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

HAITI

PROJECT PAPER

HEALTH SYSTEM 2004

AID/LAC/P-927

PROJECT NUMBER: 521-0248

UNCLASSIFIED

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HAITI

HEALTH SYSTEM 2004

521-0248

PROJECT DATA SHEET

1. TRANSACTION CODE

A = Add
 C = Change
 D = Delete

Amendment Number

DOCUMENT CODE
3

2. COUNTRY/ENTITY

HAITI

3. PROJECT NUMBER

521-0248

4. BUREAU/OFFICE

LAC

5. PROJECT TITLE (maximum 40 characters)

HEALTH SYSTEM 2004

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY
01 31 0101

7. ESTIMATED DATE OF OBLIGATION

(Under "B:" below; enter 1, 2, 3, or 4)

A. Initial FY 1915

B. Quarter 2

C. Final FY 199

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

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total						
(Grant)	(3,000)	(2,000)	(5,000)	(27,165)	(22,835)	(50,000)
(Loan)	()	()	()	()	()	()
Other U.S.						
1.						
2.						
Host Country					1,590	1,590
Other Donor(s)						
TOTALS	3,000	2,000	5,000	27,165	24,425	51,590

9. SCHEDULE OF AID FUNDING (\$000)

A. APPRO-PR'ATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1)						5,000		50,000	
(2)									
(3)									
(4)									
TOTALS						5,000		50,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

11. SECONDARY PURPOSE CODE

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

A. Code

B. Amount

13. PROJECT PURPOSE (maximum 480 characters)

The purpose of this project is to ensure equitable access to basic and reproductive health services to Haitian families in a manner that can sustain over time.

14. SCHEDULED EVALUATIONS

Interim MM YY MM YY Final MM YY
 01 91 8

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000 941 Local Other (Specify) CACM

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

I have reviewed and approved the methods of implementation and financing for this Project Paper.

Jack Winn, FM Office Chief

7. APPROVED BY

Signature

Larry Crandall

Title

Director USAID/Haiti

Date Signed

MM DD YY
1 5 14 95

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

MM DD YY

USAID/HAITI

PROJECT PAPER

HEALTH SYSTEMS 2004

Project Number: 521-0248

REPUBLIC OF HAITI
HEALTH SYSTEMS 2004 PROJECT PAPER
(USAID Project No. 521-0248)

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GLOSSARY OF TERMS USED

Aba SIDA	:	Creole/French name for AIDS Control Project No. 521-0224
AIDS	:	Acquired Immuno-Deficiency Syndrome
AIDSCAP	:	USAID centrally-funded AIDS Control Project
AOPS	:	Association of Private Health Organizations (Association des Oeuvres Privées de Santé)
APDA	:	Awareness and Prevention of Drug Abuse Project No. 521-0221
CBD	:	Community Based Distribution (of contraceptives)
CDC	:	U.S. Centers for Disease Control
CDS	:	Centers for Development and Health (Centres pour le Developpement et la Santé)
CDSS	:	Country Development Strategy Statement
CHI	:	Child Health Institute (in French, IHE, or Institut Haitien de l'Enfance)
CONT	:	USAID/Haiti Controller's Office
CS	:	Child Survival
CY	:	Calendar Year
DA	:	Development Assistance Funds
EFS	:	Enhancing Food Security
EOPS	:	End of Project Status
ESF	:	Economic Support Funds
EUHS	:	Expanded Urban Health Services Project No. 521-0218
FP	:	Family Planning
FRLC	:	Federal Reserve Letter of Credit
FX	:	Foreign Exchange
FY	:	Fiscal Year
GHEKIO	:	Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections (Groupe Haitien d'Etude du Sarcome de Kaposi et des Infections Opportunistes)
GOH	:	Government of Haiti
HIV	:	Human Immuno-Deficiency Virus
HS2004	:	Health Systems 2004 (ou Haiti Santé 2004)
IEC	:	Information, Education, Communication
INHSAC	:	Haitian Community Health Institute (Institut Haitien de la Santé Communautaire)
IO	:	International Organization
LC	:	Local Costs
LOP	:	Life of Project
LT	:	Long-Term
MCH	:	Maternal and Child Health
MSPP	:	Ministry of Public Health and Population (Ministère de la Santé Public et la Population)
MWRA	:	Married Women of Reproductive Age
NGO	:	Non-Governmental Organization
NORPLANT ^R	:	5 Year Contraceptive Implant
ORT	:	Oral Rehydration Therapy
OYB	:	Operating Year Budget

GLOSSARY - Continued

P.L. 480	:	Public Law 480, the Agricultural Trade Development and Assistance Act of 1954, as amended
PACD	:	Project Assistance Completion Date
PAHO	:	Pan American Health Organization
PASA	:	Participating Agencies Services Agreement
PHNO	:	Population, Health, Nutrition Office
PID	:	Project Identification Document
PIL	:	Project Implementation Letter
PIO	:	Project Implementation Order
pm	:	Person Month
py	:	Person Year
POD	:	Program Operations Document
PP	:	Project Paper
ProAg	:	Project Agreement
PROFAMIL	:	IPPF-affiliated Private Family Planning Association in Haiti
PSC	:	Personal Services Contract(or)
PSFP	:	Private Sector Family Planning Project No. 521-0189
PVO	:	Private and Voluntary Organization
RFP	:	Request for Proposals
SPO	:	Service Provider Organization
ST	:	Short-Term
SYLOS	:	Local Health System (Système Local de Santé)
TA	:	Technical Assistance
UCS	:	Community Health Unit (Unité Communautaire ou Communal de Santé)
UNDP	:	United Nations Development Program
UNFPA	:	United Nations Population Fund
UNICEF	:	United Nations' Childrens Fund
USAID	:	U.S. Agency for International Development
USAID/Haiti	:	the USAID Mission in Haiti
VACS	:	Voluntary Agencies in Child Survival Project No. 521-0206
VSC	:	Voluntary Surgical Contraception

EXECUTIVE SUMMARY

That Haiti's health delivery system did not collapse in the face of major political and economic stresses of the past 8 years is due in part to the existence of a dynamic private health sector. This private sector has managed to continue to provide services in times of distress, with the assistance of international donors, most importantly USAID.

In order to continue to provide assistance to the private sector, to assist the Ministry of Public Health and Population to carry out its mission, and to reach more of the population with access to basic health care services, USAID is planning a major, long-term effort in integrated family health.

Haiti has long been the poorest country in the Western Hemisphere. Gross Domestic Product (GDP) per capita is estimated at US\$225-US\$250, and some 85 percent of the 1994 estimated population of 6.8 million live in absolute poverty. Average per capita food consumption is less than 1800 KCal/day. Health status indicators have worsened due to political instability and the economic crisis of the last eight years.

Recent USAID assistance to the population, health, nutrition (PHN) sector has been provided through five major projects which, with a few exceptions for short periods of time, worked exclusively with NGOs. Due to lack of USAID and other donor support during the 1991-1994 crisis, the public sector languished, with few facilities of the Ministry of Public Health and Population (MSPP) providing more than cursory services due to severe budgetary problems.

USAID projects have focussed on vertical sectors -- child survival, family planning, HIV/AIDS and drug prevention -- with modest attempts at integration in specific geographic areas. All have project assistance completion dates (PACDs) in Fiscal Year (FY) 1996. USAID has decided to increase the efficiency and effectiveness of its PHN assistance to NGOs, and to provide critical assistance to rehabilitate key public sector functions, by integrating on-going efforts under one major project.

The goal of this project is to protect and develop Haiti's human resource base. This will help Haitian families remain healthy and well-nourished, and to have the number of children they desire. The project is conceived in two phases over a 10 year period. Phase 1 described herein is for 4.5 years, through FY 1999, for a total of US\$50 million. A second phase would begin thereafter, and end in 2004. The project is called Health Systems 2004, or HS2004, to assist Haiti to meet its health objectives for the year 2004, the bicentennial of the country's independence.

The project purpose is to ensure equitable access to basic and reproductive health services to Haitian families in a manner that can be sustained over time. At the end of the project:

- one million Haitian families (5 million people) will have regular access to immunization, family planning and HIV/AIDS prevention, and nutrition services;
- 400,000 Haitian families (2 million people) will have regular access to a full range of basic preventive and curative services;
- public and private sector health institutions will be collaborating to provide more effective supervisory, support and direct services, on a cost recovery basis where appropriate.

The project has three major components:

- public sector policy and institutional strengthening to support new decentralized health care delivery systems nationwide comprises approximately 25 percent of project funding;
- direct service delivery by MSPP, NGO and commercial providers which operate both through geographically-defined community health units (UCS) comprising registered populations, as well as through selected national level programs in immunization, family planning and HIV/AIDS prevention, and nutrition; this component absorbs approximately 65 percent of project funding; and
- support services, including information, education and communication (IEC), social marketing, and operations and evaluative research, as well as USAID management and oversight, which account for the remaining 10 percent of funds.

The project will be implemented through a competitively-selected institutional contractor, which will provide overall guidance and administrative management of about 90 percent of the funds. The contract will support long and short term international and Haitian technical assistance, short-term participant and in-country training and commodity procurement particularly targeted to reactivate MSPP facilities.

The contract will also provide for approximately US\$19.5 million for output-based payment to MSPP and NGO health care providers for achievement of minimum threshold levels of preventive and curative care. This is a shift in emphasis from the current input-driven grant and sub-grant mode to a more appropriate focus on results and quality of care. Use of one

institutional contractor to fund all of the providers represents a significant decrease in the number of direct USAID procurement and management units, with a concomitant decrease in costs. The shift to contractor-managed output-based funding thus represents increased efficiencies and responds fully to USAID re-engineering concerns.

The project defines sustainability as a state whereby all Haitians have economic and physical access to an efficiently provided cost-effective package of quality services, paid to the extent possible by users and by tax revenues. By 2004, assuming relative stability and modest economic growth, total public health care costs will be borne equally among three groups: the user, the government and donors (PVOs, bi- and multi-national).

Waivers are requested for the host government contribution to the project, procurement of motorcycles and selected participant training costs under the project. There are no major policy issues.

1. CONTEXT & RATIONALE

1.1 Statement of Problems and Opportunities

1.1.1 Country Setting and General Health Status. Haiti has long been the poorest country in the Western Hemisphere. Gross Domestic Product (GDP) per capita is estimated at US\$225-US\$250, and some 85 percent of the 1994 estimated population of 6.8 million live in absolute poverty. Adult literacy is less than 25 percent, and only about 13 percent of the population has access to potable water. Average per capita food consumption is less than what is considered a temporary maintenance level of 1800 KCal/day.

Health status indicators have worsened due to political instability and economic crisis of the last six years. The public sector economic and fiscal policies that fostered inflationary pressures and a deterioration of the local currency were exacerbated by the September 30, 1991 military coup and subsequent international economic sanctions. The occupation by the MultiNational Force (MNF) and restoration of democracy have not yet resulted in visible economic improvements.

Infant mortality estimates of 101/1000 produced by the most recent national survey (1987) are probably outdated: small area programs with defined urban and rural populations document upward mortality trends dating back to 1988. Rising infant death rates were noted in Cité Soleil, in the Central Plateau (Maissade and Mirebalais) and in the Southern peninsula (Jeremie), probably reflecting nationwide conditions. The maternal mortality ratio is 457/100,000. Morbidity data confirm the widespread prevalence of such diseases as tuberculosis (2-3 percent prevalence), sexually transmitted diseases (4 percent) and HIV infection, which affects at least 6 percent of sexually active adults and about 2.5 percent of newborns.

Malnutrition remains a severe, chronic and widespread problem in Haiti. Approximately 50 percent of children under five suffer from malnutrition. In addition, micronutrient deficiencies are common. Vitamin A deficiency affects children under six years of age, and most pregnant women are deficient in iron and folic acid. In the Central Plateau and other mountainous regions, iodine deficiency is associated with an increased incidence of goiter and cretinism.

The situation will not improve soon, as the food gap is estimated at over 350,000 tons/year (wheat equivalent). Local production only accounts for 1100 calories per person per day, or about one half of the need. Even if agricultural production were to grow spectacularly in the years to come, Haiti would still

need to import close to one million tons of food (wheat equivalent) by the year 2000 to have barely enough food for all of its people.

These shifts in health and nutritional status have coincided with a deteriorating coverage rate for key child survival interventions. Estimates of national coverage for immunization document a fall to 20 percent for DPT3, oral poliovirus and measles vaccines. The contraceptive prevalence rate (women in union using a modern method) is only 8 percent, with Haiti the only country in the Western Hemisphere where fertility rates have risen rather than declined. Fewer than 25 percent of children nationwide have received a Vitamin A capsule and efforts to prevent iodine deficiency disorders are nonexistent.

That the entire health delivery system did not collapse in the face of major political and economic stresses of the past 8 years is due in part to the existence of a dynamic private health sector which has managed to continue to provide services in times of distress with the assistance of international donors, USAID being the most important. Areas covered by USAID-funded projects provide basic health services to about two million persons, or close to one-third of Haiti's population. In areas covered, a June 1993 evaluation demonstrated that women provide oral rehydration therapy to their children with diarrhea 38 percent of the time. A child in a target area is two to three times more likely to be fully immunized than in the country as a whole. Fourteen percent of women in target areas use contraception, as compared to 8 percent nationwide.

1.1.2 Public Sector Institutional Setting: Haiti's Ministry of Health and Population (MSPP) has suffered from the general deterioration in the country and from lack of donor financing for over three years. Until 1991, the overall strategy employed by the MSPP was one of concentrating on priority health interventions (nutrition, oral rehydration, immunization, family planning, maternal care, tuberculosis control, malaria control and AIDS control). A special unit of the Ministry was created to manage these vertical programs, each sub-unit dealing independently with service delivery institutions. In 1991, this unit was disbanded and a new health policy orientation focusing on equity, decentralization, public-private sector partnership, and the creation of an autonomous public corporation to run MSPP hospitals, was proposed by President Aristide's first Minister of Health. The military coup put an end to the proposed changes.

Today, the MSPP has direct nominal management responsibility for 18 hospitals (about 2300 beds), 23 health centers with beds, 40 health centers without beds, and 132 dispensaries (staffed by auxiliary nurses). The term nominal is used because many of these facilities see few patients because their staff does not

come to work or because they have no functioning equipment or supplies; 100-bed hospitals may have only two or three hospitalized patients and no capacity for such basic services as Cæsarian sections. In 1994, all facilities, whether utilized or not, had personnel on payroll who got paid whether they showed up for work or not.

