPONENT

CLINICAL TRAINING

	Year 1												Year 2												Year 3												Year 4											
	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
Cooperative Agreement Signed					X																																											
First Year Workplan Completed and Approved						X																																										
Visits to Participating Missions									X																																							
Selection/placement of Students									X	X	X		X	X	X	X	X	X					X	X											X	X		X	X									
In-country Continuing Medical Education																					UPON REQUEST																											
Annual Workplans																					X	X	X								X	X	X										X	X	X			
Evaluations																													X	X	X	X																

IMPLEMENTATION PLAN / YEAR / COMPONENT

CLINICAL TRAINING

	Year 1												Year 2												Year 3												Year 4											
	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
Cooperative Agreement Signed					X																																											
First Year Workplan Completed and Approved						X																																										
Visits to Participating Missions										X																																						
Selection/placement of Students									X	X	X		X	X	X	X	X	X				X	X		X	X							X	X		X	X							X	X		X	X
In-country Continuing Medical Education																					UPON REQUEST																											
Annual Workplans																					X	X	X									X	X	X									X	X	X			
Evaluations																												X	X	X	X																	

ANNEX F

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

LAC/DR-IEE-85-24

ENVIRONMENTAL THRESHOLD DECISION

Project Location	:	LAC Regional
Project Title & Number	:	Technology Development and Transfer in Health (598-0632), and Essential Drugs and Malaria (596-0136).
Funding	:	$13,100,000. (Grant)
Life of Project	:	Four Years (FY 1985-1988)
IEE Prepared by	:	Linda E. Morse, LAC/DR/HN
Recommended Threshold Decision	:	Categorical Exclusion (598-0632) and Negative/Deferred Determination (596-0136)
Bureau Threshold Decision	:	Concur with Recommendations
Comments	:	The Grant Agreement will include appropriate wording that no procurement or use of pesticides will occur without first completing a workplan which will include an environmental assessment on those pesticides proposed to be used and receiving written approval of that workplan from the Chief Environmental Officer in LAC/DR, AID/W.
Copy to	:	Lars Klassen, LAC/DR,
Copy to	:	Linda Morse, LAC/DR
Copy to	:	IEE File

James S. Hester Date MAR - 4 1985

James S. Hester
Chief Environmental Officer
Bureau for Latin America
and the Caribbean

INITIAL ENVIRONMENTAL EXAMINATION

I. Project Description

The LAC Regional Health Project contains five components, three of which are funded with LAC Regional Health funds (598-0632) and two of which are funded with Central America Regional funds (596-1036). The LAC Regional funds will support technical assistance, training and operations research in health services financing, including nine cost, demand and/or private sector feasibility studies. In addition, management training and clinical, medical education will be supported in the U.S. and in LAC countries. The two components supported from Central American funds (596-1036) include technical assistance, training and operations research in essential drugs and malaria control. Technical assistance and training in essential drugs will focus on procurement, distribution, quality control and utlization of essential drugs. Technical assistance, training and operations research in malaria control will include sensitivity testing for insecticides and drugs, determination of cost effective packages of malaria control interventions, including intradomiciliary spraying, larviciding, source reduction and biological control. Such research will be undertaken in Belize, El Salvador, Honduras and possibly Guatemala.

II. Evaluation of Environmental Impact

Malaria control activities are funded in bilateral health projects in Honduras, El Salvador and Belize. Initial Environmental Examinations were undertaken in those countries and based on the AID Environmental Impact Statement (EIS), and the fact that standard procedures for intradomiciliary spraying, larviciding, source reduction, etc. were being followed, that adequate data was available to justify their use, and that adequate safety precautions were being followed, it was determined that these malaria projects had a favorable risk-benefit impact on the environment.

Operations research activities in this project will consist of testing and determining the most appropriate, cost-effective mix of interventions among standard vector control interventions, including intradomiciliary spraying with organophosphorous and chlorinated hydrocarbons insecticides, larviciding, source reduction and biological controls. (No procurement of pesticides, however, is envisaged under this project). These are approved interventions in Belize, El Salvador, and Honduras. All proposed operations research will be reviewed for technological and methodological issues by the

AID/PAHO/CDC advisory group established under this project. The LAC Regional Environmental Officer will be asked to review the operations research proposals prior to their implementation to determine, in writing, their compliance with existing environmental determinations for Belize, El Salvador and Honduras. No research plan will be approved by the AID project officer until such a written determination has been made. Any research proposed for Guatemala will require an IEE with a pesticide assessment, to be undertaken by a qualified consultant who will be selected by the AID project Officer with the LAC Chief Environmental Officer's concurrence. The project includes funding for short term consultants which will be the source of funding for such assessments. The research in this project will be directed by and undertaken primarily by PAHO and CDC personnel, both of which are familiar with AID environmental regulations and will apply them carefully.

III. Recommendation

For those activities funded with LAC Regional funds (598-0632) a categorical exclusion is recommended per Handbook 3, Appendix 2D, 22 CFR Part 216.2 (c) (2) (X). With regard to the Central America components, malaria operations research specifically, a negative determination is recommended in view of the existing negative determinations for malaria control projects in 3 of the 4 countries where activities funded under this project will take place; in view of the fact that standard, existing technologies will be utilized in the research; that competent, experienced organizations will be undertaking the research; and most importantly that the Grant Agreement will include a requirement that no pesticides will be procured or used until a workplan for each new research activity, which will include a pesticide environmental assessment, is approved in writing by the LAC Chief Environmental Officer.

ANNEX H

AID 1020-25 11-72)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

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

Life of Project:
From FY _____ to FY _____
Total U.S. Funding _____
Date Prepared: _____

Project Title & Number: Technology Development and Transfer in Health

PAGE 1

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes: (A-1)	Measures of Goal Achievement: (A-2)	(A-3)	Assumptions for achieving goal targets: (A-4)
To improve health status in LAC countries	Reduction in mortality and morbidity from the leading causes in LAC.	Government statistics from participating countries	

AID 1020-25 (1-78)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY _____ to FY _____
Total U.S. Funding _____
Date Prepared: _____

Project Title & Number: Technology Development and Tranfer in Health

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Purpose: (B-1)	Conditions that will indicate purpose has been achieved: End-of-Project status. (B-2)	(B-3)	Assumptions for achieving purpose: (B-4)
To adapt and extend existing technologies and strategies which address organizational and financial problems in delivering health services.	See specifics for components		
Component Sub-Purposes:			
1. Malaria a. Reduce malaria transmission	1. a. Malaria Slide positivity rate reduced from 8.1%.	1. a. Country reports to PAHO.	1. Appropriate country resources applied to malaria control.
b. Prevent malaria from becoming endemic in additional areas.	b. No additional areas with endemic malaria.	b. Country reports to PAHO	
2. Essential Drugs Increase the appropriate use of existing high quality, minimum cost drugs to treat or prevent the most common health problems.	2. 75% of illnesses receive appropriate drug therapy at first contact with health care system	2. Survey of clinical records	
3. Health Services Financing Maintain or increase the level of primary health care services supported by MOH and Soc Sec health care systems	3. MOH and Social Security expenditures for primary care services do not decrease in real per capita terms	3. MOH/Soc Sec expenditure records	3. Government and Social Security personnel and expenditure procedures permit full implementation of programs as budgeted
4. Management Training Improved cost-efficiency of of primary health care services in MOH/Soc Sec delivery networks.	4. Increased ratio of primary health care services delivered to expenditures.	4. MOH and Soc Sec records	4. Difficulties can be resolved within MOH/Soc Sec systems.
5. Clinical Training Improve quality and effectiveness of primary health care services	5. Revised norms for primary health care focus more on outcomes and less on quantity of activities.	5. Revised MOH/Soc Sec norms disseminated	5. Individuals trained do not loose influence due to political changes.

AID 1020-25 (1-73)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Technology Development and Transfer in Health

Life of Project:
From FY _____ to FY _____
Total U.S. Funding _____
Date Prepared: _____

NARRATIVE SUMMARY Project Outputs: (C-1)	OBJECTIVELY VERIFIABLE INDICATORS Magnitude of Outputs: (C-2)	MEANS OF VERIFICATION (C-3)	IMPORTANT ASSUMPTIONS Assumptions for achieving outputs: (C-4)
1. Malaria More effective control measures developed, implemented, & evaluated	1. All participating countries using advanced malaria control methods		
2. Essential Drugs a. Improved drug selection	2. a. Less than 5% of drugs procured (by monetary value) are not on national drug formularies	2. a. Comparison of National drug formularies with procurement records	
b. Improved procurement procedures	b. 95% of drugs procured by competitive bidding with objective specs	b. Procurement records of MOH and Soc Sec	
c. Quality control improved	c. 50% drug deliveries tested for compliance with specifications	c. National drug quality control lab records compared to procurement records	
d. Drug quality maintained while in central warehouse	d. 95% drugs warehoused under adequate conditions	d. Project manager observations and project evaluations	
e. Inventory controlled and distributed such that adequate quantities of essential drugs are available at all appropriate levels of the health system	e. No stock-outs at intended use points of drugs on national drug formulary	e. Project evaluation	
f. Improved prescribing practices	f. 95% of prescriptions for most common illnesses are appropriate with respect to drug prescribed, quantity, strength, and course of treatment	f. Project evaluation	

AID 1020-28 (1-73)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Technology Development and Transfer in Health

Life of Project:
From FY _____ to FY _____
Total U.S. Funding _____
Date Prepared: _____

NARRATIVE SUMMARY Project Outputs: (C-1)	OBJECTIVELY VERIFIABLE INDICATORS Magnitude of Outputs: (C-2)	MEANS OF VERIFICATION (C-3)	IMPORTANT ASSUMPTIONS Assumptions for achieving outputs: (C-4)
3. Health Care Financing MOH and Soc Sec planners and decision makers apply newly developed knowledge and imformation to program planning and budgeting processes	3. In all project countries, MOH and Soc Sec annual budgets and program plans for primary health care do not decrease in real, per capita terms	3. Government and Social Security budgets	3. Government budgeting processes and priorities do not reduce MOH/Soc Sec budgets more than can be compensated for by better management, cost recovery, etc.
4. Management Training MOH/Soc Sec management trainees acquire and apply new knowledge and skills to management of health care delivery systems	4. a. Number of LAC AID-funded health management trainees at participating training centers. (Bilaterally funded) b. Proportion of LAC AID-funded health management trainees working in target or higher-level management positions following training	4.a. Project Records b. Project Evaluation	
5. Clinical Training AID-funded clinical training for LAC focused on high-priority primary care technologies	5. Subject areas for training coincide with health problems in participants' countries	5. Project records	5. US foreign policy considerations do not force selection of inappropriate trainees and subjects.