The inability of USAID and other donors to work with the MSPP has fostered obvious sectoral distortions, including the absence of a common policy, framework and norms for health/population/nutrition planning, coordination and service delivery in the country. This has created a plethora of different delivery systems and some differences in norms and standards which, in the interests of efficiency and effectiveness, need to be brought into a common framework.

In late 1993, the Malval government's Minister of Health and Population, with the assistance of the Pan American Health Organization (PAHO), decided to fill the policy/strategy gap and develop an interim common framework. Under the Minister's leadership and with PAHO's facilitation, the Technical Committee for Interagency Coordination in Health was formed.

The Technical Committee includes representatives from all of the major actors in the health/population/nutrition sector. It produced a document in March 1994 that is considered to be Haiti's summary health/population/nutrition strategy framework for the future. The document is entitled "Quelques pistes pour aborder nos problèmes sanitaires," (MSPP, March 1994), and includes definition of key problems, objectives, interventions and resources required in the immediate, medium and long term. Its guiding precepts follow:

i) a strong desire to apply the recommendations of the Alma Ata conference, relative to the development of primary health care and adoption of a clear policy of nationwide community health; and,

ii) a new management approach for health activities, where the MSPP will be directed by a competent and credible manager, capable of using the experience of NGOs who have proved themselves in the field. The use of a competitive bidding process for implementation of certain tasks will be emphasized.

In addition to outlining fairly straightforward needs for humanitarian assistance in the immediate term (which USAID is already addressing), the document proposes a highly decentralized tiered system of health care based on "communal health units" (UCS) throughout the country. The units are to be supported by nine departmental level MSPP units and by national, vertical, technical and support programs.

More recently, the GOH completed a major planning exercise with the World Bank, the Inter-American Development Bank (IDB), USAID and United Nations assistance to define its Emergency Economic Recovery Program for both the next 12-18 months and a 3-5 year medium term timeframe. The health sector strategy in the EERP relies on (i) strengthening the central ministry to fulfill its normative functions and to guarantee service quality and access; (ii) decentralizing service provision to improve quality, accessibility and efficiency; (iii) ensuring access to an affordable minimum package of integrated basic health services; (iv) supporting community participation and coordinating public sector, NGO and donor activities to optimize resource utilization. The proposed project is in full support of those strategic aims.

The EERP also includes plans to reconstruct Haiti's health infrastructure, and to improve service quality and coverage, with a US\$57.2 million estimated cost for the following transitional activities: (i) definition of health priorities, norms, and procedures for supervision, monitoring, and evaluation; (ii) strengthening management capacities; (iii) development of administrative mechanisms for decentralized management; (iv) development of management information systems; (v) retraining of health personnel; (vi) health facility rehabilitation and re-equipment; (vii) essential drugs and medical supplies provision; (viii) water and environmental sanitation activities; and (ix) establishment of health supply storage and distribution systems at the provincial and local levels. The nutrition strategy includes education and communication programs to improve child care and feeding practices and actions to improve household income and food security. Although separate donor contributions are not specified in the EERP, they are so close to the HS2004 plans it is clear that USAID will be a lead supporter as the MSPP moves ahead.

1.1.3 Private Sector Health Delivery Systems: Haiti's private health sector comprises:

- over 100 secular non-government organizations (NGOs), either indigenous or foreign-based;
- over 100 church-affiliated institutions which provide health services as part of general missionary work;
- several thousand for-profit providers such as physicians in private practice, private hospitals, laboratories and pharmacies; and
- traditional healers.

NGOs: In the 1960s the non-profit Albert Schweitzer Hospital in the central part of Haiti began a large community based intervention which eliminated tetanus as a significant cause of death in its catchment area. Since that time, numerous private institutions have adopted a service delivery model with population-based community health services with a selective intervention strategy delivered on an outreach basis. Many of these programs have been funded by USAID under sequential projects since the early 1980s. Indeed, since the formal suspension of assistance to the GOH in 1987, approximately 50 NGOs funded through one of USAID's projects have been responsible for most of the preventive and a large share of the curative health care in the country.

Prior to suspension of relations with the government as a result of the September 29, 1991 coup, most of these community health service providers developed formal service delivery contracts with the MSPP specifying the catchment area for which they were responsible and the in-kind MSPP support (mostly seconded personnel) to be provided by the MSPP. These arrangements have continued on a peripatetic basis and now cover approximately 3 million persons of which 2 million are enrolled in programs funded by USAID.

Other private sector entities have focused on a single cluster of interventions. PROFAMIL, for example, the affiliate on the International Planned Parenthood Federation (IPPF) in Haiti, is involved in reproductive health, and INHSAC engages in training. Most, however, undertake at least basic curative and child survival services.

Lessons learned from these projects document that it is possible to obtain significant increases in coverage and reductions in the infant mortality rate by judicious investments in low cost primary health care programs. However, achievements have been uneven and difficult to measure. NGOs received funding through grant budgets built on detailed input-driven budgets that were carefully reviewed by USAID. Both USAID and the NGO staff often devoted more time to USAID accounting standards than to technical issues, with technical performance languishing as a result.

Given the administrative and management maturity of most participating NGOs, the proposed new project will shift to innovative methods of output-based financing. As described in more detail in subsequent sections of this PP, funding instruments will be based on achievement of minimum threshold levels of results based on per capita calculations. The methods should allow both USAID and provider staff to focus more on improving technical effectiveness and stimulate efficiency overall.

Commercial Providers: In cities, and particularly in Port-au-Prince, care is often given by private providers. There are approximately 1500 physicians in practice in Haiti, two-thirds of which are located in Port-au-Prince. Paradoxically, Port-au-Prince, with the largest number of physicians, nurses and hospital beds, has some of the worst indicators in terms of coverage or mortality. For example, the overall maternal mortality ratio for Haiti is 457/100,000 while it exceeds 1000/100,000 in the capital. This is probably due to the major class and income disparities which prevent the vast bulk of Port-au-Prince's population from using the private services.

Many patients rely on pharmacies for their health needs and drugs make up 75 percent of medical expenses overall. Recent Institute of Statistics (IHSI) data show that in urban areas, 83 percent of provider-related medical expenditures are accounted for by private physicians, as opposed to 34 percent in rural areas. These expenses account for 2.2 percent of the average household budget.

USAID has supported programs with commercial providers in a number of venues. PROFAMIL works with a Physician's Network to encourage private provision of a full menu of family planning methods, and results have been promising. Both social marketing efforts under the AIDS prevention project and the family planning project have provided training for physicians and pharmacists, with positive results. Assistance under the new project will continue to support such training to achieve improved quality of care and increased cost-efficiencies overall.

Traditional Healers: Among traditional healers, traditional birth attendants (TBAs) play an important role as only 20 percent of all deliveries currently occur in hospitals. Although great strides have been made in training TBAs, the number of deaths in the neonatal period (0-28 days) still accounts for 40 percent of all infant deaths and the maternal mortality ratio is very high. Several of the USAID-funded NGOs provide training to TBAs to improve and modernize skills and to enhance community acceptance of new interventions. The programs have proven effective and will be encouraged as part of the new project's overall focus on safe motherhood and reproductive health.

1.1.4 USAID Assistance to the Health Sector: USAID assistance has been provided through five major projects which, with a few exceptions for short periods of time, worked exclusively with NGOs until quite recently. All have project assistance completion dates (PACDs) in Fiscal Year (FY) 1996. These are:

- Voluntary Agencies in Child Survival (VACS, 521-0206), which supports a network of over 30 private voluntary

organizations (PVOs)/NGOs¹ providing 2.2 million people with access to child survival services, including immunizations, growth monitoring, breast feeding, oral rehydration therapy (ORT), pre-natal counseling, treatment of acute respiratory infections, health education, micro-nutrients, and environmental health. The VACS life of project (LOP) is 8.75 years, with LOP funding at US\$41.6 million.

- Private Sector Family Planning (PSFP, 521-0189), which supports approximately 35 PVOs/NGOs providing over 1 million people with access to family planning services, ranging from natural family planning to voluntary surgical contraception (VSC). Support through PSFP has resulted in Haiti having the largest rural Norplant^R program worldwide. The PSFP LOP is 9.75 years, with LOP funding at US\$34.9 million.

- Expanded Urban Health Services (EUHS, 521-0218), which supports the work of a major Haitian NGO, the Centers for Development and Health (CDS) in providing preventive and curative family health services to approximately 500,000 urban poor in the major urban slums of Haiti, including the infamous Cité Soleil in Port-au-Prince. Given the severe stressors on residents of these slums in the last three years, the CDS programs have clearly served an important "safety net" function for family well-being. The EUHS LOP is 7.25 years, with LOP funding at US\$18.5 million.

- AIDS Control (Aba SIDA, 521-0224), which has supported the highly successful social marketing campaign for the Pantè condom and other significant AIDS prevention and awareness campaigns. The Aba SIDA LOP is 5 years, with LOP funding at US\$10.4 million.

- Awareness and Prevention of Drug Abuse (APDA, 521-0221), which supports the work of the Association for the Prevention of Alcoholism and Drug Abuse (APAAC) in targeting education and counselling campaigns to specific at-risk segments of the population, with a focus on youth. The APDA LOP is 7.5 years, with LOP funding at US\$1.1 million.

¹ In the context of this paper, the term "non-governmental organization," or NGO, refers to a non-profit organization in the private sector. A "private voluntary organization," or PVO, is a subset of that universe, and refers to those NGOs which meet the standards for registration with USAID. These standards for registration are found in Part 203, Chapter II, Title 22 of the Code of Federal Regulations, as amended. Both PVOs and NGOs are involved in USAID health/population/nutrition activities.

Virtually all recent USAID assistance to the health/population/nutrition sector has been through the private sector, primarily NGOs, but also the commercial private sector in the successful social marketing activities. U.S. government policy has permitted bilateral assistance to the Government of Haiti (GOH) only twice in the last 8 years, in 1987 for a brief time just after VACS and PSFP were authorized, and in 1990-1991, just prior to and during President Aristide's first in-country tenure. At most other times, USAID was prohibited from direct bilateral assistance due to U.S. legislation.

As part of its post-resolution strategy, USAID is using funding from VACS and PSFP to provide US\$3 million for emergency recovery efforts of the Ministry of Public Health and Population (MSPP) during FY 95. These funds will provide essential commodities and equipment and training at a number of key facilities around the country which deteriorated during the crisis.

1.2 Proposed USAID Response

1.2.1 Goal and Purpose. The goal of this project is to protect and develop Haiti's human resource base. This will help Haitian families remain healthy and well-nourished, and to have the number of children they desire. The project is planned in two phases over a ten year period. Because of this, it is called Health Systems 2004, or HS2004, to assist Haiti to meet its health objectives for the year 2004, the bicentennial of the country's independence.

Critical assumptions supporting goal achievement are: (i) healthy, smaller families are essential to productive human capital; and (ii) the restoration of democracy and political stability will foster development and economic growth. These assumptions are elaborated in the Mission's approved Action Plan and are considered valid.

The project purpose is to ensure equitable access to basic and reproductive health services to Haitian families in a manner that can be sustained over time. At the end of the project:

- i) one million Haitian families (5 million people) will have regular access to immunization, family planning and HIV/AIDS prevention services;
- ii) 400,000 Haitian families (2 million people) will have regular access to a full range of basic preventive and curative services;

iii) public and private sector health institutions will be collaborating to provide more effective supervisory, support and direct services, on a cost recovery basis where appropriate.

Assumptions in support of the purpose include: i) the public sector will reassume its role in policy and service delivery; ii) Haiti's PVO/NGO health service organizations will continue to provide services throughout the country in collaboration with government; and iii) socially and economically feasible mechanisms for financing health care can be developed and implemented over time. The Mission is working closely with the MSPP and NGO providers and believes all three are valid bases on which to move forward.

The project is fully congruent with USAID's development objectives and strategy as outlined in this and other USAID programming documents and recent policy cables. The project also represents the next logical step for the GOH in ensuring equitable access to basic health services for its people, which is one of the stated objectives of the post-transition government. Finally, the project builds on the lessons learned from USAID's predecessor projects in the health sector and aims to achieve significant management efficiencies through greater consolidation of programs, more strategic targeting of resources to underserved populations and greater coordination between public and private sector health providers.

The project is conceived in two phases over a 10 year period. Phase 1 described herein is for 4.5 years, from second quarter FY 1995 through fourth quarter FY 1999. A second phase would begin thereafter, and end in time for Haiti's bicentennial in 2004. Project outputs and indicators in the Logical Framework are provided for Phase 1. The measures of success are cast in the full ten year timeframe, and are presented at section 4. Phase 1 funding is estimated at US\$50 million.

1.2.2 Summary Description. The project has three major components:

- public sector policy and institutional strengthening to support new decentralized health care delivery systems nationwide comprises approximately 25 percent of project funding;
- direct service delivery by MSPP, NGO and commercial providers which operate both through geographically-defined community health units (UCS) comprising registered populations, as well as through selected national level programs in immunization, family planning and HIV/AIDS

prevention, and nutrition; this component absorbs approximately 65 percent of project funding; and

- support services, including information, education and communication (IEC), social marketing, and operations and evaluative research, as well as USAID management and oversight, which account for the remaining 10 percent of funds.

The project will be implemented through a competitively-selected institutional contractor, which will provide overall guidance and administrative management of about 90 percent of the funds. Given the size and scope of the effort, the competition will encourage multi-institution teams, with one lead institution with which USAID will deal. As described in more detail in subsequent pages, the contract will include:

- 46 person years (py) comprising 13 positions for long term technical assistance (TA), split between international and local hire; the 13 positions represent a net decrease in the number of long-term TA positions in the existing portfolio, and accessing them through one contractor instead of eight should accrue significant savings in local and home office support costs;

- 100 person months (pm) of short-term TA, which for budget purposes is allocated as 30 pm expatriate and 70 pm local;

- 1094 pm of training, of which 45 pm is short-term U.S., 49 pm is short-term third country, and the remaining 1080 is in-country in a variety of fields;

- approximately US\$5 million worth of commodity procurement, covering vehicles and office furniture and equipment for itself and the MSPP at the central and departmental levels, as well as additional technical equipment to reactivate key MSPP facilities around the country; and

- approximately US\$19.5 million for output-based payment to MSPP and NGO health care providers for achievement of minimum threshold levels of preventive and curative care.

The contractor will open a project implementation office in Port-au-Prince from which it will provide technical assistance, contracting and financial management, commodity procurement, information/education/communication (IEC) and training support to the MSPP and participating private providers. At least three advisors -- Health Policy, Financial Management, and Health Information Systems (HIS) -- will work full time with and be integrated into the MSPP structure. Other TA will split time between the public and private sector to assure all stakeholders are served.