AID 1020-28 (1-73)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Technology Development and Transfer in Health

Life of Project:
From FY 1984SUD to FY 1989
Total U.S. Funding $13.1 million
Date Prepared:

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Inputs: (D-1)	Implementation Target (Type and Quantity) (D-2)	(D-3)	Assumptions for providing inputs: (D-4)
TOTAL Life of Project Budget $13.1 Million	($000) Malaria: 3500 Essential Drugs: 3000 Financing: 2000 Training: 2370 Evaluation: 350 Contingency/ Inflation: 1880 TOTAL: 13100	Annual Obligations (Grants, Cooperative Agreements, Contracts) FRLCs Payment Vouchers	Availability of funds

ANNEX I

ACTION COPY

Department of State

INCOMING TELEGRAM

PAGE 01 BELIZE 00613 191529Z 5713 071509 AID9279

ACTION AID-00

ACTION OFFICE LADR-03

INFO LADP-04 STHE-01 SAST-01 HHS-09 RELO-01 TELE-01 STHP-01
MAST-01 LACA-03 /025 A1 1119

INFO LOG-00 COPY-01 ARA-00 /001 W
----------045046 191555Z /52

O 191505Z FEB 85
FM AMEMBASSY BELIZE
TO SECSTATE WASHDC IMMEDIATE 6055

RECEIVED BY LAC/DR/HN

FEB 20 1985

UNCLAS [redacted]

AIDAC
FOR LAC/DR/H. FROM AID REPRESENTATIVE
E.O. 12356: N/A
TAGS: N/A
SUBJECT: LAC REGIONAL HEALTH PROJECTS
REF: STATE 031554

1. REGRET DELAY IN RESPONDING TO REFTEL WHICH WAS OCCASIONED BY RECENT MOVE TO NEW OFFICE BUILDING.

2. MISSION HAS REVIEWED SUBJECT PROJECTS AND OFFERS FOLLOWING COMMENTS:

A. RELATIVE PRIORITY: ESSENTIAL DRUGS; HEALTH SERVICES FINANCING; MANAGEMENT/CLINICAL TRAINING; AND MALARIA CONTROL.

B. IMPORTANT ACTIVITIES OMITTED: NONE

C. MISSION PARTICIPATION/FINANCIAL SUPPORT: POSITIVE

D. PAHO ROLE: MISSION FULLY SUPPORTIVE. IN FACT, WE WILL BE COLLABORATING VERY CLOSELY WITH PAHO UNDER THE IMPROVED PRODUCTIVITY THROUGH HEALTH PROJECT STARTING THIS YEAR.

3. ADDITIONAL COMMENTS WILL BE PROVIDED BY GDO DUFFY DURING HER FORTHCOMING EARLY MARCH CONSULTATIONS IN AID/W.

BARNEBEY

ACTION COPY

UNCLASSIFIED

Department of State

INCOMING TELEGRAM

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FEB 11 1985

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AIDAC

E.O. 12356: N/A
SUBJECT: HEALTH: LAC REGIONAL HEALTH PROJECTS

REF: STATE 031554

1. USAID/BOLIVIA SUPPORTS PROPOSED LAC REGIONAL HEALTH PROJECT. PROJECT COMPONENTS 1 AND 2 ARE OF PARTICULAR INTEREST TO USAID, NOTWITHSTANDING THEIR RESTRICTION TO CENTRAL AMERICA AND PANAMA.

2. USAID HAS REVIEWED NEW AID MALARIA POLICY AND NOTED THE EMPHASIS ON PROVIDING TECHNICAL SUPPORT TO ONGOING MALARIA PROGRAMS. AS AID/W IS AWARE, USAID HAS SUPPORTED GOB'S MALARIA PROGRAMS WITH PL480 TITLE III RESOURCES SINCE 1978. PAHO AND THE PEOPLE'S REPUBLIC OF CHINA HAVE PROVIDED LIMITED TECHNICAL ASSISTANCE ADDITIONAL TECHNICAL ASSISTANCE AND TRAINING SUCH AS THAT INCLUDED IN PROPOSED PROJECT WOULD BE VERY USEFUL. AS IN BRAZIL AND COLOMBIA, P. FALCIPARUM INFECTIONS ARE COMMON IN THE EASTERN LOWLANDS OF BOLIVIA AND NEAR THE BRAZILIAN BORDER, BOLIVIA PARTICIPATED IN THE RECENT CONFERENCE OF ANDEAN COUNTRIES IN LIMA WHERE REGIONAL COOPERATION IN MALARIA PROGRAMS WAS THE MAIN ISSUE. USAIDS ECUADOR AND PERU WERE ORGANIZERS OF CONFERENCE. WHEREAS MALARIA IS NOT THE MAJOR HEALTH PROBLEM IN BOLIVIA, IT IS AN OBSTACLE TO DEVELOPMENT OF THE SPARSELY POPULATED TROPICS, AND A MAJOR PROBLEM AMONG PRESENT INHABITANTS OF THAT REGION.

3. USAID IS INTERESTED IN THE POSSIBILITY OF SENDING PARTICIPANTS TO TRAINING PROGRAMS IN ALL ASPECTS OF ESSENTIAL DRUGS. IT IS HOPED THAT MISSIONS AND PROJECTS OUTSIDE CENTRAL AMERICA AND PANAMA WILL BENEFIT FROM SPIN OFFS, SUCH AS INFORMATION, MANUALS AND IMPROVED ESSENTIAL DRUG PROCUREMENT PROCEDURES FOR AID FUNDED PROJECTS.

4. CURRENT USAID/BOLIVIA PROJECT IN SELF-FINANCING PRIMARY HEALTH CARE INCLUDES TECHNICAL ASSISTANCE SIMILAR TO THAT OFFERED IN COMPONENTS 3 AND 4 OF BUDGET PROJECT. MISSION FORSEES LITTLE NEAR-TERM PARTICIPATION IN THESE PROJECT COMPONENTS. CORR

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ADM AID

FOR LAC/DR/HN

E.O. 12356: N/A
TAGS:
SUBJECT: HEALTH: LAC REGIONAL HEALTH PROJECTS

REF: STATE 31554

1. YOUR PARAGRAPH 18 IN REFTEL, IN WHICH YOU EXCLUDE BRAZIL FROM PARTICIPATION IN THIS PROJECT, DISCOURAGES A RESPONSE FROM BRAZIL.

2. YET, WE URGE YOU KEEP IN MIND THE LARGE HMO MOVEMENT IN THIS COUNTRY AND THE OPTIONS IT PROVIDES FOR PROJECT SITE. IT IS ALSO IMPORTANT TO NOTE THAT BRAZIL SENDS MANY PARTICIPANTS ABROAD FOR TRAINING INCLUDING TRAINEES IN THE HEALTH SECTOR. THE ENTITY RESPONSIBLE FOR PLACEMENT OF THESE BRAZILIAN PARTICIPANTS (CAPES) COULD USE ASSISTANCE TO HELP THEM PLACE CANDIDATES. WITH A SMALL AMOUNT OF FUNDING, THE AIDREP OFFICE COULD HELP CAPES AND IN THAT WAY WEDGE GOOD FAVOR FOR U.S. INTERESTS. YOUR MANAGEMENT AND CLINICAL TRAINING INITIATIVE (REFTEL PARA 13), WOULD HELP. EXCLUDING BRAZIL LESSENS THE CHANCE THEY CAN PARTICIPATE AS A TRAINING SITE FOR LAC COUNTRIES, AND THEY ARE A GOOD SOURCE FOR SUCH TRAINING.

3. AIDREP HAS SHARED WITH AID/W THE MANY OPPORTUNITIES FOR COLLABORATION WITH BRAZILIAN PUBLIC AND PRIVATE HEALTH SECTOR INITIATIVES. AID/W DETERMINATION THAT BRAZIL'S PARTICIPATION IS NOT ACCEPTABLE IS UNFORTUNATE AND AN OPPORTUNITY LOST FOR FURTHERING THE ADC STRATEGY. WATSON

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FOR LAC/DR/HN

E.O. 12356: N/A
SUBJECT: HEALTH: LAC REGIONAL HEALTH PROJECTS

REF: STATE 031554

1. MISSION WISHES TO RESPOND TO PARA. 16 OF REFTEL AS FOLLOWS:

A. COSTA RICA'S PRIORITY UNDER SUBJECT PROJECT IS FOR HEALTH MANAGEMENT TRAINING, SINCE CLINICAL TRAINING IN THE AREA OF PEDIATRICS, OB-GYN AND FAMILY MEDICINE IS RELATIVELY WELL COVERED BY THE MEDICAL SCHOOLS.