USAID will directly procure an estimated US\$1.6 million of contraceptive commodities and issue a direct international organization grant to PAHO. It will additionally retain funds for USAID management and oversight, including a project evaluation in Year 4. All other project activities will be managed by the institutional contractor.

1.2.3 GOH and NGO Participation in Design. The past ten years have witnessed the strengthening of public-private sector partnership, the MSPP entering into formal agreements with NGOs and other institutions for the delivery of services to geographically and demographically defined populations, and for more vertical interventions such as immunization, tuberculosis control and AIDS. This process has been facilitated by the existence of strong indigenous NGOs working in the health sector. The project will build upon this history of collaboration and will provide a means to reinforce it.

As summarized above, current MSPP-approved plans call for the progressive addition of new community-based integrated health systems, which the MSPP calls "UCS" (Unité Communale de Santé), throughout the country. These systems will include provisions for child survival and family planning activities as well as basic curative care. This coincides with recommendations stemming from the evaluation of the USAID-funded "Voluntary Agencies for Child Survival" project (VACS) which calls for the establishment of "local health systems" (SYLOS) in the country. This approach is also consistent with the recently issued Action Plan for the 1994 Summit of the Americas Conference which calls for all national leaders in the Western Hemisphere to "ensure equitable access to basic health services" for their populations, in ...exercising, as locally appropriate, cost-effective package of public health and clinical services.

In Haiti, these objectives are best served by an integration of preventive health services and a prioritization of interventions determined by the epidemiology of diseases most important for the Haitian family. The combination of family planning and child survival and limited curative care interventions under one integrated health program in selected geographic areas will improve efficiency and maximize the impact of scarce development resources by fostering close collaboration between the public and private sectors. This approach is consistent with PAHO recommendations on the development of SYLOS in this hemisphere and with the approach promoted by the World Bank for the Health Sector (WORLD DEVELOPMENT REPORT - INVESTING IN HEALTH, 1993).

USAID has consulted closely with the Minister and key personnel of the MSPP to the extent possible in project design. The consensus presented by the multi-agency Technical Committee in "Quelques pistes ..." were incorporated into a USAID project

concept paper and design issues were discussed at several meetings with the Minister of Health and his key advisers in August, September and October 1994.

The NGO community was also closely involved in project design, starting at the concept paper phase. Issues related to the functioning of planned UCSs, output-based financing systems, indicators of achievement and methods of monitoring were fully discussed at several workshops to which NGO managers were invited and at individual meetings with NGO leaders. From these meetings, a consensus emerged on the desirability of a results-oriented approach and on the need to reduce USAID micro-management of project activities. Of particular importance was the issue of better coordination of PL480 Title II food programs with envisioned nutrition services. Specific workshops were held with the active participation of food donors on the one hand (USAID, the EEC, the World Food Program), NGO food agencies and NGOs involved in nutrition services. From these sessions emerged models of integration which have been incorporated into the project design.

1.2.4 Conformance with USAID Strategy and Programs. The goal of the USAID/Haiti program remains as before the coup: to advance the establishment of the necessary conditions for the majority of the Haitian people to improve the quality of their lives. This goal, and the strategic objectives that contribute to its achievement, were first articulated in the September 1991 Country Development Strategy Statement (CDSS), and later reconfirmed in the Mission's FY 1995-2000 Program Objectives Document (POD) of April 1993. The latter was approved by the Bureau for Latin American and the Caribbean (LAC) in June 1993. They were more recently further defined in the FY 1995 to FY 1996 Action Plan, which was approved in June 1994.

The goal has been restated slightly in the recent post-resolution strategy: to support the Haitian people to build a participatory, accountable, responsive democracy and establish the basis for long-term equitable growth.

The POD, Action Plan and post-resolution strategy recognize the necessary conditions to achieve these goals: 1) public and private democratic institutions that reinforce the rule of law, foster respect for human rights and respond to the needs of the Haitian people, 2) sustainable, equitable economic growth and development, with **active participation of the private sector** and 3) protection and development of the human resources needed to lay a sound basis for enduring democracy and sustained economic growth. These three conditions form the basis for the Mission's approved strategic objectives. An important cross-cutting element of the strategy, empowering the disadvantaged, is included in all of these conditions.

The HS2004 project responds to all three of the objectives and the cross-cutting element. Through support to a decentralized network of over 20 service provider organizations, the project strengthens institutions that respond to one of the most basic needs of the Haitian people, i.e. assuring the health of their families. Through its renewed emphasis on public-private partnership for service delivery, it promotes sustainable economic development. And, importantly, through improving the access to health services for the Haitian population, it directly provides protection and development of the human resource base throughout the country. Finally, it will accomplish these objectives through a system based on community health units and participation in management -- promoting empowerment at all levels.

Although the project is cast in a medium- and long-term framework, it includes immediate support for the post-resolution period. USAID/PHNO has already authorized US\$ 3 million for the MSPP in the VACS project, and is providing that funding for procurement of necessary commodities essential to rebuilding public sector health infrastructure. While those procurements are implemented, the HS2004 project will be authorized and other mechanisms for quick disbursement for MSPP activities will be implemented, thereby ensuring continued direct support to the MSPP.

The HS2004 project responds to USAID management strategy as well, in terms of decreasing the units of management per staff and per office. The five projects outlined in section 1 comprise funding to almost 100 different entities through over 60 different direct procurement instruments, many of which need to be amended annually for incremental funding and all of which need to be monitored by USAID. All five projects will begin phasing out in FY 1995 and will end in FY 1996, providing a useful overlap during the HS2004 start-up period. By mid-FY 1996, USAID/Haiti's office of Population, Health and Nutrition (PHNO) will be managing only one large health project.

1.2.5 Relationship with other USAID-funded projects

The HS2004 project is linked to several projects composing the Mission's portfolio. The project will complement the Enhancing Food Security activities by providing the beneficiaries with a complete health package. In addition, by increasing the income of many poor Haitian families, the Labor-Intensive Infrastructure Rehabilitation Initiative strengthens their capabilities to meet their basic health and nutritional requirements. Finally, The objectives of the HS2004 project are fully in accordance with those of the PL-480 Title III program. It is, therefore, anticipated that the HS 2004 project could benefit from local currency provided, as counterpart funding, by the PL-480 Title III program.

2. ASSISTANCE INTERVENTIONS

2.1 Public Sector Policy and Institutional Strengthening

The MSPP policy summarized above focuses on the following objectives: 1) local participation in the managing and financing of services; 2) decentralization of health delivery systems; 3) more equitable allocation of resources; 4) impact evaluation of programs and services; and 5) protection of the poor. The HS2004 policy and institutional strengthening component will facilitate the MSPP's realization of these objectives by assisting in: consensus building and formulation of a health reform policy agenda; developing deconcentrated and decentralized organizational structures and systems; and implementing a health information and service delivery monitoring system at the central and departmental levels which improves the MSPP's supervisory capacity to ensure quality.

2.1.1 Consensus Building: The project will support the MSPP to establish a National Commission on Health Policy, similar to structures established in the education and agriculture sector with USAID and other donor support. The Commission will be composed of public and private sector representatives active in the population, health and nutrition sectors. It will provide a forum where issues of policy may be discussed, where research necessary to illuminate eventual policy issues may be identified and coordinated, where actual policy statements, regulations and enabling legislation may be developed and through which eventual policy choices may be disseminated through the governmental and non-governmental structures concerned with the application and effects of health policy.

In order to avoid redundancy as the MSPP reestablishes itself, the Commission will not establish a permanent office but may add some staff to the Policy Division of the MSPP to serve as its secretariat. Following existing models (eg, the National

Education Plan process), the Commission will serve as the mantle to conduct national, regional and departmental colloquia to foster dialogue and to establish mechanisms for full grassroots participation of all stakeholders in policy development. The project will provide funding for such conferences, symposia, or roundtables through the main institutional contractor at a level of US\$50,000 for Year 1 and US\$25,000 for each year thereafter. Limited TA to prepare discussion papers may also be provided from the overall policy rubric described below.

2.1.2 Health Policy Reform: The project will place a long term resident technical Health Policy Advisor at the MSPP to assist it in carrying out an agenda of health policy reform initiatives. The agenda will be developed through a broadly participatory consultative process led by the National Commission above and will be designed to further the MSPP's stated objective of ensuring equitable access to basic care. It will include attention to identifying necessary revisions to enabling legislation and regulations as needed. The agenda will include a priority list and analysis of feasible initiatives to be phased in over time. Illustrative reform measures to be reviewed and further developed include restructuring central and peripheral level MSPP departments consistent with decentralized operations, financing public health services through a mix of cost recovery and public sector subsidies, structural mechanisms to promote public/private sector partnerships, redeployment of staff, use of generic drugs according to standard norms, the introduction of medical technology.

USAID will provide up to 5 pm of short-term TA to assist in the development of the preliminary policy reform agenda, either from HS2004, or from VACS and PSFP should the MSPP so request prior to the arrival of the long-term institutional contractor team. The preliminary agenda should be completed within the first six months of 1995. The resident Health Policy Advisor should arrive shortly thereafter to further policy reform efforts. The MSPP will also be able to draw upon up to 4 pm per year of specialists from Haiti, the U.S. and neighboring countries to support the process. In this vein, the project will support 15 pm of observational visits to other programs in the Caribbean and the region who are also undergoing health policy reform. Over the life of the project, 12 pm of short-term participant training will also be provided to MSPP policy makers at designated U.S. training institutions.

2.1.3 Decentralization and Decentralized Systems Development: Decentralized management requires not only deconcentration of staff, but development of new organizational structures and functional relationships at the center and periphery to meet new needs. The MSPP is already taking steps to

deconcentrate staff and some services, but needs to realign financial, administrative and other support services to support the new structures.

Project funding will provide 8 py of expatriate and 8 py of local long term TA to help focus on these issues. The institutional contractor Chief of Party will be a Senior Health Administrator and is expected to devote approximately half of his/her time to these MSPP issues. A second Advisor will be a specialist in Financial Management, to assist the MSPP to better manage domestic and donor funds over time. Two other long-term Advisors will focus on Commodity/Logistics Planning & Operations, to facilitate procurement planning and end use, and Facilities Maintenance, to assure improved maintenance over time.

In close collaboration with the MSPP, these Advisors, the Policy Advisor and up to 9 pm of short term consultants (of which the majority shall be residential hire) will lead a participatory institution-wide audit and systems analysis during Year 1. This will identify the weaknesses in financial, personnel and material management within the Ministry. It will also examine the competencies and training needs of major facility managers as well as those responsible for resource management within the MSPP. From this audit and analysis, the institutional contractor will develop a systems development and training program that will put in place systems and managers to carry out the decentralization plans.

One major output of the institutional audit will be a detailed elaboration of the MSPP's model for decentralization, including a strategic plan for service delivery. The strategic plan will be presented and discussed within the context of a National Commission or any other organizational structure agreed upon by USAID and MSPP,

to assure that it meets all stakeholders' concerns. Once the plan is approved, the contractor will provide for continuous in-service training for central and departmental level technical and administrative health officials in decentralized administration, supervision, quality control and team planning throughout the life of the project. In collaboration with local training institutions, courses will be introduced sequentially throughout the country to disseminate concepts.

A second output of the audit will be a detailed action plan that will allow the MSPP to qualify for direct USAID financing within a three year period. The Financial Management Advisor will consult closely with the USAID Controller's Office to ensure necessary preparation in this regard.

The institutional audit and systems analysis, including development of the strategic plan, is expected to involve much of the time of the resident Advisors (Policy, Financial, Health

Administration) and approximately 9 pm of short-term TA during Year 1. The Advisors will continue to work with the ministry through the life of project to help implement the plans. Their work will be supported through provision of necessary commodities (vehicles, office furniture, equipment and supplies) and an estimated 10 pm of financial/institutional and 20 pm in equipment/facilities maintenance over the LOP. The project will additionally fund an estimated 3 pm per year of short-term participant training, in fields to be defined during the course of the audit, and an estimated 30 pm per year of in-country training, primarily in finance, administration and data management.

2.1.4 Service Delivery Monitoring and Quality of Care:

As part of the decentralization of the health care delivery system and the changing role of the MSPP structure, greater attention will be paid to the MSPP health departments assuming a greater supervisory, oversight and quality control function in their surrounding communities, with a particular focus on quality control and respect of norms and standards, *and to ensure that optimal quality services are provided to the beneficiary population.* There are currently nine health departments in the country.

Major considerations in developing models for departmental supervisory and oversight teams are the number of qualified personnel available to the ministry at civil service wages, and the cost of maintaining such staff over time. Some of these issues are well beyond the scope of this project and may be alleviated only through coordinated GOH/donor efforts in broad-based budgetary and civil service reform, for example, through USAID's Policy and Administrative Reform project. Within the MSPP, a number of options in terms of desirable types and levels of staffing are under discussion. This process is likely to continue as the MSPP reinstates, reassigns and/or recruits staff to all of its facilities, and should not be hurried. It is likely that consensus will have been reached by the time the institutional contractor arrives in Haiti.

The project will support the strengthening of departmental units or teams in the 13 departments/programmatic areas. The COP/Health Administration and other resident advisors will establish a program to provide periodic technical assistance to departmental teams, including facilitating annual strategic and operational evaluation and planning efforts. Funding is provided for procurement of basic commodities for each team, including vehicles, motorcycles, office equipment and furniture, and power sources (both generator and solar as appropriate). Provision of 30 pm/year of in-country training is also provided, with topics to be determined as roles and functions are developed. Emphasis is likely to be on medical technologies and supervisory skills,

the collection and analysis of epidemiological data, the design and execution of qualitative research techniques, logistics and equipment maintenance.

2.1.5 Health and Management Information Systems: Obtaining reliable management data for decision-making is a vital function for the central MSPP. Equally important is accessing morbidity and mortality data, and other health statistics from departmental and other teams as a basis for rational policy development and planning. The project will provide four person years of a resident HIS Advisor, and 10 pm of short term TA to work with the MSPP statistics unit to define MSPP minimum data needs, and establish decentralized systems for collection, transfer and analysis of data. In addition, the Center for Disease Control (CDC) will be contracted through a PASA to assist the MSPP in the setting of its epidemiological surveillance system and strengthening the MSPP's capability to conduct clinical surveys. The project will also finance the purchase of computer equipment, including hardware and software for the central ministry, including the nine departments mentioned above, to improve its ability to synthesize and analyze information. Forty person months of in-country training of staff to operate the data collection systems as well as the computers will be provided. Personnel at all levels will also receive training in the use of the system outputs for improved planning and service delivery.

2.2 Direct Service Delivery

The project will support direct service delivery to one million Haitian families (five to six million persons), of which approximately 400,000 families (two million persons) will have regular access to a full range of basic preventive and curative services. This will be accomplished through the following venues: i) a reactivation of selected essential MSPP service delivery facilities; ii) support to approximately 20 sub-departmental population-based accountable health plans in urban and rural areas, **based on MSPP selection criteria**; iii) funding of nationwide programs in immunization, family planning and AIDS/STD prevention, and nutrition.

2.2.1 Reactivation of MSPP Facilities: MSPP facilities and operations were devastated by three years of crisis operations, with no development budget resources to carry out basis program maintenance and, during 1994, not enough regular budget resources to pay all staff. As described above, a number of urgent needs for reconstruction are being met by USAID and other donors within the context of the EERP. HS 2004 will provide resources to meet needs not met through the donor appeal.

Equipment for Health Facilities: A lump sum of US\$500,000 each in FY 96 and FY 97 is reserved for essential equipment for

the rehabilitation of MSPP hospitals, clinics, dispensaries and training institutions that are not covered by the US\$3 million provided under the existing USAID PHNO programs and/or by other donors as part of the EERP. Specifications will be developed by a the Logistics and Facilities Advisors working with the MSPP and the Technical Committee, which includes other donors. The items will be in accordance with standard lists developed by PAHO for maternal and child services at hospitals, health centers and dispensaries throughout the public sector's network of facilities. *The concept of rehabilitating the health infrastructure includes the improvement of physical facilities, the construction of certain essential units (morgue, laundry) with provision for basic utilities (water and sanitation) in compliance with international norms and standards.*

Laboratory and Radiology Services: In addition to and in accordance with MSPP policy, the project will provide up to US\$500,000 worth of commodities to upgrade laboratory and radiology services connected with, and appropriate to hospitals, health centers and dispensaries. Special attention will be given to ensure the establishment of a national network of laboratories for the effective diagnosis of sexually transmitted diseases, including HIV. A total of 130 pm of in-country training is planned to assure that equipment can be operated and maintained over time. Some of this training will be provided by suppliers during installation. Where this is not possible, the institutional contractor will arrange for specialized training courses to be provided.

Radio Communications: An informal communications network based on hand-held radios has been used for medical emergencies for some time. The radios have also been used by rural health facilities to advise referral posts of the arrival of patients, to order specific critically needed supplies from larger towns or cities and for long-distance learning for health providers who are unable to leave their post for in-service education. Project funds will be used to purchase additional radio equipment for the UCS described below, central MSPP and the selected service provider groups that work in rural inaccessible areas. A lump sum of US\$300,000 is planned for radio procurement and installation, with specifications to be developed by the Logistics Advisor in consultation with concerned MSPP and PAHO technicians. One hundred person months of in-country training is also provided to assure knowledgeable operation and maintenance of the network.

2.2.2 Decentralized Provision of a Basic Package of Services. The project will encourage and support provision of a basic package of health services to approximately 400,000 Haitian families, or about 2 million Haitians, by Year 3. This will be accomplished through sub-contracts, grants, and/or other

procurement mechanisms with MSPP, NGO and commercial health care providers working with defined populations throughout Haiti. Results of this coverage are described in section 4.

The Basic Package of services consists of a set of interventions that the USAID, the MSPP and other donors have determined are most necessary to protect and preserve human life. It is summarized in Figure 1, with interventions grouped in four clusters. Some providers may initially offer only one or two clusters of services, but over the LOP it is hoped that a minimum of 20 organizations will be offering the full range of basic services.

The basic package will be provided to registered populations within a Communal Health Unit (Unité Communale de Santé or UCS). The UCS is defined by the MSPP as an administrative entity which coordinates various sectoral resources for the provision of a basic package of health services for a geographically and demographically defined population. The UCS may correspond to the geographic border of one commune, of several communes, or part of a commune, particularly in urban areas. In all instances, a UCS will function under the supervisory authority of the Departmental office of the MSPP. In many cases, a UCS will include MSPP, NGO, commercial service providers, with the active involvement of the participating communities.

The basic package will be provided in an estimated 20 UCS by public and/or private sector Service Provider Organizations (SPOs), which may be MSPP or NGO, or a combination thereof. In order to be eligible for funding, SPOs will be required to register populations and maintain technical and administrative standards which meet the institutional contractor's requirements for funding. The project may fund more than one SPO in a given UCS, depending on relative competencies and coverage. In areas where several providers are active, a competitive process may be used in order to avoid redundancy. The objective is to promote provision of the full package of basic services to the population of the UCS over time.

As described in section 1 above, USAID has provided funding to over 50 NGOs throughout Haiti through a number of mechanisms and projects. Under previous projects, the SPOs received USAID funding based on level of effort funding tied to inputs. Under HS2004, the institutional contractor will work with USAID, the MSPP and old and possibly new SPOs to develop funding mechanisms and instruments which define on specific service-delivery related outputs². This is an innovative concept which will be phased in over the first two years of the project, starting with willing and capable SPOs providing the full package to approximately 300,000 people in at least 3 UCS in Year 1. Based on the registered

² Note: It should be pointed out that the basic benefits package considered under the HS2004 Project does not include neither the emergency medical surgery nor the dental care services which usually fall under regular basic health package. Funding for these two services will be provided by the MSPP.

population and based on the service statistics of the organization, the SPO will receive a per capita payment for the basic services, or cluster of basic service, in which it participates in order to and assuming that it provides a minimum acceptable threshold level of care. Based on the registered population, the institutional contractor will work with individual SPOs to determine the number of procured services (vaccinations, weighing, vitamin A capsules, etc.) that should be provided by

the organization on a defined periodic basis in order to achieve the minimum coverage threshold for payment.

More detailed descriptions of the activities to be undertaken, minimum thresholds and one possible funding mechanism are found as Annex B. The description of the mechanism is considered illustrative, and a key factor in the evaluation of prospective contractors will be their proposed elaboration of this, or alternative, output-based financing mechanisms that conform to USAID requirements.

It is important to emphasize that increasing efficiency through output-based financing does not imply a decrease in attention to quality of care. On the contrary, the mechanism will include requirements for quality as well as the quantitative outputs, and the contractor will monitor results on both bases. The MSPP departmental teams, as they become functional, will assure quality control, with assistance as necessary from the central ministry and/or institutional contractor. Under the contract, some incentive payment for quality of care might also be considered.

Figure 1: BASIC BENEFITS PACKAGE

CHILDHOOD IMMUNIZATIONS/NUTRITION

- DPT	3 Doses
- Polio	3 Doses
- Measles	1 dose
- BCG	1 dose

- Identify low birth weight infants
- Weigh infants/children
- Distribute cups, spoons for breastmilk
- Identify growth faltering
- Distribute Vitamin A, 6 mos-7 yrs
- Food supplement, Nutrition rehab
- Deworming

FAMILY PLANNING

- Family Planning counselling and services
- Adolescent Family Life Education
- STD counseling and condom promotion/distribution

PRE-NATAL, MATERNITY CARE, STDS

- Pre-natal consultations, risk assessment and referral
- T Tox, 5 doses, women 15-49 yrs
- Iron, folic acid, malaria prophylaxis, syphilis diagnosis/trtmt
- Attended birth, maternity care
- Newborn resuscitation, postpartum care, vitamin A, physical assessment
- Post partum family planning, STD, child survival counseling

TREATMENT OF THE SICK CHILD

- Diagnose, refer or properly treat diarrhea, malaria, pneumonia, measles, and intestinal parasites using WHO algorithm and approved products.
-

It is also important to recognize that a shift to output-base financing implies a level of sophisticated management that not all NGOs possess. Although no new NGOs will be provided grants under HS2004, the institutional contract will include provision on a case-by-case basis for grants or sub-grants to existing USAID grantees and sub-grantees to assure service delivery can continue. However, the contractor will work with these NGOs to improve systems so that they can move to the more efficient output-based mode as soon as possible. A long-term Financial Management Advisor (NGOs) particularly for this purpose is included on the contractor team.

A detailed analysis of historical cost-per-beneficiary and cost-per-service for health care in Haiti was prepared for this PP. It arrived at a figure of US\$2.61 per person per year for the basic package. This analysis is somewhat lower than the average of US\$4.20 used by the World Bank for countries at Haiti's economic level. The HS2004 budget uses an average of US\$3.00 per person per year, with contraceptive commodities and some vaccines assumed to be provided outside of the basic cost.

However, it should be noted that the \$3 per capita per year estimate is made for budgetary purposes only. a better estimation of the amount paid for any part of the Basic Benefits Package will be determined during project implementation. An attempt will be made to standardize the amount paid for each of the four modules irrespective of the costs incurred by any given SPO. Therefore, the amount paid should be considered as a contribution to the costs of providing the procured services rather than a payment aimed at covering all incurred costs.

A LOP total of US \$19.5 million is programmed for the institutional contractor to reimburse or pay SPOs for provision of the basic package to an estimated 2 million Haitians. This will include continuing support to UNICEF, as a more specialized SPO, for its area-specific program. HS2004 funding for basic services will be initiated in at least 3 UCS covering approximately 300,000 persons in FY 95, while many of the potential non-governmental SPOs will still be funded under existing USAID projects, and the MSPP is reactivating facilities that have been closed. The FY 95 efforts will serve as tests for procurement instruments and contractor monitoring. In FY 96, it is hoped that the new funding will cover SPOs in 12 UCS, and by FY 97, a full 20, or over 2 million persons.

Development of the instrument and the procurement themselves will be undertaken by the COP/Health Administrator and a long-term Administration/Contracts Advisor specifically charged with this task. The institutional contract team will also include resident experts in Financial Management and the Logistic Planning and Facilities Maintenance personnel mentioned above, to help SPOs as needed. A long-term Research and Evaluation

Specialist and staff will provide for technical monitoring to assure compliance with minimum thresholds are met.

2.2.3 National Reproductive Health: To complement the work of the MSPP and NGOs in the UCS, and to provide essential services in areas not yet covered by a full basic package, the project will provide support to national programs in reproductive health: (i) continuation of national family planning service delivery by the private sector; (ii) provision of contraceptive commodities through national distribution channels and through social marketing; (iii) specialized counselling and treatment for HIV/AIDS by selected trained personnel; (iv) "safe motherhood" activities; and (v) in-country training to assure all methods are known and promoted. All activities are heavily dependent on and linked to the IEC program described in 2.2.5. All are intended to complement and not duplicate activities by the MSPP and SPOs described in previous sections.

As a result of these activities, it is anticipated that the number of continuing contraceptive users will go from an estimated 100,000 to 378,000, or 30 percent of married women of reproductive age, and all sexually-active Haitians will have access to and know how and why to use condoms.

Family Planning Services through the Private Sector: Under PSFP funding, PROFAMIL operates six family planning clinics, three mobil surgical teams and nine CBD programs. The clinics and CBD programs together serve urban and rural populations throughout Haiti and the mobil surgical teams provide critical support to facilities nationwide. The HS2004 institutional contractor will provide funding through a sub-contractor or sub-grant arrangement to assure that this level of services will continue. The private sector will be encouraged to play an active role in training and assisting the MSPP to set-up and strengthen both clinical services and CBD networks. A total of US\$2.625 million, exclusive of funding for contraceptives, is provided for this purpose.

Procurement of contraceptive commodities: USAID Haiti will undertake contraceptive commodity procurement through standard central procurement procedures. The storage and distribution of contraceptive commodities will be the primary responsibility of the Central Drug Procurement Agency (PROMESS). PROMESS is a non-governmental entity established in 1991 by multi- and bi-lateral donors, including USAID, to ensure the availability of essentials drugs, vaccines, contraceptives and medical supplies to member non-profit institutions. PROMESS grants contraceptives, and sells essential drugs to member institutions. USAID contributions to PROMESS are provided through its International Organization (IO) grant to PAHO and consists of support to

management costs of the program as well as the donation of contraceptives. All USAID procured contraceptives are provided free of charge to member institutions. End-use monitoring will be the responsibility of the institutional contractor. Annual requirements will be determined through a consultative process with MSPP and providers. A life of project estimate of US\$1.750 million is budgeted for commodities. An additional US\$1.5 million will be provided to PROFAMIL by UNFPA.

HIV/AIDS and STD Prevention and Counselling: It is estimated that the country-wide prevalence of HIV is between 6 and 10 percent. The project will support a nationwide AIDS/STD prevention program that will revolve around four focal points.

- i) IEC and other high-risk group directed activities to produce behavior change, encourage safe sex practices and a reduction in the average number of sexual partners; these are covered by activities described in 2.3 below;
- ii) More accessible *without any* HIV testing and STD diagnosis and treatment, especially for pregnant women; the testing will be made possible through the laboratory upgrading and training described in 2.2.1 and the reproductive health service provided through the MSPP (2.2.1) and SPOs operating in UCSs (2.2.2);
- iii) Increased condom use through an expanded condom social marketing program; the successful approach to social marketing implemented under the Aba SIDA project will continue under project funding through the institutional contractor. The institutional contractor will arrange for procurement of commodities and local commercial promotion. The overall target is to reach sales levels of 10 million per year by Year 5, at an estimated cost of US\$250,000 per year. As activities will continue under Aba SIDA into FY 96, a total of US\$.875 million is budgeted for the HS2004 LOP.
- iv) Better counselling of HIV positive individuals and AIDS patients and their families. Project funding will support training 500 physicians in application of a standardized protocol for counselling patients prior to and after HIV testing. This protocol provides detailed guidelines on the indications for testing, the information to give patients being referred for testing, counselling to give patients who test negative, and counselling to give patients who test positive.

Given its long term and high quality experience working with STD/AIDS issues in Haiti and its particular expertise in the diagnosis, treatment and counseling aspects, a local organization, the Groupe Haitien d'Etude du Sarcome de kaposi et

des Infections Opportunistes (GHESKIO), may be considered to play a particularly active role in the diagnosis, treatment and counseling components of this program.

Safe Motherhood: Project activities will reduce the delays which typically lead to maternal deaths: delay in recognizing an emergency situation and the need for medical care; delay in travelling to an emergency facility; delay in getting adequate and appropriate medical treatment once at the facility. This result will be obtained via adequate counselling of pregnant women during prenatal visits, appropriate training of traditional midwives as well as health personnel, and establishing a reliable system of referrals for complicated cases.

Counselling will be offered at fixed facilities at the UCS and Departmental level, as well as on an outreach basis so that pregnant women are evaluated for high risk conditions, fully vaccinated with tetanus toxoid, receive supplementation of iron and folic acid (and iodine in high risk areas) and malaria prophylaxis. No separate line item is provided for this purpose. Training will be carried out by SPOs within their UCS financial instruments, and on a national basis with in-country training funds summarized below. Up-grading of TBAs will be particularly encouraged. Urgent care will be provided at larger facilities and/or at single function urgent care facilities as a piece of the basic benefits package at the UCS level. Again, no separate line item is included for this purpose.