B. THE ESSENTIAL DRUGS PROGRAM COULD BE IMPORTANT AS A COMPLEMENT TO PRESENT ACTIVITIES IN PROCUREMENT AND SUPPLIES MANAGEMENT, AND RATIONALIZATION OF DRUG UTILIZATION. THE IMPROVEMENT OF QUALITY CONTROL TECHNIQUES FOR COSTA RICA'S CONTROL LABORATORIES HAS BEEN IDENTIFIED AS AN AREA NEEDING SOPHISTICATED TECHNICAL ASSISTANCE AND TRAINING.

C. HOSPITAL COST CONTAINMENT WILL BE ADDRESSED UNDER AN EXISTING PROJECT.

D. MALARIA IS VIRTUALLY ERRADICATED, AND THE OCCASIONAL OUTBREAK IS CONTROLLED.

2. JACKSON PLAN TRAINING FUNDS MAY BE AVAILABLE FOR LIMITED AMOUNTS OF PARTICIPANT TRAINING IN HEALTH MANAGEMENT.

3. PAHO'S ROLE SEEMS TO BE THAT OF COORDINATOR AND ADMINISTRATIVE FACILITATOR, A ROLE IT CARRIES OUT WELL. IN MISSION'S EXPERIENCE PAHO'S CONSULTANTS RANGE FROM EXCELLENT TO FAIR.
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AIDAC

FOR: LAC/DR/HN

E.O. 12356:N/A
SUBJECT: HEALTH: LAC REGIONAL HEALTH PROJECTS
REF: STATE 031554

1. USAID/DR ENDORSES THE DIRECTION OF THE SUBJECT PROJECT AND REGRETS THAT THE DOMINICAN REPUBLIC IS NOT TARGETTED IN THE MALARIA AND ESSENTIAL DRUGS COMPONENTS. SPECIFIC COMMENTS FOLLOW USING TOPICS REQUESTED IN PARA 16 OF REFTEL.
2. RELATIVE PRIORITY: IN VIEW THAT THE DR HAS ONLY LIMITED PARTICIPATION IN COMPONENTS 1 AND 2, THE RELATIVE PRIORITY OF REMAINING COMPONENTS IS 3 AND 4.
3. ACTIVITIES WHICH MAY HAVE BEEN OMITTED: PROPOSAL APPEARS TO BE COMPLETE AND FLEXIBLE ENOUGH TO ADDRESS ANY SPECIFIC NEEDS THAT COULD ARISE. SEE COMMENTS BELOW.
4. COMPONENT-SPECIFIC LIKELIHOOD OF MISSION PARTICIPATION, FUNDING AND COMMENTS:

(A) MALARIA: USAID WOULD LIKE TO SEND SECRETARIATE OF HEALTH STAFF TO TRAINING COURSES RELATED TO MALARIA IN SUCH AREAS AS MANAGEMENT AND LOGISTICS AT RATE OF 4-6 CANDIDATES PER YEAR. WITH REGARD TO ESTABLISHMENT OF REGIONAL BASE FOR TA AND TRAINING, SUGGEST THAT AID INSIST THAT PAHO ESTABLISH FORMAL TIES WITH U.S. UNIVERSITY CURRENTLY INVOLVED IN TRAINING IN TROPICAL DISEASES. THE INTERNATIONAL CENTER FOR PUBLIC HEALTH RESEARCH OF THE UNIVERSITY OF SOUTH CAROLINA IS ALREADY OFFERING SHORT COURSES ON VECTOR-BORNE DISEASES. RATHER THAN STARTING FROM ZERO, USC SHOULD BE CONTACTED TO SEE IF THEY COULD PARTICIPATE.

(B) ESSENTIAL DRUGS: WITH PAHO ASSISTANCE, THE GODR HAS ESTABLISHED ITS OWN ESSENTIAL DRUG PROCUREMENT AND DISTRIBUTION PROGRAM. THE MISSION, HOWEVER, HAS NO INFORMATION ON THE SUCESS OR LIMITATIONS OF THE PROGRAM. SECRETARIAT OF HEALTH (SESPAS) BELIEVES IT NEEDS NO FURTHER TA IN THIS AREA. NEVERTHELESS, USAID WOULD LIKE TO BE KEPT ABREAST OF PROGRESS UNDER THIS COMPONENT AND RECEIVE COPIES OF WORK PRODUCTS. WE WOULD DEFINITELY WANT TO RECEIVE: (1) INFORMATION FROM A VENDOR PRICING INFORMATION NETWORK, (2) UNBIASED DRUG THERAPY INFORMATION, AND (3) PROTOTYPE DOCUMENTS AS DESCRIBED IN REFTEL.

(C) HEALTH SERVICES FINANCING: UNDER THE PROVISION OF SUB-REGIONAL MEETINGS AND TRAINING, USAID/DR SUGGEST THAT AT LEAST TWO YEARLY ONE-WEEK SEMINARS SHOULD BE PRESENTED IN SPANISH ON ALTERNATIVE WAYS TO FINANCE TRADITIONAL PUBLIC SECTOR HEALTH PROGRAMS. THESE SEMINARS WOULD BE INTENDED TO PRESENT ALTERNATIVE FINANCING SCHEMES TO MID AND SENIOR LEVEL ADMINISTRATORS. CONCRETE EXAMPLES OF COST REDUCTION PROGRAMS OBTAINED THROUGH PRIVATE SECTOR PARTICIPATION NEED BE PRESENTED. ALSO, DISCUSSION OF GENERIC HMOS AND COMMUNITY FINANCING SCHEMES SHOULD BE DISCUSSED DRAWING ON PRICOR EXPERIENCE AND ACCOMPLISHMENTS IN LAC REGION.

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USAID/DR, BECAUSE OF ITS RELATIVELY STRONG PUBLIC SECTOR ORIENTATION, WOULD LIKE TO BE AMONG THE FIRST COUNTRIES TO PARTICIPATE IN FEASIBILITY STUDY ON DEVELOPING HMOS. TO THIS EFFECT, USAID IS FUNDING A STUDY OF ALTERNATIVE (TO PUBLIC SECTOR) PHC DELIVERY MECHANISMS IN THE DR. THIS WORK IS CONSIDERED AS BACKGROUND TO A MORE IN-DEPTH STUDY OF HMOS AND OTHER MORE COST EFFECTIVE DELIVERY SYSTEMS.

(D) MANAGEMENT AND CLINICAL TRAINING: USAID/DR STRONGLY SUPPORTS THE NON-ACADEMIC PILOT PRECEPTORSHIP. THIS IS A MUCH NEEDED RESOURCE FOR PRESENTING GENERIC HEALTH DELIVERY ISSUES TO LAC PHYSICIANS WHO GENERALLY HAVE A BIAS AGAINST NON-HOSPITAL ORIENTED COMMUNITY MEDICINE. SPECIFICALLY, IN THE CASE OF THE DR, THERE ARE A LARGE NUMBER OF UNEMPLOYED PHYSICIANS WHICH SESPAS WOULD LIKE TO RETRAIN AS PHC PHYSICIANS. SEEING AMERICAN PHYSICIANS WORKING IN RURAL SETTINGS WOULD LEND STATUS TO PHC. MISSION WILL SUPPORT 4-6 PARTICIPANTS PER YEAR.

USAID IS LESS INTERESTED IN OTHER MANAGEMENT IMPROVEMENT ELEMENTS OF THIS COMPONENT IN VIEW THAT WE HAVE A BILATERAL PROJECT (NO. 517-0153) ALREADY SIGNED WITH THE GODR TO ACCOMPLISH SIMILAR OBJECTIVES, HOWEVER, AS AID/W KNOWS, THIS PROJECT IS HELD UP IN THE DR CONGRESS AND THE LIKELIHOOD OF BEING APPROVED IS NOT KNOWN AT THIS TIME. SHOULD THIS PROJECT BE DEOBLIGATED, MISSION WOULD CONSIDER A MAJOR BUY-IN TO THIS COMPONENT WITH GRANT PORTION UP TO 1 MILLION) OF PROJECT ASSUMING DEOB-REOB AUTHORITY PERMITS.

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~~UNCLAS QUITO 1591~~ ECUADOR

AIDAC

E.O. 12356: N/A
SUBJECT: HEALTH: LAC REGIONAL PROJECT

REF: STATE 31544

1. SUMMARY: USAID/E IS HIGHLY SUPPORTIVE OF SUBJECT PROJECT AS OUTLINED IN REFTEL. THE FOUR PROJECT COMPONENTS ARE IMPORTANT AREAS FOR AID SUPPORT, AND USAID EXPECTS TO BOTH DRAW UPON BUY-INTO VARIOUS ELEMENTS OF THE PROJECT. ORDER OF PRIORITY OF COMPONENTS IN OUR VIEW IS (A) HEALTH SERVICES FINANCING; (B) MANAGEMENT TRAINING; (C) MALARIA CONTROL; AND (D) ESSENTIAL DRUGS. SPECIFIC COMMENTS BY COMPONENT ARE DESCRIBED BELOW.

2. MALARIA CONTROL. RECENTLY AUTHORIZED ECUADOR MALARIA CONTROL PROJECT 518-0009 PROVIDES FOR U.S. DOLS. 900,000 FOR TRAINING AND U.S. DOLS. 535,000 FOR OPERATIONS RESEARCH IN MALARIA AND VECTOR BORNE DISEASES OVER THE PERIOD 1985-1990. WE WOULD ANTICIPATE SENDING A SUBSTANTIAL NUMBER OF SHORT-TERM TRAINEES TO THE TRAINING PROGRAMS DEVELOPED UNDER THE REGIONAL PROJECT. AS FOR OPERATIONS RESEARCH, REFTEL DOES NOT INDICATE POSSIBLE BUY-INS, WORKSHOPS TO DISSEMINATE FINDINGS, OR COLLABORATIVE RESEARCH EFFORTS IN WHICH MISSION OUTSIDE CENTRAL AMERICA MIGHT PARTICIPATE. THIS SHOULD BE PROVIDED FOR. AS AID/W IS AWARE, AN ANDEAN REGIONAL MALARIA INITIATIVE HAS ALSO BEGUN, WITH RECENTLY HELD MEETING OF MALARIA TECHNICIANS IN LIMA. RECOMMENDATIONS FROM THAT MEETING WILL BE PRESENTED TO ANDEAN HEALTH MINISTERS. FINANCIAL AND TECHNICAL SUPPORT FOR IMPLEMENTING THIS PROGRAM WILL BE REQUIRED. WE STRONGLY RECOMMEND THAT A SMALL PORTION OF THE PROPOSED PROJECT (E.G., U.S. DOLS. 250,000) BE SET ASIDE TO ASSIST THE ANDEAN REGIONAL ACTIVITY AND/OR TO PERMIT NETWORKING AND INFORMATION EXCHANGE BETWEEN THE CENTRAL AMERICAN AND ANDEAN REGIONS.

3. ESSENTIAL DRUGS. LITTLE PARTICIPATION OUTSIDE CENTRAL AMERICAN IS ANTICIPATED. WE URGE, HOWEVER, MAXIMUM INFORMATION DISSEMINATION AS THIS IS A PROBLEM AREA FOR ALL LAC COUNTRIES.

4. HEALTH SERVICES FINANCING. MISSION PLANS TO INITIATE THIS FISCAL YEAR A FEASIBILITY STUDY OF PRIVATE SECTOR ALTERNATIVES TO FINANCING AND DELIVERY OF HEALTH SERVICES. WHEN WILL REGIONAL PROJECT RESOURCES BE AVAILABLE TO COMPLIMENT MISSION RESOURCES IN THIS REGARD - ESPECIALLY IN TERMS OF PROMOTIONAL VISITS.

5. MANAGEMENT TRAINING. ECUADOR HEALTH PROJECT

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(518-0015) INCLUDES A COMPONENT FOR MANAGEMENT TRAINING. THIS PROJECT RUNS THRU LATE 1986. WE STRONGLY ENDORSE NEED FOR MORE TA AND TRAINING IN THIS FIELD AND WE WOULD HOPE TO PARTICIPATE AS FULLY AS POSSIBLE WITHIN LIMITS OF EXISTING RESOURCES.

6. REGIONAL PROJECT SHOULD SPECIFICALLY PROVIDE BUDGET FOR PRODUCING TRAINING MATERIALS, PROTOCOLS, INFORMATION REPORTS AND OTHER PUBLICATIONS IN THE SPANISH LANGUAGE. YOU WILL RECALL THE CONCERN EXPRESSED AT LAC HEALTH OFFICERS MEETING THAT MUCH VALUABLE INFORMATION NOW EXISTING (I.E., MEDEX SERIES, AUPHA MANAGEMENT ASSESSMENT MODULES, WATER FOR THE WORLD, TECHNICAL NOTES, ETC.) IS ONLY MINIMALLY USEFUL TO OUR COUNTERPARTS BECAUSE NO FUNDS WERE PROVIDED FOR TRANSLATION INTO SPANISH. IT IS ESSENTIAL TO SPECIFICALLY PLAN AND BUDGET FOR THIS PURPOSE.

7. PLEASE ADVISE ANTICIPATED PROJECT REVIEW SCHEDULE AND DATE WHEN RESOURCES WILL BE AVAILABLE TO THE FIELD. IN PARTICULAR, WHEN WOULD TRAINING COURSES IN MALARIA BE INITIATED, AND WHEN WILL POOL OF TA ON HMOS BE AVAILABLE TO THE FIELD.
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ADM AID

FOR: LAC/DR/HN

E.O. 12356: N/A
SUBJECT: HEALTH: LAC REGIONAL HEALTH PROJECT

REF: STATE 031554

1. MISSION IS PROVIDING COMMENTS AS REQUESTED IN REFTEL, ALTHOUGH GUYANA IS CURRENTLY INELIGIBLE FOR THE ASSISTANCE WHICH MAY BECOME AVAILABLE DUE TO FAA 620Q RESTRICTIONS.

2. THE TWO COMPONENTS, MALARIA CONTROL AND ESSENTIAL DRUGS, WOULD BE OF TREMENDOUS BENEFIT TO GUYANA. GUYANA HS FOR THE LAST FOUR YEARS BEEN EXPERIENCING A RESURGENCE OF MALARIA INCIDENCE AFTER TOTAL ERADICATION IN THE LATE 50'S EARLY 60'S MOST OF THE INCIDENCE OCCURS IN THE BORDER AREAS AND ARE PRIMARILY VIVAX, ALTHOUGH FALCIPARUM HAS BEEN OBSERVED IN ISOLATED CASES, USUALLY IMPORTED FROM BRAZIL OR VENEZUELA. RECENTLY CASES HAVE BEEN IDENTIFIED ON THE OCASTLAND BUT THESE HAVE ALSO BEEN IMPORTED. FORTUNATELY SO FAR THE VECTOR IS NOT PRESENT ON THE COASTLAND, BUT EFFORTS AT CONTROL AND ERADICATION IN THE INTERIOR AREAS HAVE BEEN LARGELY INEFFECTIVE OVER THE LAST FOUR YEARS. SEVERAL REASONS HAVE BEEN ADVANCED FOR THIS. PRIME AMONGST THESE ARE INEFFECTUAL MANAGEMENT OF THEPROGRAM, VECTOR RESISTANCE TO INSECTICIDES, LACK OF TRANSPORTATION, AND LACK OF FOREIGN EXCHANGE FOR PURCHASING SPRAYING EQUIPMENT AND MATERIALS. WERE GUYANA ELEIGIBLE FOR ASSISTANCE UNDER THE PROJECT, A PLEA WOULD HAVE BEEN MADE FOR TECHNICAL ASSISTANCE AND FOR ENGLISH LANGUAGE PARTICIPANT TRAINING. ASIDE FROM THIS MISSION FINDS THE PROPOSED ACTIVITES IDEALLY SUITED AS AN INTERVENTION FOR GUYANA'S MALARIA PROBLEMS.

3. MISSION IS CURRENTLY PROCURING DOLLARS 250,000 WORTH OF ESSENTIAL DRUGS FOR THE GUYANA MOH IN ORDER TO BOOST THE SUPPLY SITUATION. WHILE THE MOH HAS HAD COMMENDABLE SUCCESS IN ACQUIRING DONATIONS FROM FRIENDLY COUNTRIES, ANDHPURCHASES AT LOW PRICES FROM NON TRADITIONAL SOURCES, THE CURRENT FOREIGN EXCHANGE DIFFICULTIES CAN ONLY CONTINUE TO EXACERBATE AN ALREADY UNSATISFACTORY SITUATION WITH REGARD TO DRUG AVAILABILITY. TECHNICAL ASSISTANCE PROVIDED TO THE MOH IN DECEMBER 1984 FOR SELECTION OF THE DRUGS TO BE PROCURED IDENTIFIED AS A POTENTIAL PROBLEM THE LACK OF CURRENT, UP TO DATE INFORMATION ON DRUG CONTRAINDICATIONS WHICH MAY BECOME AVAILABLE AFTER THE DRUG HAS BEEN ON THE MARKE FOR SEVERAL YEARS. THUS, MOH STILL HAD ON ITS LIST OF ESSENTIAL DRUGS ITEMS WHICH WERE NO LONGER IN USE IN THE US OR WHICH WERE NOT RECOMMENDED THERE IS A CLEAR CRITICAL NEED FOR THE MOH AND GUYANA TO MANAGE LIMITED FOREIGN EXCHANGE AVAILABLE FOR DRUGS IN ORDER TO OBTAIN THE GREATEST BENEFIT ECONOMICALLY AND HEALTH-WISE. THE PROPOSED ACTIVITES UNDER THIS COMPONENT WOULD, THEREFORE, BE USEFUL TO GUYANA.

4. HEALTH SERVICES FINANCING IS AN AREA TO WHICH NO GREAT ATTENTION HAS BEEN PAID BY MOH. ALTHOUGH REDUCING RECURRENT

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BUDGETS HAVE POSED SEVERE PROBLEM. IN THE LAST YEAR FEES FROM SOME BASIC CARE AT MINISTRY HOSPITALS AND HEALTH CENTRES WERE INSTITUTED. THESE FEES ARE NOMINAL ONLY AND WERE PERHAPS INTENDED ONLY TO REMOVE THE "TAINT" OF FREENESS. HOWEVER, MISSION SEES IT AS A SIGNIFICANT STEP IN THE RIGHT DIRECTION AND ONE WHICH WE WOULD HAVE LIKED TO BUILD ON. CURRENTLY THERE IS A NATIONAL SOCIAL SECURITY INSURANCE TO WHICH EVERY EMPLOYEE CONTRIBUTES AND SEVERAL GROUP HEALTH INSURANCE SCHEMES WHICH PRIVATE INSURANCE COMPANIES TO WHICH MANY EMPLOYERS CONTRIBUTE FOR THEIR EMPLOYEES. THE MOH DOES NOT NOW BENEFIT FROM PAYMENTS FOR SERVICES RENDERED AT ITS FACILITIES TO NATIONAL INSURANCE COVERED EMPLOYEES. PROPOSALS TO EFFECT THIS HAVE BEEN MADE BUT NO DECISIONS HAVE RESULTED, PERHAPS DUE TO THE FACT THAT NATIONAL INSURANCE IS GOVERNMENT OWNED AS ARE MOST OF THE HEALTH FACILITIES IN THE COUNTRY.