Training: Nine person months of U.S. participant training and 250 pm of in-country training are provided to support and promote the reproductive health activities described above. The institutional contractor will subcontract with a local institution for this purpose.

The institutional contract team will include a long-term Reproductive Health Specialist to assure smooth implementation of these activities and to assure that reproductive health issues remain integrated at the UCS and departmental levels. An additional 6 pm of short-term expatriate and 5 pm of short-term local TA are budgeted to reinforce these long-term efforts.

2.2.4 Expanded Program on Immunizations (EPI) and Essential Drugs: Given the critical importance of immunization to family health, HS2004 has adopted an objective of immunizing 75 percent of all women and children by the end of the project. In addition to the work with the UCS and MSPP fixed facilities summarized in sections 2.1.2 and 2.2.1 above, the project will provide special assistance to EPI on a national basis. The project will additionally continue to support efforts at decentralized provision of essential drugs.

Based on established relationships and successes, this assistance will be provided through a HB 13 International Organization (IO) grant to PAHO. The objectives of the PAHO grant will be to ensure an effective and active vaccine and other essential drugs distribution system, to train MSPP health workers in immunizations, to maintain and complete an integrated cold chain and drug storage facilities, and to fund special immunization activities. The storage and distribution will be undertaken through the central drug entity, PROMESS, which should become self-sufficient by 2004. Pharmaceutical will be procured with separate PAHO funding, although USAID funds will support administrative costs of PROMESS. By the end of the project, with this special national program reinforcing work in the UCS, 75 percent of Haitian mothers and children will be receiving all required vaccines at recommended intervals.

US\$700,000 per year beginning in FY 96 is budgeted for the PAHO IO grant, to begin after VACS funding ceases.

2.2.5 Nutrition: The 1978 National Nutritional Survey revealed that almost three-quarters of children under five years of age were undernourished, with approximately 30 percent suffering from moderate or severe malnutrition (second and third degree Gomez classification). A national nutrition survey was repeated in 1991, and demonstrated there had been no change in the nutritional status of the survey population in the past decade. The USAID Monitoring Unit reports over the 1991-1994 crisis demonstrate a measurable decrease in nutritional status in selected areas of the country. Forthcoming data from the 1994 DHS will provide more detail in this regard.

The HS2004 contractor will promote and monitor the integration of the Title II food inputs into the maternal and child health activities, through fixed health facilities and program outreach sites. The contractor will also seek that nutritional considerations be integrated into food supplemental activities, especially those carried out by HS 2004 grantees.

The contractor will encourage organizations currently implementing effective health and nutrition integration models to enhance and expand them. The contractor will invite other institutions to apply those models and will provide technical assistance to those wishing to implement them.

The contractor will, in addition, ensure that appropriate operations research studies on effective integration models are conducted and that the results are applied and evaluated.

Nutrition education: Nutrition education will be one of the key themes of the national IEC program described in section 2.3.1 below. Illustrative principal themes will include: exclusive breast-feeding in the first 6 months of life; promotion of

micronutrient-rich foods; and a "best-buy" program which promotes the most economical way to obtain a balanced diet. Mass media will be the principal channel for message diffusion, with reinforcement in the field by face-to-face communication at fixed facilities and in UCS-run community health outreach programs. The cost of these activities is incorporated in the IEC and UCS components described elsewhere in this PP.

However, funding for 250 person months of in-country training specifically in nutrition are provided to assure that public and private sector health care providers are able to undertake nutritional screening and face-to-face communications at the field level. The training will be carried out by a local training institution in collaboration with the institutional contractor.

Supplemental Food: The basic package for all UCSs will include nutrition surveillance activities. These activities will identify children with moderate and severe malnutrition for whom more attention is needed. In collaboration with USAID's PL 480 Title II program, strategies to assist malnourished children will be identified and tested for more widespread use as part of the HS2004 operations research program described in 2.3.2 below.

Funding for 6 pm of observation tours is provided in FY 95 to expose key MSPP and NGO to successes in Haiti and in other countries. Based on the knowledge gained from the observation tours, selected SPOs will be encouraged to develop strategies and small scale activities to implement them. Several models have been identified. The Catholic Relief Services (CRS) MCH model which incorporates supplemental feeding where necessary, has recently been evaluated and found extremely successful. Organizations considering supplemental food as part of a nutrition component would be encouraged to use and adapt the CRS model. Other models also exist, including the nutrition foyer, the Adventist Development and Relief Agency (ADRA) MCH model and the UNICEF/AOPS model. Some of these would be worth exploring. There will also be opportunities for coordinated nutrition interventions in areas outside UCSs, with particular attention to developing programs which broaden the measurable impact of existing Title II distribution mechanisms.

These and other models will be tested within the operations research program and implemented under the UCS or other, to be established, delivery channels. Provision of Title II food will be programmed jointly with the participating PVO cooperating sponsors. No additional funding is programmed.

Micronutrient: Under the VACS project, USAID has provided funding for several years to the U.S./Haitian NGO EYECARE for national vertical efforts at Vitamin A supplementation to decrease xerophthalmia. It has additionally funded the

public/private sector Coordinating Committee to Combat Iodine Deficiency Disorder (CCI/DDI) to provide iodine supplementation to high risk groups in the Central Plateau and other mountainous areas of Haiti. These programs have both been considered successful at a relatively low cost.

Funding provided under the HS2004 institutional contract will continue to support micronutrient programs. Vitamin A will be made available to all children 6 months to 6 years of age, iron and folic acid to pregnant women, and iodine capsules to children and women, particularly in the Central Plateau where the prevalence of goiter and cretinism is very high. Venues for these vertical programs will be initially be the US/Haitian PVO EYECARE for Vitamin A and the Coordinating Committee to Combat Iodine Deficiency Disorders (CCI/DDI) for iodine. Iron and folic acid will be distributed through UCSs and other prenatal care providers.

Funding of the Vitamin A and iodine programs will continue through existing national mechanisms for through FY 96. The institutional contractor will work closely with the MSPP and participating NGOs to assess alternative mechanisms to these vertical programs, e.g. accelerated efforts at social marketing of iodized salt or other products, and to develop possible operations research efforts to other mechanisms. By the end of the project it is hoped that these vertical efforts will have been deconcentrated to the SPO level in all UCSs. The total estimated funding for the Vitamin A and iodine programs is \$200,000 in FY 96; after that time, coverage will be undertaken by the SPOs in the UCS and/or the MSPP within other programs.

2.3 Support Services

In order to support and reinforce the policy and service delivery components of the project two crosscutting initiatives will be undertaken. These are support for an information, education and communications strategy and action plan, and for operations and evaluative research.

2.3.1 Information, Education and Communications (IEC):

The GOH, international and PVO community currently have well-organized IEC sub-committees which have developed IEC action plans for family planning and child survival. Historically, USAID's health and population program has financed successful integrated marketing communications plans for both the health and population sectors using local private sector market research, public relations and advertising agencies. In order to support the GOH/PVO action plans, this project will fund an expansion of public education campaigns to promote healthy, smaller families; the use of oral rehydration solutions, immunization, nutrition

education, AIDS prevention and control and other preventive services.

The institutional contractor will provide a resident IEC Advisor who will work with the IEC subcommittee to develop within the first six months of the project an integrated marketing communication plan to support these interventions. A total of \$700,000 has been allocated for the LOP national education campaign.

In addition to public education campaigns the project will continue to support the **product-specific social marketing** to expand and strengthen the commercial supply and distribution of low-cost socially acceptable family planning and essential pharmaceutical products. Building on the successful foundation of the projects which have introduced in pharmacies a social marketing low-dose oral contraceptive (Minigynon), a low priced condom (PANTE) and oral rehydration solution (ORS), this project will fund the gradual introduction of new products. These products may include a progest in-only pill targeted to breast-feeding women; a re-introduction of ORS; the CUT-380 Intrauterine device; Norplant; an STD self-treatment kit; antimalarial (chloroquine); and deworming medication (Elbendazoles).

The commercial introduction of these products will be phased in during the first two years of the project. Project support for the social marketing program will include 4 person years of a marketing manager; US\$250,000 per product for market research, advertising and associated marketing costs and US\$250,000 for each of the original products introduced through USAID predecessor projects. A total of \$1.250 million has been allocated for this activity.

2.3.2 Operations and Evaluative Research: Both the policy and service delivery components of HS2004 involve new models of service delivery as well as new operational and administrative relationships, arrangements and structures. To assure that these new approaches are yielding optimal health impact, the project will finance both operations and evaluative research. *Mission will judiciously select each operational research project on a case by case basis.*

The institutional contractor will manage a small competitive grants program to promote research on innovative techniques and problems solving. This element is designed to solicit from both the private and public sectors innovative approaches to service delivery or financing health care. Annual "open season" will be declared at which time potential investigators will submit proposals. A proposal selection committee made up of the institutional contractor, USAID, the MSPP and NGO representatives will review submitted proposals and evaluate them, using standard criteria. In addition, annual project reviews may identify

specific areas of research which may be pursued through competitive sub-contracts.

Illustrative topics in service delivery include: the introduction of new contraceptive technology; the effectiveness of itinerant service delivery interventions and functions at the field level; removing medical barriers to improved service delivery; the effects of food supplementation on low birth weight and the ideal food supplement package for pregnant women; the effects of deworming medication and antimalarial on pregnancy outcome; improved methods of addressing severe malnutrition in different age cohorts; and nutrition rehabilitation for children who don't respond to standard rehabilitation formulas. In the area of policy development two key issues related to effective cost recovery are the effects of pricing on patients use and demand for health services, and means testing.

US\$50,000 per study or a total of US\$600,000 has been set aside for the grants program.

Under USAID financing, Haiti has for many years conducted periodic population-based national evaluative surveys to document demographic and mortality status and trends. The Child Health Institute (CHI) has been the key implementing agency involved in these surveys. The institutional contractor will sub-contract for a follow-on survey in Year 4 of the project to document impact of the health reform program. This will serve as the national 5 year benchmark, as well as provide hard data for the project evaluation planned the same year. A total of US\$500,000 has been budgeted for the national survey.

2.3.3 AID's Global Bureau Support

HS2004 will access Global Bureau Field Support assistance to (a) provide technical compliments in areas not covered by the Institutional Contractor, (b) ensure that service providers incorporate the newest technologies, and (c) provide assistance in areas that are complimentary to other donor efforts.

3. PLAN OF ACTION

3.1 Administrative Arrangements

3.1.1 Government of Haiti. The project will be structured as a bilateral grant to the GOH through a Project Grant Agreement (ProAg) in accordance with USAID HB 3 requirements. Although the ProAg will most likely be negotiated with at least one central ministry (Finance or Plan) it will designate the MSPP as the lead implementing agency for the GOH. At least one representative of the MSPP will be considered a key GOH signatory under the grant.

The MSPP will designate a *Project Coordination committee* to serve as key counterpart for the USAID Project Officer and the institutional contractor Chief of Party (COP). *This committee* will maintain current knowledge of activities under the project and will be able to brief the Minister, and other ministries, on progress and problems. Importantly, *the committee* will help facilitate MSPP support to project activities and personnel, both at the national and sub-national levels. The MSPP will designate lead personnel for each project component or activity.

Under the lead of the Minister, a Project Committee was formed to review successive drafts of the PP and offer comments and advice on formulation. The Minister will be encouraged to broaden participation in the Project Committee to participants outside the MSPP, e.g. from lead NGOs in the sector and from the Ministry of Finance and/or Plan, and to maintain it during implementation. The Committee would meet periodically with the institutional contractor and USAID representatives to review progress to date, identify problems, and arrive at means to resolve problems.

Facilitating linkages among all players is expected to become increasingly important as decentralization proceeds and elected communal/municipal officials become more proactive in communal development activities. As Departmental offices are staffed up and begin more active supervision and monitoring, they will also be encouraged to develop committees or other participatory structures with elected government officials and NGOs active in the department to assure stakeholders' concerns are aired and, preferably, resolved. If the InterDepartmental Councils provided in the Constitution are established, the Departmental Director would participate as appropriate to assure appropriate coordination.

It is planned that at least three long-term TA, the Health Policy Advisor, the Financial Management Advisor and the HIS Advisor, will sit in the MSPP and work as part of the ministry management team. The MSPP will designate one or more counterparts for these Advisors and will encourage the Advisors and counterparts to enter into "learning contracts" so that knowledge and skills are transferred in a planned and measurable manner.

The MSPP will also provide space for half-time TA and short-term consultants on an as-needed basis. The project includes funding for vehicles, office furniture and equipment, including power back-up systems, for both MSPP and related contractor personnel. The Financial Management officer will assist as necessary in establishing systems to assure that operating funds for power and vehicles are available on a timely basis.

As described below, other contractor personnel will be based in a rented project implementation office, which ideally will be situated near the ministry to facilitate communication. It is hoped that over time relationships can be established so that the project office is considered a valued "annex" of the MSPP.

3.1.2 Institutional Contractor. The bilateral ProAg will include appropriate wording to direct USAID on behalf of the MSPP to procure a competitively selected institutional contractor to be the lead implementing entity under the project. The contractor will essentially take over responsibility for many of the activities that have been carried out by 5-6 implementing agency offices under the current portfolio.

The contractor will collaborate closely with the MSPP and USAID in all undertakings. *S/he will be directed and supervised by a board of five to seven members comprised of, among others, the Minister of Public Health, USAID Mission Director, the Contractor representative and the Minister of Finance.* During the first 120 days in country, it will undertake a detailed institutional diagnostic audit of the ministry which will serve as the basis for a detailed annual, and more general LOP, workplan. It will subsequently develop annual implementation plans for MSPP and USAID approval and will report quarterly on achievements as compared to the plans.

Funding is provided for the contractor to rent, equip, staff and operate an office in Port-au-Prince for a 4 year period for the purposes of the project. As stated above, it is hoped that the office will be near to the MSPP so that close collaboration is facilitated. The contract will include:

Long Term Technical Assistance: The following positions are planned, although contractors will be encouraged to propose different mixes as capabilities permit. For budget purposes 6 positions have been designated as "expatriate" and 7 as "local". Contractors will be encouraged, however, to maximize local hiring to the extent possible. Although the project is authorized for 4.5 years, the contractor budget assumes the competition and award will take approximately 6 months, so provides four years total for most positions.

- i) Chief of Party/Senior Health Administrator: to provide guidance and direction for all aspects of project implementation and all contractor personnel, to serve as key counterpart to the MSPP Project Coordinator particularly on issues of decentralization, and to serve as contractor representative in dealings with USAID.
- ii) Health Policy Advisor: as a counterpart to the Chief of the MSPP Planning and Evaluation Unit, in close

consultation with the National Commission, to assist the MSPP to develop a health policy reform agenda and to assist in identifying and implementing mechanisms and procedures to enact the reforms over time.

iii) HIS Advisor: as a counterpart to the Chief of the MSPP Epidemiology and Statistics Unit, in close consultation with IHSI, NGOs and others involved in health information systems, to improve the MSPP's capability to collect, collate, analyze, synthesize and use improved data for decision-making.

iv) Financial Management Advisor - Public Sector: as a counterpart to the MSPP Chief Accountant, to work with the MSPP accounting staff at the central and departmental levels improved budget and financial management capability, with the specific objective of establishing adequate systems and controls to provide for recurrent operating costs for service delivery facilities and to allow the ministry of receive USAID direct funding in the Phase 2 project.

v) Contracts Administrators, 2 positions: to develop, negotiate and administer the output-based financing mechanisms with SPOs in the UCSs; to maintain overall personnel and administrative systems for prudent contract operation, and to oversee all project-financed procurement of goods and services. The project budget provides for an expatriate Administrator for the initial two years to help establish systems, and for a full four years of a local hire Administrator to assist in system establishment and to maintain the systems after the expatriate leaves.

vi) Financial Management Advisor - NGOs: to work with the Contracts Administrators and NGOs to assure that the implications and requirements of output-based financing are clearly identified and understood by all parties, and to develop training and staff development tools for NGO Board members, technicians and financial management staff to facilitate the transition.

vii) Commodities/Logistics Specialist: to develop and/or assist in development of specifications for all commodities to be procured under the project, to undertake all direct contractor procurement in accordance with applicable USAID regulations, to assure proper receiving and end use reporting, to provide advice and assistance as necessary to MSPP and NGO SPOs in developing their own commodity and logistics systems, and to work with the Human Resource/Training Specialist to assure that operation and maintenance of specific categories of equipment are included as training topics.

viii) Facilities/Maintenance Specialist: to assist the MSPP at the center and in the departments to develop and implement facilities up-grading and maintenance (funded by existing projects, HS2004, the GOH and other donors), with particular attention to developing maintenance plans and developing training and recurrent cost requirements to support the plans for service delivery facilities.

ix) IEC Specialist: to serve as advisor to the IEC cross-sectoral committee and the **MSPP unit in charge of Health Education** to expand implementation of the national IEC strategy initiated under PSFP. This is budgeted as a two year position as it is assumed the DES will be reactivated and able to undertake implementation itself at the end of that time.

x) Reproductive Health Specialist: to serve as project advisor for all reproductive health issues and to particularly ensure HIV/AIDS and STD programs, including social marketing, do not get lost under the integrated project. This is budgeted as a two year expatriate position but could be a longer local hire, or could be proposed for extension depending on need.

xi) Research/Evaluation: to work with the MSPP, NGOs, and Contracts Administrators to identify appropriate strategies for monitoring technical compliance with minimum threshold levels of care, and to work with the MSPP and NGO personnel to identify appropriate operations research topics and to implement operations research both in the special grant program and as part of on-going service delivery.

xii) Human Resources/Training Specialist: to work with the MSPP personnel office and NGO partners to develop staff development programs which respond to program needs, to identify appropriate venues for such training, and to manage the regular and specialized participant and in-country training program funded by the project.

Short-Term Technical Assistance: The budget includes provision for an estimated 100 pm of short-term TA over the five year LOP, which for budget purposes is allocated as 30 pm expatriate and 70 pm local. The TA will be programmed collaboratively with the MSPP and USAID on an annual basis, and will cover the wide range of technical and administrative needs described in the preceding section of this PP.

USAID-funded skills bank will provide the contractor with a reliable source of highly skilled Haitian-Americans and other American professionals who are interested in working short-and long-term in Haiti.

Training: The budget provides for an estimated 1094 person months of contractor-managed training, of which 45 pm is short-term U.S., 49 pm is short-term third country, and the remaining 1080 is in-country in a variety of fields. The contractor will be required to use PIO/Ps and follow all relevant requirements of USAID HB 10 for the participant training. The Human Resource/Training Specialist on the contract team will work closely with the MSPP and SPOs to develop annual in-country training plans, to identify resources for such training, to develop trainee selection procedures and to assure that training is carried out.

Commodities: The budget provides for the contractor to undertake approximately US\$5 million worth of commodity procurement, covering vehicles and office furniture and equipment for itself and the MSPP at the central and departmental levels, as well as additional technical equipment to reactivate key MSPP facilities around the country. The contractor will collaborate with the MSPP, as appropriate, and develop specifications for all equipment to be procured. It will undertake such procurement in accordance with all relevant USAID requirements, and will assure that recipients -- notably the MSPP -- develop inventory and control systems to adequately protect and maintain the commodities. The MSPP and/or Ministry of Finance will undertake the necessary steps to assure that all commodities enter duty free as provided in the ProAg. (Note that USAID will retain approximately US\$1.750 million for direct USAID procurement of contraceptive commodities.)

Other: The other costs category of the contractor budget will include:

- **UCS Financing:** The contract will include approximately US\$20 million for output-based payment to MSPP and NGO health care providers for achievement of minimum threshold levels of preventive and curative care in UCSs. Prospective contractors will be encouraged to propose innovative appropriate mechanisms in their offers for the project. The Contractor will be responsible for developing, negotiating and executing the instruments with competent SPOs, and for assuring compliance with minimum thresholds against which payments are made.

- **National Program Financing:** The contractor will execute a sub-contract or grant with PROFAMIL for the national family planning program, and will provide more limited support to national micronutrient efforts.

- **Support Services Financing:** The contractor will manage funding for all IEC activities in public education and social marketing, as well as operations and evaluative research described in section 2. To supplement on-going

efforts in HIS and to provide summative data on program impact, it will additionally sub-contract for the conduct of a national demographic health survey in 1998.

Funding is provided for limited home office direct costs for backstopping, particularly commodity procurement and US participants, during the life of the project. Lump sums have been estimated for local staff and operating costs, to assure that contractors design appropriate structures to meet their own organizational needs.

3.2 Other Donors

The primary donors in population, health and nutrition in Haiti are USAID, PAHO, UNICEF and UNFPA. USAID is by far the largest, and will continue to provide International Organization (IO) grants to PAHO and UNICEF under HS2004. UNFPA will continue to receive central funding outside of this project, and will provide an increasing share of contraceptives over the LOP.

PAHO has been a leader in the humanitarian efforts over the last three years. PAHO was instrumental in the formation of the Technical Committee for Interagency Coordination mentioned above, and is committed to pursuit of the objectives outlined in "Quelques pistes ...". With USAID funding under VACS, PAHO has also been instrumental in provision of essential drugs nationwide through PROMESS.

PAHO has historically been involved in provision of TA and training to the MSPP in immunizations and prevention of major communicable diseases, particularly tuberculosis, and foresees continuing such a relationship when conditions permit. The USAID IO grant will support PAHO's continuing efforts in these areas.

UNICEF is a key donor in terms of provision of vaccines and assistance in immunization campaigns. UNICEF plans to maintain an emphasis on the "sick child" approach in coming years, and focus on mother/child health and nutrition. UNICEF is also active in some aspects of food security and in improvement of the status of women. Under USAID VACS funding, it has supported area-specific child survival programs in two sites. HS2004 funding to UNICEF is provided to support these two sites as they move within the national policy of a basic package to a defined population.

UNFPA had traditionally focussed on the public sector, but has shifted to a humanitarian program in the last three years. UNFPA is working with PAHO on the decentralization of PROMESS warehouses in order to improve distribution of contraceptive commodities throughout the country. UNFPA's major emphasis in the coming years will be on continuing to increase the supply of

contraceptive commodities throughout the country, with particular emphasis on increasing supply to adolescents. It is also a lead donor in population policy.

Rotary International, IPPF and Canadian aid also provide some funding and commodities in the health and family planning sectors, through Haiti's NGO community.

All the actors above participate actively and regularly with MSPP and selected NGO participants in the Technical Committee and sub-committee process. Coordination among the group is not expected to be problematic as the new project comes on line. What will be more difficult is integrating new donors, and those that left Haiti during the crisis, into what has become a very tight and effective group.

3.3 Implementation Schedule

A summary implementation schedule is found at Figure 2 overleaf.

4. DEFINITION OF SUCCESS

4.1 Intended Results

The project is conceived in a 10 year timeframe, of which this 4.5 year PP represents Phase 1. The two goal level indicators for the 10 year period, which will only be incrementally achieved during Phase 1, are:

- the national Infant Mortality Rate (IMR) will have declined by 50 percent, from 101/1,000 to 50/1,000 live births; and
- the national Total Fertility Rate (TFR) will have declined from 4.8 to 3.6.

Within the 4.5 year Phase 1 timeframe, the following purpose-level indicators will be achieved:

- one million Haitian families (five million Haitians) will have regular access to immunizations, nutrition and reproductive health services, including family planning and HIV/AIDS prevention;
- 400,000 families (two million Haitians) will have access to a "full health care package" in demographically defined areas of the country;
- national modern contraceptive prevalence rates will have increased from the current estimated 8 - 10 percent of women in union to 20 percent by 1999 and 30 percent by 2004;
- the MSPP will be providing more and better quality services, as well as fulfilling its normative, supervisory and oversight roles within a context of public/private collaboration.

4.2 Indicators for Monitoring Progress

The institutional contractor, with USAID oversight, will monitor the following indicators and report on them in quarterly reports:

Process Indicators

- acceptance and use of a national health policy, a population policy and a national health plan with well defined indicators;
- existence, quality of a national health information system;

- effectiveness of nine MSPP departmental offices in providing supervision and technical direction and oversight to health activities in the department;
- effectiveness of laboratories at 150 sites in diagnosing and treating STDs;
- mix and quality of services available in UCS throughout the country.

The institutional contractor will monitor the following indicators through its output-based financing mechanisms in areas receiving USAID funds. The contractor will assist the MSPP in establishing a national HIS to provide similar information on a national basis.

Coverage Indicators (10 year objectives)

- national immunizations and vitamin A coverage rate of 70 percent;
- national contraceptive prevalence rate of 30 percent;
- 80 percent of pregnant women receiving three pre-natal consultations and attended births;
- 80 percent of Haitian children have access to correct treatment of diarrhea, measles, pneumonia and malaria;

Project impact will be measurable through the planned demographic and health survey in 1998:

Impact Indicators (10 year objectives)

- Infant Mortality Rate of 50 per 1,000;
- Child Mortality Rate (Probability) of 65 per 1,000;
- Total Fertility Rate of 4.5;
- proportion of low birthweight babies at 50 per 1,000 live births, proportion of children under two with severe malnutrition is less than 30 per 1,000.

5. ANALYSIS OF FEASIBILITY, KEY ASSUMPTIONS AND RELATED RISKS

5.1 The Issues

The HS2004 project is a bold strategic initiative which responds to both the GOH and USAID needs for a coordinated program in health delivery. The project marks the renewal of

USAID's formal relationship with Haiti's public health sector after an eight year funding hiatus and promises to forge greater linkages between all service delivery providers. The project builds on the successes of past USAID projects in the health and population sectors and will replicate these successes on a broader scale. The mission believes the project to be **technically feasible and responsive** to the challenges facing Haiti for the next decade.

The design team has worked closely with public and private sector institutions in the preparation of the document. The mission also included local Haitian health consultants on the design team. The final product reflects the views of the most respected Haitian health experts.

During the course of the design a number of assumptions have been made concerning Haiti's political stability, the willingness of the MSPP to decentralize its operations and to ensure greater equity in the access to basic health services. The design team has also taken into account a number of management concerns in framing the final product.

Political Setting: Haiti's recent history over the past eight years has been marked by frequent changes of government, often accompanied by changes at the ministerial level. During this period USAID has not been able to work with the public sector. Needless to say, there remains a core cadre of public sector technical staff with whom USAID has maintained a continuous policy dialogue. At present the HS2004 project responds to the MSPP's strategic agenda laid out in the documents "Quelques Pistes...", the "Propositions d'Actions urgentes...", and the draft EERP. These documents offers a broad policy endorsement for a program of action endorsed by WHO/PAHO and other international agencies.

The current Aristide government has indicated that support for decentralization of services and equity is a crosscutting theme for its administration. USAID, through the HS2004 project has the opportunity to facilitate the GOH's ambitious health reform agenda. A change in ministers or in political parties in 1996 could however decrease the program's range in terms of health policy reform. It is unlikely however, to dramatically affect the delivery of health services by the nonprofit service providers as these groups have continued to provide uninterrupted service to the populations they serve throughout the many changes in administrations. Given the political uncertainties, every effort must be made during the life of this project to base program growth and new initiatives on a clear understanding and broad-based deliberations at the central and district levels prior to program commencement.

Public/Private Sector Collaboration: In keeping with a spirit of reconciliation and reconstruction which is emerging following the return of the Aristide Government, HS2004 proposes to enhance the cooperation and collaboration between public and private sector service providers. Using a strategic planning framework to ensure equitable access and coverage of the Haitian population, the project will work to optimally utilize the comparative strengths of the innovative and decentralized PVO/NGO health provider network, while assuring that health status benchmark are met, quality of care norms are followed and a standard benefit package is available for all Haitians.

HS2004 will assist the MSPP in decreasing the fragmentation of health services delivery by designating providers to cover certain areas. The MSPP will monitor the quality of these programs and enhance their accountability by actively assessing coverage and monitoring changes in health behavior through annual coverage assessments. This process will entail a new way of doing business for the PVO/NGO community and will require extensive dialogue to establish clear operating procedures and benchmark. While the changes proposed represent a new challenge, the opportunity to have a health impact is far greater in the context of a collaborative GOH-initiated policy framework than presently exists. Nevertheless it should be expected that some PVO/NGO providers will not be able to adapt to this new policy context and that not every group currently receiving USAID funding for service delivery will continue to do so.

Management Concerns: The administrative and management structure of the project has taken into account USAID financial management and audit requirements as well as the mission's need to consolidate the portfolio. The elimination of the many individual buy-ins and other direct contracting mechanisms currently in place will greatly decrease the number of contracting and subobligation actions which PHN staff must carry out each year and should reduce the amount of overhead currently being paid to support home office costs for multiple U.S. institutions. The proposed structure will also free up staff time to engage in a meaningful policy dialogue with GOH counterparts and to carefully monitor the project's implementation. Finally, the mission has simplified the design by eliminating a proposed non-project assistance instrument for the policy component, opting instead for a more direct technical assistance approach to policy development.