5. MISSION HAS SUBSTANTIALLY ADDRESSED THE NEED FOR MANAGEMENT AND CLINICAL TRAINING IN THE MOH THRU THE ON GOING RURAL HEALTH SYSTEMS PROJECT. THE PRIVATE SECTOR HAS BEEN EXCLUDED HERE, BUT THOUGH NOT LARGE, IT PLAYS AN INCREASINGLY IMPORTANT ROLE IN HEALTH CARE DELIVERY PARTICULARLY IN THE URBAN AREAS.

6. FOR GUYANA THE RELATIVE PRIORITIES OF THE FOUR PROJECT COMPONENTS WOULD BE FIRSTLY, MALARIA; SECONDLY, EQUAL PRIORITY TO STUDYING HELATH SERVICES FINANCING AND IMPROVING ESSENTIAL DRUG SELECTION, PROCUREMENT AND MANAGEMENT, AS THEY BOTH IMPACT ON THE DIRE FOREIGN EXCHANGE AND RECURRENT BUDGET SHORTAGES; AND LEAST PRIORITY TO MANAGEMENT AND CLINICAL TRAINING SINCE MUCH HAS ALREADY BEEN DONE, AND THE GROUND WORK IS LAID FOR CONTINUING THIS WITH LOCAL RESOURCES.

7. AS MENTIONED IN PARA 1, MISSION UNLIKELY TO PARTICIPATE DUE FIRSTLY TO COUNTRY PROGRAM BEING CLOSED ON JUNE 30, AND SECONDLY CONTINUING RESTRICTION OF FAA 620Q ON NEW ASSISTANCE TO GUYANA.
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FOR LAC/DR/HN

E.O. 12356: N/A
SUBJECT: HEALTH: LAC REGIONAL HEALTH PROJECTS

REF: STATE 031554

1. MISSION COMMENTS ON PROPOSED LAC REGIONAL HEALTH PROJECT FOLLOW.

2. MALARIA CONTROL: MISSION STRATEGY, EXCEPT FOR THE POPULATION PROGRAM AND THE CURRENTLY UNDER DEVELOPMENT CHILD SURVIVAL/IMMUNIZATION PROGRAM HAS BEEN TO CONCENTRATE IN THE INDIAN AREAS, THE HIGHLANDS, WHERE MALARIA DOES NOT OCCUR AS A BASIC HEALTH PROBLEM DUE TO THE ALTITUDE. THE MAJORITY OF THE POPULATION OF GUATEMALA IS CROWDED INTO THE HIGHLANDS AND GUATEMALA CITY, ANOTHER PLACE WHERE THE ALTITUDE PRECLUDES THE OCCURRENCE OF MALARIA AS A MAJOR HEALTH PROBLEM. HOWEVER, THE MISSION WOULD BE PLEASED TO PUBLICIZE THE PROGRAM IN THE APPROPRIATE QUARTERS AND COOPERATE IN FINDING USES FOR THE TECHNICAL ASSISTANCE AND PARTICIPANTS FOR THE TRAINING COURSES. THE EXISTING MOH MALARIA SERVICE STILL ENJOYS A GOOD REPUTATION ALTHOUGH THEY ARE CONSIDERABLY UNDERFUNDED. THE MISSION REGARDS SUCH A PROGRAM AS HIGH PRIORITY FOR GUATEMALA BUT WOULD NOT EXPECT TO BE DIRECTLY INVOLVED IN THE SAME ACTIVITY. MISSION PREFERS NOT TO COMMENT ON PAHO INVOLVEMENT IN THIS ACTIVITY UNTIL WE UNDERSTAND MORE CLEARLY THE SPECIFICS OF THEIR ROLE.

3. ESSENTIAL DRUGS: THE MISSION STRONGLY SUPPORTS THIS ACTIVITY. AVAILABILITY OF MEDICINES TO THE PUBLIC HAS BEEN A PRIORITY ITEM FOR THE CURRENT GOVERNMENT. FOREIGN CURRENCY HAS GENERALLY BEEN MADE AVAILABLE FOR PURCHASES OF THE NECESSARY MATERIALS, EVEN THOUGH THE FOREIGN EXCHANGE SHORTAGE IS A MAJOR PROBLEM. ALTHOUGH THE MISSION KEEPS TABS ON THE SITUATION ONLY IN AN INFORMAL MANNER, WE ARE NOT AWARE OF MAJOR CURRENT SCARCITIES OF ESSENTIAL DRUGS.

FOR ITS PART, THE MOH HAS NOT REDUCED ITS BUDGET FOR THE PURCHASE OF ESSENTIAL MEDICINES, ALTHOUGH THAT BUDGET HAS BEEN INADEQUATE FOR THE PAST SEVERAL YEARS TO BEGIN WITH. WE SUPPORT THE PROPOSED ACTIVITIES, BUT MUST NOTE THAT THE MISSION FOCUSED INTENSIVELY ON SEVERAL ASPECTS OF THE MOH MEDICINES SYSTEM WITH STRONG INVOLVEMENT AND SUPPORT BY CDC AND OTHER SOURCES TO LITTLE AVAIL. AS YOU WILL NOTE FROM THE QUARTERLY REPORTS PERTAINING TO HEALTH PROJECT 520-0251, WE HAVE HAD TO FASHION AN INDEPENDENT PURCHASING AND DISTRIBUTION SYSTEM SO THE PROJECT TRAINED MIDWIVES AND PROMOTERS CAN BE EFFECTIVELY RESUPPLIED. BEARING THE PREVIOUSLY NOTED RESISTANCE IN MIND, THE MISSION IS VERY PLEASED TO

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SUPPORT THE PROPOSED ACTIVITIES, SEEING THEM AS ANOTHER WAY OF TRYING TO ATTACK THIS MOH PROBLEM.

AS WITH THE MALARIA COMPONENT, MISSION PREFERS TO HOLD COMMENTS ON PAHO INVOLVEMENT UNTIL MORE INFORMATION IS AVAILABLE.

4. HEALTH SERVICES FINANCING: MISSION IS IN FULL AGREEMENT, AND AS YOU KNOW FROM THE HEALTH OFFICER'S CONFERENCE, HAS BEEN EXPLORING OTHER ALTERNATIVES. THIS COMPONENT IS HIGH PRIORITY FOR THE MISSION AND IT IS VERY LIKELY THAT WE WILL EXERCISE THE BUY-IN OPTION ON THE TA.

5. MANAGEMENT AND CLINICAL TRAINING: MISSION IS IN AGREEMENT AND CONSIDERS THIS SECOND IN PRIORITY ONLY TO THE HEALTH SERVICES FINANCING COMPONENT.
6. MISSION WISHES TO KNOW WHAT THE LINKAGES WILL BE BETWEEN THE TRAINING ACTIVITIES UNDER ALL COMPONENTS AND THE CENTRAL AMERICAN PEACE SCHOLARSHIP PROJECT (CAPS) DESCRIBED IN DRAFT IN GUATE 01857. CAN THESE TRAINING ACTIVITIES BE COORDINATED OR MERGED? IS FUNDING DUPLICATED? WE WOULD APPRECIATE YOUR COMMENTS.

WE APPRECIATE BEING KEPT INFORMED ON THESE FOUR REGIONAL HEALTH PROJECTS. PIEDRA

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ADM AID

FOR LAC/DR/HN

E.O. 12356: N/A
SUBJECT: HEALTH: LAC REGIONAL HEALTH PROJECTS

REF: STATE 031554

1. MISSION SUPPORTS OVERALL PROJECT THRUST AND NOTES THAT THE PROPOSAL COMPLEMENTS ASPECTS OF MISSION'S HEALTH SECTOR I PROJECT.

2. PER PARA 16 A - RELATIVE PRIORITY - MISSION WOULD GIVE PRIORITY RANKING, GIVEN ITS ONGOING ACTIVITIES IN THESE AREAS, AS FOLLOWS FROM HIGHEST TO LOWEST: MALARIA, ESSENTIAL DRUGS, HEALTH SERVICES FINANCING AND, FINALLY, MANAGEMENT AND CLINICAL TRAINING.

3. PER PARA 16 B - IMPORTANT ACTIVITIES WHICH HAVE BEEN OMITTED - MISSION HAS NOT IDENTIFIED ANY ADDITIONAL AREAS WHICH ARE NOT ALREADY COVERED UNDER MISSION PROJECTS.

4. PER PARA 16 C - LIKELY MISSION PARTICIPATION - MISSION WOULD ANTICIPATE PARTICIPATING IN THE PROJECT. DEGREE AND TYPE OF PARTICIPATION WOULD DEPEND ON AVAILABILITY OF THE SAME RESOURCES FROM THE MISSION'S OWN PORTFOLIO PARTICULARLY THE HEALTH SECTOR I PROJECT. THERE ARE ASPECTS OF ALL PROJECT COMPONENTS, HOWEVER, THAT THE MISSION WOULD ANTICIPATE TAPPING INTO.