Technical Concerns: The mission in consultation with the MSPP has narrowed the range of technical interventions which will be supported in HS2004. Consistent with the July 1994 USAID/W Action Plan guidance, the mission has eliminated support for drug prevention programs. Other interventions eliminated from the proposed basic health benefits package include dental and ocular care. The basic health benefit package to be supported under

this project has embraced interventions which will have the greatest health impact for the funds invested. The design of the package has also taken into account the ability of the GOH to sustain this level of care.

5.2 Summary Social Soundness Analysis

The overall project is considered socially feasible and beneficial, in that it proposes providing highly valued goods and service on an equitable basis. It is low risk, in that it seeks to increase access to goods and services that for the most part are not sensitive. However, the full Social Soundness Analysis at Annex D highlights a number of factors that have been addressed but need to continue to be taken into account as implementation proceeds:

- uneven coverage among departments and between urban and rural areas must be rectified, and the MSPP must extend at least priority national programs (immunizations, nutrition, reproductive health) on a more equitable basis;
- extreme poverty prevents many families from participating or benefiting from many activities in terms of time, money and competing responsibilities, and providers need to develop means of reaching these people;
- institutional overload is a risk as new tasks and requirements for integration place demands on fragile organizational structures with limited staff and experience, and shifting to integrated services and output-based financing will require phasing and consistent planned clinical and financial supervision;
- individual and institutional distrust between and among all stakeholders must be mitigated through establishing clear lines of support, clarification of expectations, and well defined requirements for results;
- already overburdened mothers cannot commit substantial time to non-urgent care, and the project's strategies to increase mass media IEC and to integrate multiple services into each health contact should be more effective;
- illiteracy requires attention to more creative IEC strategies and careful pre-testing of printed materials; and
- religious considerations must be considered in relation to STD/AIDS prevention and contraception, and alternative delivery systems for these services need to be identified for areas where such considerations prevail.

Direct project beneficiaries to receive technical assistance, training, and commodity support are as follows:

- the employees of the MSPP, who will benefit from an enhanced work environment due to facilities reactivation and provision of equipment, as well as from increased job satisfaction as systems are installed;
- approximately 3000 - 4000 MSPP and NGO employees who will participate in 1100 person months of participant and in-country training;
- approximately 400,000 Haitian families (or at least 2 million Haitians) who will have access to the full package of basic curative and preventive care in their UCS; and
- one million Haitian families (at least 5 million Haitians) who will at a minimum benefit from national programs in immunization, IEC, reproductive health and nutrition.

Benefit incidence and benefit spread will vary by component. Given the high value Haitians place on the health of their children, and the non-controversial nature of most of the services offered, it is likely that all the estimated 8 million resident Haitians in 1999 will be affected by the project at some point, at least through listening to a radio broadcast, using a project condom, or having a child vaccinated. Benefits to women are specifically assured through the safe motherhood and other women-specific programs. Benefit spread, through strengthening IEC at the national level and the SPOs ability to reinforce messages at the local level should similarly affect all Haitians now and in the future.

In the final analysis, HS2004 has been designed to meet the most critical health needs of the Haitian family. The integrated preventive and curative intervention clusters are not in conflict with Haitian beliefs or practices. The PP has incorporated an essential element of flexibility for implementation of the interventions at the community through the MSPP levels. Cultural considerations have been analyzed, and obstacles to realization of the project have been weighted. The underlying philosophy of the project is to improve health delivery utilizing existing and potential human and material resources in a coordinated manner through participation of the community in the broadest sense. Through thoughtful planning, execution and monitoring, the project will assist in the goal of improving and protecting the human resource base now and in the future.

5.3 Sustainability Analysis

Haiti's absolute poverty is unmatched in the Western Hemisphere. In the 1980s, Haiti's economic position fell even further behind other least developed countries. The country is caught in a vicious downward spiral characterized by a high population growth rate (just under 3 percent per annum), high infant and child mortality, high adult illiteracy, low school enrollment rate, an acute shortage of cultivable land, and dismal economic performance with declining GDP, rising prices, negative net investment and an unemployment rate in excess of 40 percent. It is further constrained by weak management capability and an acute shortage of financial resources.

The series of political crises has resulted in repeated setbacks, canceling even the modest gains realized from wide-ranging economic reforms adopted in 1986-87. A 1992 analysis by USAID characterized the economy as "in freefall," and it did not improve during the two years prior to restoration of President Aristide. He returned to a bankrupt treasury and a civil service bereft of some of its most competent individuals.

As a consequence of the generally unfavorable economic situation which has persisted for many years, the financial constraints for public sector programs are severe. Simply stated, Haiti does not currently have the necessary financial resources to mount an effective national health and family planning program without substantial external financing.

Per capita income in Haiti is currently between \$225 and \$250. Given this low income level and the relative high prices of basic subsistence needs of food and shelter, the average Haitian simply cannot afford to pay a significant portion of the actual cost of the health care services he needs to survive. The project will work with the MSPP to increase revenues available for public health and to improve the efficiency of use of resources it does obtain. It will also work with providers to maximize the revenue generating potential of its services, through user-fees, while maintaining proper balance between equity and sustainability concerns. It will also work to diversify sources of donor-provided subsidies.

In any case, unless Haiti's per capita income triples by 2004, it should be assumed that Haiti's public health system will require exogenous subsidies through the life of the project. The project will seek, through three stages, to reduce the current level of exogenous subsidies to approximately one third of the public health system costs. In this scenario, the government will provide for one third and user fees will pay for one third of Haiti's public health system costs.

Prospects for sustainability must be assessed in a three phase timeframe, as follows.

Present - March 1996: In the context of the 12-15 months of the Emergency Economic Recovery Program (EERP), the emphasis will be placed on restoring essential human and capital infrastructure so that the most basic functions can be implemented. That is, most donors and Haitians agree that replenishment of a bankrupt treasury and regeneration of public revenues is going to take two-to-three years at the outset, and the GOH will be hard pressed to pay any social sector costs until some revenue generation accrues. Outside of realigning civil service levels and salary scales, public investment is apt to be limited to law and order and fiscal measures such as customs and taxes. The donors, the NGOs, and the Haitian citizens will have to look to themselves for health financing.

The project will assist the MSPP during this period with basic refurbishing and reequipping of facilities, training of personnel and will undertake a major institutional audit, which will identify areas where efficiency gains may be obtained, particularly with regard to physical and human resource allocations. During this period it is likely that all but staff and the most basic operating costs will be covered by donor financing. NGO providers will for the most part continue efforts under current financing, and will continue to seek assistance from new donors entering Haiti. Providers will continue current fee-for-service and other cost recovery plans.

It should be emphasized that the MSPP developed an effective cost-minimization strategy in the early 1980s, when it began developing joint programs with NGOs. By placing key trained personnel at well-stocked NGO facilities, the MSPP provides the NGO with competent personnel while the NGO supports the operating costs of the facilities. There are numerous examples of this public/private collaboration around the country, and they have generally proven effective and useful. The project will continue to foster such collaboration and highlight the different partners' comparative advantages where possible.

April 1996 - March 1999: This is the medium term recovery period. During this period the GOH and supporting donors will focus on economic growth to generate revenues to move beyond recovery to development. In the health sector, it will be the time when HS2004 Phase 1 is in full implementation, and efficiencies due to the emphasis on outputs should become evident. Project TA will pursue a "least cost" strategy and work with the MSPP to identify ways to streamline its expenditures, including increased collaboration with NGOs and commercial providers. Depending on how efforts with other GOH privatization proceed, the TA team may help assess options for privatization of selected facilities to decrease public costs

and, in the short term, generate some revenue. TA will also be provided to NGOs to assess means of expanding revenue sources to decrease dependency on USAID financing. Depending on recovery of the economy in general, some additional cost-recovery schemes may be developed. However, the emphasis will clearly remain on cost-minimization and cost-effectiveness in the medium term.

April 1999 - March 2004: Subject to the availability of funds and directions of U.S. foreign policy, this period would constitute Phase 2 of HS2004. If economic recovery and political stability are achieved, the project could begin to examine more creative health financing schemes that have met with some success in other countries such as "head taxes" or social financing arrangements (e.g. insurance).

By the end of this period it is anticipated that the total public health care costs will be borne equally among three groups: the user, the government and donors (PVOs, bi- and multi-national). More importantly it is assumed that services will be delivered in a more effective and efficient manner, that quality of care will be such that even poor Haitians will be willing to contribute what they can to the costs of their health care, that prices will be established to both maximize revenues and ensure that all Haitians have fair economic access to health care. It is assumed further that an effective partnership of shared responsibilities between the public and private sectors will be established.

The project does not, nor can it responsibly define "sustainability" in terms of the absence of donor assistance. Rather, the project defines sustainability by a state whereby all Haitians have economic and physical access to an efficiently provided cost-effective package of quality services, paid to the extent possible by users and by tax revenues.

6. FINANCIAL PLAN

6.1 Budget

The project is an LOP total of US\$51.6 million over the five year period, of which US\$50 million is USAID grant funds and an estimated \$1.5 million is the MSPP contribution in kind. A more precise estimate of the MSPP contribution to per capita service delivery is not possible at this time, but will be developed as part of the institutional audit. As Haiti has been classified as a relatively least developed country by USAID Washington, the project authorization will include a waiver of the requirements of FAA Section 110(a) for a standard 25 percent.

Table 1 provides a summary of source and use of funds for the life of the projects.

**Table 1: HS2004 LOP Source and Use of Funds
(US\$1,000)**

<u>Element</u>	<u>USAID</u>		<u>GOH</u>	<u>TOTAL</u>
	<u>FX</u>	<u>LC</u>	<u>LC</u>	
1. Tech. Asst.	5,870	3,110	-	8,980
2. Training	813	2,160	1,022	3,995
3. Commodities	6,558	75	568	7,201
4. Other Costs	13,952	17,490	-	31,442
a. Support to MSPP (25%)				
b. Direct Services (65%)				
c. USAID Mgt & Eval(9.5%)				
d. Audit(0.5%)				
TOTALS	27,193	22,835	1,590	51,618

Due to the proposed GOH contribution at this time, a request has been made and a waiver granted on the host country contribution requirement. The institutional contractor will undertake a better assessment of MSPP costs and potential contributions as part of the institutional audit during the first six months of the project, and will track such contributions through the LOP.

To these tables must be added an estimated US \$5-6 million representing the PVO/NGO contributions to service delivery over the LOP. These contributions have not been rigorously tracked under existing projects, but are believed to range from approximately 10 percent of costs for very small NGOs to 50-60 percent for the larger ones. As part of the TA provided SPOs, the institutional contractor will carefully assess PVO/NGO contributions to be able to more accurately assess actual service delivery costs.

Table 2 provides a summary of LOP obligations for USAID funds by fiscal year.

**Table 2: HS2004 LOP Obligations
(US\$ 1,000)**

<u>Element</u>	<u>FY 95</u>	<u>FY 96</u>	<u>FY 97</u>	<u>FY 98</u>	<u>FY 99</u>	<u>TOTALS</u>
1. TA	1,244	2,706	2,378	1,862	790	8,980
2. Training	600	834	662	562	315	2,973
3. Commod.	1,710	1,710	1,757	954	502	6,633
4. Other	1,272	7,077	9,277	9,527	4,289	31,442
TOTALS	4,826	12,327	14,074	12,905	5,898	50,030
ROUNDED TO	5,000	12,000	14,000	13,000	6,000	50,000

At full implementation in FY 97 and FY 98, the annual obligation levels represent a 25 - 30 percent decrease in current annual levels of US\$16 - 18 million for the entire PHN portfolio. The savings will accrue in two ways: i) through the significant decrease in the number of management units and consequent direct office costs and overheads paid; and ii) through increased efficiencies obtained by SPOs under output-based financing arrangements.

Regarding the first factor, excluding the Expanding Urban Health and Awareness and Prevention of Drugs Project, which have only local implementing agencies, there are at least nine U.S.-based organizations that are implementing organizations under the current portfolio (URC, IPPF/PAPFO, JSI, PSI, PCS, INOPAL, FHI/AIDSTECH, Futures/OPTIONS, Futures/SOMARC). Some of the offices incur direct and indirect costs at their home offices, and send short-term TA to Haiti from time to time. Several, however, maintain an office in Port-au-Prince and incur costs for rental, utilities, local administrative staff, and other maintenance costs in addition to home office direct and indirect costs. The melding of the functions of these organizations under one institutional contractor will save an estimated US\$ 1.8 - 2 million per year.

Regarding the second factor, the use of output-based financing will discourage extraneous budget items and staff redundancies, and should encourage program cost efficiencies. SPOs will be encouraged to innovate under the project's operations research program, but otherwise will be focussed on high quality service delivery at reasonable costs. The institutional contractor will work with SPOs to assure that cost-

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centered accounting is adopted, so that high cost services can be identified and adjustments made if appropriate. The contractor will also work more closely with SPOs that has been the case to date in terms of quantifying and tracking SPO and client contributions. It is hoped that the combination of these actions will reduce costs and result in more affordable health care over time.

Tables 3-1 to 3-5 provides detailed line item budgets for each of the major USAID budget categories.