5. PER PARA 16 D - LIKELY MISSION FINANCIAL SUPPORT - MISSION WOULD BE LIKELY TO PROVIDE THE NEEDED FINANCIAL SUPPORT IN ALL THE INDICATED AREAS.

6. FOR PARA 17 - PROPOSED PAHO ROLE - MISSION CONCURS THAT PAHO IS IN BEST POSITION FOR IMPLEMENTING THOSE COMPONENTS GIVEN ITS WELL ESTABLISHED POSITION IN THE MOH'S. HOPEFULLY, THE PROJECT CAN SERVE AS A CATALYST FOR IMPROVED COORDINATION/COMMUNICATION AT THE COUNTRY LEVEL BETWEEN AID AND PAHO. NEGROPONTE

1. Chief
2. Notebook

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FOR LAC/DR/HN

E.O. 12356: N/A
SUBJECT: HEALTH: LAC REGIONAL HEALTH PROJECTS

REF: STATE 031554

1. USAID/JAMAICA WELCOMES THE PROPOSED LAC REGIONAL HEALTH PROJECT AND IS INTERESTED IN RECEIVING ASSISTANCE, PARTICULARLY [redacted] COMPONENT NO. 3, HEALTH SERVICES FINANCING. WE CONSIDER THIS COMPONENT AS A PRIORITY FOR JAMAICA.

2. USAID/JAMAICA HAS INITIATED DIALOGUE WITH MOH TO EXPLORE ALTERNATIVE MECHANISMS FOR HEALTH CARE FINANCING. MOH IS ENTHUSIASTIC AND HAS ENTERTAINED OFFERS FROM SEVERAL US-BASED HMO'S. A SPECIAL, HIGH-LEVEL TASK FORCE HAS BEEN ESTABLISHED TO SUGGEST ALTERNATIVES FOR HEALTH FINANCING, AND RECENT MEASURES HAVE BEEN TAKEN BY MOH TO INTRODUCE FEES FOR SERVICE AS WELL AS TO CONSOLIDATE (RATIONALIZE) SMALL, RURAL HOSPITAL FACILITIES. DESPITE THESE EFFORTS, THERE REMAINS A NEED TO CONDUCT STUDIES RELATED TO SUCH AREAS AS HEALTH CARE COST AND HMO FEASIBILITY. TECHNICAL ASSISTANCE IS ALSO REQUIRED.

3. PENDING DETERMINATION OF AVAILABLE FUNDING UNDER EXISTING BILATERAL LOAN AGREEMENT, MISSION AND GOJ WOULD CONSIDER BUY-IN TO THE PROPOSED LAC PROJECT.
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E.O. 12356: N/A
TAGS:
SUBJECT: HEALTH: LAC REGIONAL HEALTH PROJECTS

REF: 1) STATE 031544 2) BRASILIA 001344

AID/MEXICO ECHOES BRASILIA'S RESPONSE AND WE ARE MOST DISAPPOINTED THAT WE WERE NOT INCLUDED IN THE LAC REGIONAL HEALTH PROJECT. GAVIN

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E.O. 12356: N/A
SUBJECT: HEALTH: LAC REGIONAL HEALTH PROJECTS

REF: STATE 031554

1. THIS CABLE IS IN RESPONSE TO REFTEL SOLICITING MISSION REACTION TO PROPOSED LAC REGIONAL HEALTH PROJECT.

2. FYI, THE MISSION TERMINATED HEALTH SUPPORT TO PANAMA WITH THE COMPLETION OF THE HEALTH LOAN PROJECT IN 1982 AND HAS NO BILATERAL HEALTH PROGRAM. FOLLOWING SEVERAL YEARS OF ASSISTANCE AND SATISFACTORY RESULTS, PANAMA HAS REACHED A RELATIVELY WELL-DEVELOPED STATE OF HEALTH SERVICES. THIS WAS NOTED IN THE NATIONAL BI-PARTISAN COMMISSION REPORT IN CITING COMPARATIVE HEALTH INDICATORS IN THE CA REGION. THEREFORE, HEALTH NO LONGER HAS HIGH PRIORITY IN THE USAID ASSISTANCE STRATEGY. WHILE THE MISSION DOES NOT RULE OUT OCCASIONAL NEED FOR SPECIAL TECHNICAL ASSISTANCE, DRUG PRICES AND DISTRIBUTION INFORMATION, AND PARTICIPANT TRAINING IN THE HEALTH AREA, THE MISSION DOES NOT VIEW ALL ACTIVITIES PROPOSED IN THE LAC REGIONAL HEALTH PROJECT AS APPROPRIATE FOR INCLUSION IN AID ASSISTANCE TO PANAMA.

3. THE MISSION'S REACTIONS TO THE FOUR COMPONENTS PROPOSED UNDER THE SUBJECT PROJECT ARE AS FOLLOWS:

A. MALARIA CONTROL

PANAMA EXPERIENCED AN ALL TIME LOW OF 126 CASES IN THE PAST YEAR AND THESE CASES WERE LARGELY OF COLOMBIAN ORIGIN. THE PAN AMERICAN HEALTH ORGANIZATION (PAHO) CURRENTLY HAS A STAFF OF THREE MALARIA EXPERTS WHO OFFER TECHNICAL ASSISTANCE AND TRAINING IN THE LAC REGION. IN PART, PAHO IS ALREADY DOING WHAT THE SUBJECT PROJECT PROPOSES. ALSO THERE ARE THREE INSTITUTIONS IN PANAMA THAT HAVE MEDICAL ENTOMOLOGISTS IN ADDITION TO THE U.S. MILITARY: 1) GORGAS MEMORIAL LABORATORY, 2) UNIVERSITY OF PANAMA AND, 3) PANAMA CANAL COMMISSION. THEREFORE SELECTING AN INSTITUTION IN PANAMA, AS SUGGESTED IN THE PROPOSED PROJECT, TO SERVE AS A REGIONAL BASE FOR TECHNICAL ASSISTANCE AND TRAINING ON MALARIA RELATED TOPICS, WOULD SEEM APPROPRIATE AND USEFUL FOR THE CA AND PANAMA REGION. PROVISION OF SOME REGIONAL TA AND TRAINING UNDER THE PROJECT WOULD BE DESIRABLE TO EXPAND AND IMPROVE ON-GOING PAHO ACTIVITIES.

B. ESSENTIAL DRUGS

MISSION RECOMMENDS THAT AID/W CONSIDER THE ASSIGNMENT OF THIS COMPONENT TO U.S. HEALTH DEVELOPMENT ORGANIZATIONS, I.E., MANAGEMENT SCIENCES FOR HEALTH, PRITECH, WESTINGHOUSE HEALTH SYSTEMS, PRICOR, ETC. THESE HEALTH DEVELOPMENT ORGANIZATIONS ALREADY HAVE WELL ESTABLISHED [illegible] FACILITIES FOR PROCUREMENT, DISTRIBUTION, WAREHOUSING AND SO ON.

C. HEALTH SERVICES FINANCING

THE MISSION ANTICIPATES THAT THE PROJECT MAY RECEIVE OCCASIONAL REQUESTS FOR CONSULTANTS FOR THIS TYPE OF SERVICE. SUCH SUPPORT SHOULD BE PROVIDED WITHIN PROJECT FUNDS AS NO MISSION BUY-IN INTO THIS ACTIVITY IS PLANNED.

D. MANAGEMENT AND CLINICAL TRAINING

SUPPORT OF APPROPRIATE U.S. TRAINING INSTITUTIONS FOR PARTICIPANT TRAINING AND ATTENDANCE OF HEALTH OFFICIALS IN REGIONAL WORKSHOPS ARE VIEWED AS USEFUL FOR PANAMA. PARTICIPANT TRAINING IS A HIGH PRIORITY AREA, ESPECIALLY IN SPECIALIZED HEALTH PROGRAMS.

4. PROPOSED ROLE FOR PAHO

FROM USAID EXPERIENCE WITH PAHO WE SUGGEST THAT IT MAY BE PRUDENT TO ESTABLISH CLEAR, MANDATORY REPORTING AND COORDINATING CRITERIA FOR THAT AGENCY. SUCH CRITERIA BECOME ESPECIALLY NECESSARY IN LIGHT OF THE INABILITY OF THE USAID/PANAMA TO PROVIDE QUALIFIED PERSONNEL TO CLEAR ON OR EVALUATE PAHO PERFORMANCE. WE SUGGEST THAT AID/W DESIGNATE ROCAP OR AN AID/W OFFICE TO PROVIDE SUPPORT TO THE PROJECT.

5. USAID SUPPORT FOR PARTICIPANT TRAINING

FINALLY, WHILE THE USAID MISSION DOES NOT PRESENTLY HAVE FUNDS TO SUPPORT PARTICIPANT TRAINING, UNDER THE MALARIA CONTROL AND ESSENTIAL DRUGS COMPONENTS WE WOULD SUPPORT SUCH PARTICIPANT TRAINING AS FUNDS BECOME AVAILABLE UNDER THE CARIBBEAN LATIN AMERICAN SCHOLARSHIP PROGRAM.
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FOR LAC/DR/HN

E.O. 12356: N/A
SUBJECT: HEALTH: LAC REGIONAL HEALTH PROJECT

REF: STATE 031554

1. SUMMARY: USAID/PERU SUPPORTS LAC REGIONAL HEALTH PROJECT, AND IS PLEASED TO NOTE STRONG PAHO PARTICIPATION. WE REGRET THAT PERU IS NOT INCLUDED IN FIRST TWO COMPONENTS FOR MALARIA AND ESSENTIAL MEDICINES AS THESE ARE AREAS OF HIGH CONCERN TO BOTH PERUVIAN MOH AND USAID. OF THE LATTER TWO COMPONENTS MANAGEMENT AND CLINICAL TRATNING IS HIGHER PRIORITY. AS LAC KNOWS A MAJOR MISSION FINANCED HEALTH SECTOR ANALYSIS IS UNDERWAY THAT WILL ADDRESS HEALTH SERVICES FINANCING ISSUES. THEREFORE, WE DO NOT ANTICIPATE BUY-INS FOR TA. SPECIFIC COMMENTS FOR EACH COMPONENT FOLLOW.

2. MALARIA CONTROL PERU IS EXPERIENCING A RESURGENCE IN MALARIA. RELIABLE DATA ON THE INCIDENCE OF MALARIA, HOWEVER, ARE NOT AVAILABLE BECAUSE MOH UNITS CHARGED WITH DIAGNOSIS AND SURVEILLANCE ARE VERY WEAK OR NON-FUNCTIONAL. OF PARTICULAR CONCERN IS THE SPREAD OF THE MORE DEADLY PLASMODUM FALCIPARUM MALARIA WHICH HAS BEEN REPORTED IN AREAS BORDERING BRAZIL, COLOMBIA, AND ECUADOR. IN HIS REPORT OF NOVEMBER 1983, KENT CAMPBELL OF CDC IDENTIFIED RAINFALL AS A PRINCIPAL FACTOR INFLUENCING MALARIA TRANSMISSION IN PERU. RAINS IN THE NORTHERN DESERT CAUSED BY THE EL NINO DISASTER IN 1983 RESULTED IN INCREASES IN INSECT POPULATIONS OF THE AREA (INCLUDING MALARIA VECTORS). THE DIAGNOSIS OF P. FALCIPARUM IN TUMBES ON THE ECUADOR BORDER LAST YEAR IS A CONCERN. IT IS ALSO FEARED THAT CHLOROQUINE RESISTANT STRAINS OF MALARIA WILL SOON APPEAR IN PERU ON THE NORTHERN BORDER. A PAHO MEETING HELD IN LIMA, NOVEMBER 28 TO 30, 1984 BROUGHT TOGETHER MALARIA TECHNICIANS FROM THE ANDEAN REGION AND RESULTED IN A SERIES OF RECOMMENDATIONS TO ANDEAN HEALTH MINISTERS FOR PLANNING A SUB-REGIONAL MALARIA PROJECT. USAID RECOMMENDS THAT THIS ANDEAN INITIATIVE BE SUPPORTED BY THE LAC PROJECT, INCLUDING TA AND TRAINING. RATHER THAN LIMIT THE MALARIA CONTROL COMPONENT TO CENTRAL AMERICA, WE URGE LAC TO INCLUDE THE ANDEAN REGION INCLUDING PERU FOR BOTH TA AND TRAINING, PARTICULARLY IN DIAGNOSIS AND SURVEILLANCE.

3. ESSENTIAL DRUGS. SUGGEST YOU CHANGE TITLE TO ESSENTIAL MEDICINES OR PHARMACEUTICALS AS THE WORD DRUGS HAS OTHER CONNOTATIONS IN THIS REGION. USAID PROVIDES TRAINING AND MATERIALS TO MOH PHARMACY DIRECTORATE IN

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SUPPORT OF PERUVIAN ESSENTIAL MEDICINES PROGRAM. A 1983 USAID STUDY ON POTENTIAL HEALTH INTERVENTIONS IN THE PRIVATE SECTOR RESULTED IN A PROPOSAL SUBMITTED TO USAID THIS MONTH BY THE US AND PERUVIAN DAUGHTERS OF CHARITY. THE DAUGHTERS PROPOSE TO CREATE A NETWORK OF HEALTH PVO'S BY ESTABLISHING THREE RESOURCE CENTERS IN PERU TO COORDINATE, TRAIN STAFF AND SHARE MATERIALS ON PHC SERVICE DELIVERY. THE PROJECT INCLUDES A SYSTEM FOR PURCHASING AND DISTRIBUTING PHARMACEUTICAL PRODUCTS. IN ADDITION TO MEDICINES THE GROUP PLANS TO PURCHASE OTHER HEALTH CENTER SUPPLIES. IT MIGHT BE COST-EFFECTIVE TO INCLUDE SELECTED SUPPLIES IN THE LAC PROJECT VENDOR PRICING NETWORK. THE LAC PROJECT WOULD ALLOW US TO CONTINUE TRAINING SUPPORT TO THE MOH AND PERHAPS TO SOME MEMBERS OF THE PVO NETWORK PROJECT. WE REGRET THAT TA TO THESE GROUPS WILL NOT BE AVAILABLE. WE URGE AID/W TO SEND QUOTE UNBIASED DRUG THERAPY INFORMATION UNQUOTE TO KEY INDIVIDUALS AND USAID HEALTH OFFICERS IN ALL LAC COUNTRIES. PLEASE INCLUDE IN THE PROJECT DESIGN SOME MECHANISM FOR SHARING LESSONS LEARNED FROM THE VENDOR PRICING NETWORK WITH ALL LAC COUNTRIES.

4. HEALTH SERVICES FINANCING. USAID ENDORSES THIS APPROACH TO IMPROVE HEALTH RESOURCE ALLOCATION AND SYSTEM EFFICIENCIES AND WILL ADDRESS FINANCIAL AND ECONOMIC ISSUES IN ITS HEALTH SECTOR ANALYSIS. USAID CAUTIONS THAT THE AMOUNT OF TA AND NUMBER OF STUDIES PROPOSED IN THE REGIONAL PROJECT APPEAR VERY LIMITED GIVEN THE COMPREHENSIVE NATURE OF ANALYZING HEALTH SECTOR RESOURCES AND BUDGET ALLOCATIONS, I.E. THE GATHERING OF UNIT COST DATA IS PARTICULARLY DIFFICULT AND TIME CONSUMING. CONSULTANTS WITH SPANISH LANGUAGE SKILLS AND APPROPRIATE EXPERTISE MAY ALSO BE DIFFICULT TO FIND IF OUR EXPERIENCE IS ANY INDICATION. USAID WOULD LIKE TO PARTICIPATE IN SUB-REGIONAL MEETINGS OR PROMOTIONAL VISITS TO SHARE EXPERIENCES ON ALTERNATIVE FINANCING OF HEALTH DELIVERY SYSTEMS. WE SUGGEST THAT STUDIES AND PROJECTS DEVELOPED UNDER THIS COMPONENT BE DISTRIBUTED TO ALL USAIDS (IN ENGLISH AND SPANISH).

5. MANAGEMENT AND CLINICAL TRAINING. THERE IS AN URGENT NEED TO IMPROVE MANAGERIAL SKILLS OF MOH STAFF, PARTICULARLY REGIONAL AND HOSPITAL AREA DIRECTORS. MORE TRAINING IS ALSO REQUIRED IN COMMUNITY MEDICINE, PHC AND PUBLIC HEALTH. A COMPREHENSIVE TRAINING PLAN OUTLINING THE NEEDS AND RECOMMENDING SPECIFIC TRAINING COURSES IS BEING DEVELOPED AT THIS TIME BY THE WESTINGHOUSE TA TEAM WORKING WITH THE MOH/USAID PROJECTS. AS YOU KNOW WE HAVE EXPERIENCE SENDING STUDENTS TO JOHN HOPKINS UNIVERSITY FOR MPH DEGREES. THE LAC PROJECT COULD ASSIST US IN IDENTIFYING OTHER APPROPRIATE TRAINING INSTITUTIONS AND FACILITATING PLACEMENT OF STUDENTS. WE ANTICIPATE A HIGH DEGREE OF PERUVIAN PARTICIPATION IN THIS PROJECT COMPONENT.

6. PLEASE ADVISE PROJECT REVIEW SCHEDULE AND START-UP DATES FOR TRAINING COMPONENTS. JORDAN

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ANNEX J

APPENDIX 5A
HANDBOOK 13
(TM 13:24)
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SAMPLE FORMAT

(Appropriate Letterhead)

(date)

Mr. John Doe
Title of Authorized Organization Representative
Name of International Organization
Address

Subject: Grant No._____; AID Accounting and Appropriation Data;

_____;

PIO/T No._____

Dear Mr. Doe:

1. I have the honor to refer to your letter request of _____(date)_____ relating to _____(brief title of program)_____.

2. I am pleased to inform you that, pursuant to the authority contained in the Foreign Assistance Act of 1961, as amended, the Government of the United States of America, acting through the Agency for International Development (hereinafter referred to as AID) hereby grants to _____(grantee's name)_____ (hereinafter referred to as the Grantee) the sum of _____(amount)_____ United Stated Dollars ($XXXXX), to be used for support of _____(general description of program)_____, as more fully described in Attachment A.

3. This Grant is effective as of the date of this letter and is applicable to commitments made by the Grantee in support of the program during the period _____(date)_____ through _____(date)_____. Funds disbursed by AID but uncommitted by the Grantee at the expiration of this period shall be refunded to AID.

4. It is understood that financial records, including documentation to support entries on accounting records and to substantiate changes against this Grant shall be maintained in accordance with the Grantee's usual accounting procedures, which shall follow generally accepted accounting practices. All such financial records shall be maintained for at least 3 years after final disbursement of funds under this Grant.

Select only one of the two following paragraphs.

5. The Grantee confirms that this program will be subject to an independent audit by the Grantee's outside certified or chartered public accountant and agrees to furnish copies of these audit reports to AID along with such other related information as may be requested by AID with respect to questions arising from the audit report. *1

or

5. The Grantee agrees to make available to AID for the Comptroller General of the United States all records and documents which support expenditures made under this program. *2

6. It is understood that the funds granted hereunder shall be disbursed as set forth in Attachment B hereto entitled Payment Provisions.

7. The parties agree that this grant and the activities financed therewith, shall be managed by the Grantee in accordance with its established policies and procedures. The proposed budget for this Grant (indicating other donors) is provided in Attachment C.

8. If the use of the Grant funds results in the accrual of interest to the Grantee or to any other person to whom the Grantee makes such funds available in carrying out the purposes of this Grant, the Grantee shall refund to AID any amount of interest earned.

9. The Grantee shall prepare and submit to AID at least _____ copies of reports in accordance with the schedule set forth in Attachment D.

10. This agreement, in whole or in part, may be terminated by either party at any time upon 30 days written notice. This agreement may be revised only by the written mutual consent of the parties hereto.

11. Please indicate your acceptance of this Grant by signing the original and _____ copies of this letter in the space provided below and return the original and _____ copies to the Grant Officer. Two copies may be retained for your files.

12. The AID Technical Office responsible for monitoring this Grant is _____.

THE UNITED STATES OF AMERICA

BY:_____

TITLE:_____

DATE:_____

Attachments:
A. Purpose and Implementation Plan
B. Payment Provisions *3 and *4
C. Budget *5
D. Reporting Requirements *6

ACCEPTED:

PUBLIC INTERNATIONAL ORGANIZATION

BY:_____

TITLE:_____

DATE:_____

NOTES:

*1 Use this language when AID is not the sole or major contributor. (See 16C3(2)(c) of Supplement B, Handbook 1).

*2 Use this language when funds for the program are solely from U.S. contributions or the U.S. is determined to be the major contributor (see 16C3(2)(c)) and Grantee is other than a U.N. department, since this option is not available for U.N. departments.

*3 The transfer of monies made available under grants to international organizations under this chapter is managed by M/FM. M/FM will review disbursements as monies are drawn-down and keep the appropriate Grant Officer informed. Payment procedures and provisions to be included in Attachment B to the grant are set forth in Appendix 5B or Appendix 5C to this Chapter.

* * New Material * *

*4 All correspondence concerning Letters of Credit, letters of transmittal and other transfer documents directed to designated banks and/or international organizations under the United Nations (U.N.) shall be forwarded through the responsible United States Mission. For grants to U.N. departments, transfers are effected through U.S. Mission to the United Nations, 799 U.N. Plaza, New York, N.Y. 10017.

*5 Inputs to each grant from other donors shall be shown on the budget page. The budget shall also make clear the amount included for overhead, if appropriate, or, for administrative support costs in the case of the U.N. departments.

*6 List all program and financial reports required and provide the addresses to which they are to be forwarded. This will include two copies of all technical reports to the Development Information Utilization Service, Bureau for Science and Technology (S&T/DIU), A.I.D., Washington, D.C. 20523. The title page of all technical reports forwarded to S&T/DIU shall include the grant number, project number, and project title as set forth on the first page of the grant. Attachment D to the grant may identify specific reports desired by AID, when AID is the sole contributor. If AID is not the sole contributor, requested reports will be limited to those normally issued by the grantee to all donors unless the grantee specifically agrees to do otherwise. Financial reporting requirements should be coordinated with the Office of Financial Management (M/FM).

*

* Revised Material

APPENDIX 5B

PAYMENT PROVISIONS: FEDERAL RESERVE LETTER OF CREDIT (FRLC) ADVANCE

This provision is applicable when the following conditions are met: (i) the total advances under all the Grantee's cost-reimbursement contracts and assistance instruments with AID exceed $120,000 per annum, (ii) AID has, or expects to have, a continuing relationship with the Grantee of at least one year; (iii) the Grantee has the ability to maintain procedures that will minimize the time elapsing between the transfer of funds and the disbursement thereof, (iv) the Grantee's financial management system meets generally accepted accounting standards for fund control and accountability, and, either (v) the foreign currency portion of the total advance under this grant is less than 50%; or (vi) the foreign currency portion of the total advance under this grant is more than 50%, but more than one foreign currency country is involved).

(a) AID shall open a Federal Reserve Letter of Credit (hereinafter referred to as an "FRLC") in the amount of funding obligated by this grant, against which the Grantee may draw cash only for immediate disbursing needs. The term "immediate disbursing needs" when applied to FRLC's is defined as the cash requirements for a three-day period. Any subgrantee funded by the Grantee from funds provided by this grant, shall obtain such funds from the Grantee only as needed for disbursement. The financial management system of the Grantee shall provide for effective control over and accountability for Federal funds in accordance with its usual procedures and generally accepted accounting practices.

(b) FRLC Operational Requirements

(1) The Grantee will select a commercial bank that agrees to receive payment vouchers, TFS Form 5401, "Payment Voucher on Letter of Credit," drawn on the U.S. Treasury and to forward such payment vouchers to the applicable Federal Reserve Bank or branch. The Grantee shall select a commercial bank that will credit the account of the Grantee at the time of presentation of the completed payment voucher. Immediate credit by the commercial bank will enable the Grantee to meet its responsibilities to draw cash only when actually needed for disbursements.

(2) After arranging with a commercial bank for operations under FRLC and obtaining the name and address of the Federal Reserve Bank or branch serving the commercial bank, the Grantee shall deliver to the AID Controller, three originals of Standard Form 1194, "Authorized Signature Card for Payment Vouchers on Letters of Credit," signed by those officials authorized to sign payment vouchers against the FRLC and by the designated official of the Grantee who has authority to specify individuals to sign payment vouchers. Only those officials whose signatures appear on the SF-1194 can sign the TFS Form 5401. New signature cards must be submitted whenever there is a change in the persons authorized to sign payment vouchers.

(3) The Grantee shall subsequently receive one certified copy of the Federal Reserve Letter of Credit, SF-1193. No payment vouchers shall be presented to the commercial bank before the FRLC is opened. The SF-1193 indicates the effective date the FRLC is opened.

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(4) As funds are required for immediate disbursement needs, the Grantee will submit a properly completed payment voucher (Form TFS 5401) to the commercial bank for transmission to the Federal Reserve Bank or branch. The commercial bank may at this time credit the account of the Grantee with the amount of funds being drawn down. Payment vouchers shall not ordinarily be submitted more frequently than daily and shall not be less than $5,000 or more than $5,000,000. In no event shall the accumulated total of all such payment vouchers exceed the amount of the FRLC.

(5) In preparing the payment voucher, the Grantee shall assign a voucher number in numerical sequence beginning with 1 and continuing in sequence on all subsequent payment vouchers submitted under the FRLC.

(6) After the first payment voucher (Form TFS 5401) has been processed, succeeding payment vouchers shall not be presented until the existing balance of previous drawdowns has been expended or is insufficient to meet current needs.

(c) FRLC Reporting

Fifteen days following the end of each calendar quarter, the Grantee shall submit, to the office designated in the grant letter, a report showing for that quarter the cash on hand at the beginning of the quarter plus cash drawn under the FRLC during the quarter, the amount of project disbursements, and cash remaining on hand at the end of the quarter. The Grantee will indicate the number of days cash requirements represented by the amount shown as cash remaining on hand.

(d) Suspension of FRLC

(1) If at any time, the AID Controller determines that the Grantee has failed to comply with the terms and conditions of the FRLC, the AID Controller shall advise the Grant Officer who may cause the FRLC to be suspended or revoked.

(2) The Controller may recommend suspension or revocation to the Grant Officer on the grounds of an unwillingness or inability of the Grantee to: (A) establish procedures that will minimize the time elapsing between cash drawdowns and the disbursement thereof, (B) timely report cash disbursements and balances as required by the terms of the grant and (C) impose the same standards of timing of advances and reporting on any subrecipient or any of the Grantee's overseas field organizations.

APPENDIX 5C

PAYMENT PROVISIONS: PERIODIC ADVANCES

(This provision is applicable when the conditions for use of an FRLC cannot be met (including those pertaining to mixed dollar and local currency advances) and when: (i) the Grantee has the ability to maintain procedures that will minimize the time elapsing between the transfer of funds and the disbursement thereof, and (ii) the Grantee's financial management system meets generally accepted accounting standards for fund control and accountability.

(a) Periodic advances shall be limited to the minimum amounts needed to meet current disbursement needs and shall be scheduled so that the funds are available to the Grantee as close as is administratively feasible to the actual disbursements by the Grantee for program costs. Cash advances made by the Grantee to secondary recipient organizations or the Grantee's field organizations shall conform substantially to the same standards of timing and amount as apply to cash advances by AID to the Grantee.

(b) Grantees shall submit requests for advances at least monthly to the office specified in the grant letter. Requests for advances shall state the estimated disbursements to be made during the period covered by the request, less the estimated balance of cash on hand at the beginning of the period and the advance amount being requested. At the expiration of the grant, the grantee will submit within 90 days a report showing total disbursements, total advances received and any cash remaining on hand, which will be refunded to AID.

(e) If at any time, the AID Controller determines that the Grantee has demonstrated an unwillingness or inability to: (1) establish procedures that will minimize the time elapsing between cash advances and the disbursement thereof, (2) timely report cash disbursements and balances as required by the terms of the grant, and (3) impose the same standards of timing of advances and reporting on any subrecipient or any of the Grantee's overseas field organizations; the AID Controller shall advise the Grant Officer who may suspend or revoke the advance payment procedure.