Line Item	Unit	FY 1996				FY 1997				FY 1998				FY 1999				LIFE OF PROJECT TOTALS			
		No	USAID	GOH		No	USAID	GOH		No	USAID	GOH		No	USAID	GOH		No	USAID	GOH	
	Unit Cost	Units	FX	LC	LC	Units	FX	LC	LC	Units	FX	LC	LC	Units	FX	LC	LC	Units	FX	LC	LC
I TECHNICAL ASSISTANCE																					
***NOTE LISTING SPECIFIC POSITIONS AS "EXPATRIATE" OR "LOCAL" IS ARBITRARY FOR BUDGET PURPOSES											CONTRACTORS ARE ENCOURAGED TO PROPOSE THEIR OWN MIX										
LONG TERM EXPATRIATE																					
COP/Health Admin	py 325	05	160	13	0	1	300	25	0	1	300	25	0	05	160	13	0	4	1200	100	0
Contracts Administrator	py 300	05	138	13	0	1	275	26	0	05	1376	13	0	0	0	0	0	2	550	50	0
Health Policy Advisor	py 325	05	160	13	0	1	300	25	0	1	300	25	0	05	160	13	0	4	1200	100	0
Financial Mgmt	py 300	05	138	13	0	1	275	26	0	1	275	26	0	05	1375	13	0	4	1100	100	0
IEC Specialist	py 300	03	69	63	0	1	275	26	0	08	2053	19	0	0	0	0	0	2	550	50	0
Reproductive Health	py 300	03	69	63	0	1	275	26	0	08	2053	19	0	0	0	0	0	2	550	50	0
LONG TERM LOCAL																					
Contracts Administrator	py 80	05	0	40	0	1	0	80	0	1	0	80	0	05	0	40	0	4	0	320	0
Financial Mgmt	py 80	05	0	40	0	1	0	80	0	1	0	80	0	05	0	40	0	4	0	320	0
Commodities/Logistics	py 80	05	0	40	0	1	0	80	0	1	0	80	0	05	0	40	0	4	0	320	0
Facilities/Maintenance	py 80	05	0	40	0	1	0	80	0	1	0	80	0	05	0	40	0	4	0	320	0
Research/Evaluation	py 80	05	0	40	0	1	0	80	0	1	0	80	0	05	0	40	0	4	0	320	0
HIS Advisor	py 80	05	0	40	0	1	0	80	0	1	0	80	0	05	0	40	0	4	0	320	0
Human Res/Training	py 80	05	0	40	0	1	0	80	0	1	0	80	0	05	0	40	0	4	0	320	0
ILLUSTRATIVE SHORT TERM EXPATRIATE																					
Health Policy	pm 20	2	40	0	0	2	40	0	0	2	40	0	0	0	0	0	0	8	160	0	0
Regulations/Legislation	pm 20	0	0	0	0	1	20	0	0	1	20	0	0	0	0	0	0	3	60	0	0
Institutional Dev	pm 20	1	20	0	0	1	20	0	0	1	20	0	0	0	0	0	0	4	80	0	0
MSP Training Currcu	pm 20	0	0	0	0	2	40	0	0	0	0	0	0	0	0	0	0	2	40	0	0
Reproductive Health	pm 20	0	0	0	0	2	40	0	0	2	40	0	0	0	0	0	0	8	120	0	0
Others TBD	pm 20	1	20	0	0	2	40	0	0	2	40	0	0	0	0	0	0	7	140	0	0
ILLUSTRATIVE - SHORT TERM LOCAL																					
Health Policy/Regulations	pm 6	3	0	18	0	1	0	6	0	1	0	6	0	0	0	0	0	6	0	36	0
Institutional Audit & Follow	pm 6	8	0	48	0	3	0	18	0	3	0	18	0	0	0	0	0	15	0	90	0
MSP Training Curriculum	pm 6	0	0	0	0	2	0	12	0	2	0	12	0	0	0	0	0	4	0	24	0
Reproductive Health	pm 6	1	0	6	0	2	0	12	0	0	0	12	0	0	0	0	0	5	0	30	0
HIS/Statistics	pm 6	1	0	6	0	3	0	18	0	3	0	18	0	0	0	0	0	10	0	60	0
Equipment Maintenance	pm 6	2	0	12	0	2	0	12	0	2	0	12	0	2	0	12	0	10	0	60	0
Facilities Maintenance	pm 6	2	0	12	0	2	0	12	0	2	0	12	0	2	0	12	0	10	0	60	0
Others TBD	pm 6	1	0	6	0	1	0	6	0	3	0	18	0	2	0	12	0	10	0	60	0
MID TERM EVALUATION	pm 20	0	0	0	0	0	0	0	0	0	120	0	0	0	0	0	0	0	120	0	0
SUB TOTAL TECH ASSISTANCE			793	451	0		1900	806	0		1685	793	0		1165	707	0		4375	354	0

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Line Item	Unit Unit Cost	FY 1995				FY 1996				FY 1997				FY 1998				FY 1999				LIFE OF PROJECT TOTALS								
		No. Units	USAID FX	GOH LC	GOH LC	No. Units	USAID FX	GOH LC	GOH LC																					
II. TRAINING																														
S-T PARTICIPANT - US																														
- Policy	pm	12	0	0	0	0	6	72	0	0	3	36	0	0	3	36	0	0	0	0	0	0	0	0	0	0	12	144	0	0
- Decentralized Systems	pm	12	0	0	0	0	6	72	0	0	3	36	0	0	3	36	0	0	0	0	0	0	0	0	0	12	144	0	0	
- Reproductive Health	pm	12	0	0	0	0	3	36	0	0	3	36	0	0	3	36	0	0	0	0	0	0	0	0	0	9	108	0	0	
- Other TBD	pm	12	3	36	0	0	3	36	0	0	3	36	0	0	3	36	0	0	0	0	0	0	0	0	0	12	144	0	0	
S-T PARTICIPANT - TC																														
- Policy Observation Vis	pm	7	6	42	0	0	3	21	0	0	3	21	0	0	3	21	0	0	0	0	0	0	0	0	0	15	105	0	0	
- Decentralized Systems	pm	7	0	0	0	0	3	21	0	0	3	21	0	0	3	21	0	0	0	0	0	0	0	0	0	9	63	0	0	
- Nutrition	pm	7	6	42	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	42	0	0	
- Other conferences, etc	pm	7	0	0	0	0	3	21	0	0	3	21	0	0	3	21	0	0	0	0	0	0	0	0	0	9	63	0	0	
IN-COUNTRY																														
- Consensus Roundtable	ls	-	-	0	50	5	-	0	25	2	-	0	25	2	-	0	25	2	-	0	15	1	NA	NA	140	12	NA	NA	140	12
- Decentralized Systems	pm	2	15	0	30	15	30	0	60	30	30	0	60	30	30	0	60	30	30	0	60	30	135	0	270	135	75	0	150	75
- Departmental Teams	pm	2	15	0	30	15	15	0	30	15	15	0	30	15	10	0	20	10	5	0	10	5	40	0	80	40	40	0	80	40
- HIS	pm	2	5	0	10	5	10	0	20	10	10	0	20	10	0	0	0	0	0	0	0	0	130	0	260	130	100	0	200	100
- Lab/Radiology Equip M	pm	2	30	0	60	30	50	0	100	50	50	0	100	50	0	0	0	0	0	0	0	0	100	0	200	100	250	0	500	250
- Radio Commo Mince	pm	2	50	0	100	50	50	0	100	50	0	0	0	0	0	0	0	0	0	0	0	0	250	0	500	250	250	0	500	250
- Reproductive Health	pm	2	50	0	100	50	50	0	100	50	50	0	100	50	50	0	100	50	50	0	100	50	250	0	500	250	250	0	500	250
- Nutrition	pm	2	50	0	100	50	50	0	100	50	50	0	100	50	50	0	100	50	50	0	100	50	250	0	500	250	250	0	500	250
- Other TBD	pm	2	0	0	0	0	10	0	20	10	10	0	20	10	10	0	20	10	0	0	0	0	80	0	60	30	80	0	60	30
NOTE																														
1 pm = 1 person in a one month course, or																														
2 persons in a 2 week course, or																														
4 persons in a 1 week course, or																														
30 persons in a 1 day course																														
SUB TOTAL TRAINING																														
		230	120	480	220	292	270	555	287	236	207	465	217	186	207	365	167	150	0	915	151		813	2160						

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Line Item	Unit Unit Cost	FY 1996			FY 1996			FY 1997			FY 1998			FY 1999			LIFE OF PROJECT TOTALS				
		No Units	USAID FX	GOH LC	No Units	USAID FX	GOH LC	GOH LC													
IV OTHER																					
INSTITUTIONAL CONTRACTOR																					
NOTE: ALL LT TA SUPPORTS COSTS INCLUDED IN WEIGHTED TA COSTS																					
NOTE: ALL LT AND ST TRAVEL & PER DIEM INCLUDED IN WEIGHTED TO COSTS																					
- Home Office Direct	lot/yr 200	06	100	0	0	1	200	0	0	1	200	0	0	06	100	0	0	4	800	0	0
- PAP Office Rental	yr 60	06	30	0	0	1	60	0	0	1	60	0	0	06	30	0	0	4	240	0	0
- PAP Office Ops Costs	yr 180	06	0	90	0	1	0	180	0	1	0	180	0	06	0	90	0	4	0	720	0
- PAP Office Local Staff	yr 180	06	0	90	0	1	0	180	0	1	0	180	0	06	0	90	0	4	0	720	0
COMM HEALTH UNITS																					
- US\$3/person/year																					
- one UCS = 100,000 per																					
- therefore 300,000/UCS/yr																					
- of which 200,000 LC	yr 200	3	0	600	0	12	0	2400	0	20	0	4000	0	10	0	2000	0	65	0	13000	0
& 100,000 FX	yr 100	3	300	0	0	12	1200	0	0	20	2000	0	0	10	1000	0	0	65	6500	0	0
[includes UNICEF grant]																					
NATIONAL PROGRAMS																					
- Family Planning	yr 750	0	0	0	0	1	750	0	0	1	750	0	0	06	375	0	0	36	2826	0	0
- EPI/DRUGS PAHO	yr 700	0	0	0	0	1	700	0	0	1	700	0	0	06	360	0	0	36	2450	0	0
- Micronutrients	yr 200	0	0	0	0	1	200	0	0	0	0	0	0	0	0	0	0	1	200	0	0
SUPPORT SERVICES																					
- IEC public education	yr 200	0	0	0	0	1	0	200	0	1	0	200	0	06	0	100	0	36	0	700	0
- IEC social marketing	prod 250	0	0	0	0	2	0	500	0	2	0	500	0	0	0	0	0	6	0	1250	0
RESEARCH																					
- Operations Research	stud 60	0	0	0	0	4	0	200	0	4	0	200	0	0	0	0	0	12	0	600	0
- 1998 DHS	stud 500	0	0	0	0	0	0	0	0	0	0	500	0	0	0	0	0	1	0	500	0
USAID MGMT																					
- Vehicles	car 27	2	54	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	54	0	0
- Computers	unit 2	2	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	4	0	0
- Local staff (average)	py 30	0	0	0	0	6	150	0	0	6	150	0	0	26	75	0	0	176	625	0	0
- Internal PSC	py 160	0	0	0	0	1	160	0	0	1	160	0	0	06	75	0	0	36	625	0	0
- Vehicle Ops/Mntnc	yr 6	06	3	0	0	1	6	0	0	1	6	0	0	06	3	0	0	4	24	0	0
- Misc Supplies	yr 12	06	06	0	0	1	12	0	0	1	12	0	0	06	06	0	0	4	48	0	0
SUB TOTAL OTHER			492	780	0		3417	3660	0		4017	6260	0		2009	2280	0		13952	17490	0

10/9/04

Line Item	Unit	Cont	FY 1986			FY 1987			FY 1988			FY 1989			TOTALS		
			No	USAID	GOH	No	USAID	GOH									
			Units	FX	LC	Units	FX	LC									
COMMODITIES																	
VEHICLES																	
TA Team	car	27	10	270	0	0	0	0	0	0	0	0	0	0	0	0	0
For Central Ministry	car	27	10	270	0	0	0	0	0	0	0	0	0	0	0	0	0
For Departmental Teams	car	27	13	351	0	0	0	0	0	0	0	0	0	0	0	0	0
MOTORCYCLES																	
For TA Team	bike	2	5	18	0	0	0	0	0	0	0	0	0	0	0	0	0
For Central Ministry	bike	2	18	20	0	0	0	0	0	0	0	0	0	0	0	0	0
For Departmental Teams	bike	2	30	78	0	0	0	0	0	0	0	0	0	0	0	0	0
TA TEAM OFFICE																	
FURNITURE & EQUIPMENT																	
Computers/Peripherals	set	4	10	48	0	0	0	0	0	0	0	0	0	0	0	0	0
Phone/Fax/Copier	lot	2	4	6	0	0	0	0	0	0	0	0	0	0	0	0	0
Desk, Chairs, File Cab	lot	13	20	30	0	0	0	0	0	0	0	0	0	0	0	0	0
Power System	sys	10	1	16	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Equipment	lots	3	05	15	0	0	0	0	0	0	0	0	0	0	0	0	0
Basic Supplies	lot	02	6	88	00	0	0	0	0	0	0	0	0	0	0	0	0
CENTRAL MINISTRY																	
FURNITURE & EQUIPMENT																	
Computers/Peripherals	set	4	15	80	0	0	0	0	0	0	0	0	0	0	0	0	0
Phone/Fax/Copier	lot	2	15	30	0	0	0	0	0	0	0	0	0	0	0	0	0
Desk, Chairs, File Cab	lot	15	25	375	0	0	0	0	0	0	0	0	0	0	0	0	0
Power System	sys	10	2	20	0	0	0	0	0	0	0	0	0	0	0	0	0
Basic Supplies	lot	02	25	5	0	0	0	0	0	0	0	0	0	0	0	0	0
DEPT TEAMS																	
FURNITURE & EQUIPMENT																	
Computers/Peripherals	set	4	38	156	0	0	0	0	0	0	0	0	0	0	0	0	0
Phone/Fax/Copier	lot	2	13	26	0	0	0	0	0	0	0	0	0	0	0	0	0
Desk, Chairs, File Cab	lot	15	52	78	0	0	0	0	0	0	0	0	0	0	0	0	0
Power System	sys	10	13	130	0	0	0	0	0	0	0	0	0	0	0	0	0
Basic Supplies	lots	06	13	0	78	0	0	0	0	0	0	0	0	0	0	0	0
HEALTH FACILITIES																	
EQUIPMENT - SPECS TBD																	
LAB & RADIOLOGY	lot	00	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
RADIOIS	set	1	20	20	0	0	0	0	0	0	0	0	0	0	0	0	0
For TA Team	lot	308	TBD	50	0	0	0	0	0	0	0	0	0	0	0	0	0
MSPF to be determined	lot	NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
USAD CONTRACT/DEPT	lot	NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Social Marketing Course	lot	NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SUB-TOTAL COMMODITIES			1782	84	0	1895	2	15	275	1748	7	16	275	935	2	15	275
SUB-TOTAL COMMODITIES														4811	15	25	548

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Line Item	Unit Unit Cost	FY 1995			FY 1996			FY 1997			FY 1998			FY 1999			LIFE OF PROJECT TOTALS								
		No Units	USAID FX	GOH LC	No Units	USAID FX	GOH LC																		
GRAND TOTALS			3106	1719	220		7291	6038	642		7560	6624	492		6314	6691	182		2932	2984	164		27194	22834	1600
TOTAL USAID			4826				12327				14074				12905				5897				60028		

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6.2 Methods of Implementation and Financing

Table 4, Methods of Implementation and Financing, reflects the primary project procurement from DA funds and means of disbursement over the LOP. As seen, there will be four primary procurement -- the institutional contractor, two IO grants (PAHO and UNICEF), and the central contraceptive procurement -- in addition to the standard USAID management requirements. Following USAID policies to decrease management units per project and per office, this represents an enormous decrease in the number of management units for the PHNO portfolio.

**Table 4: Health Systems 2004
Methods of Implementation and Financing
(US\$ 1,000)**

<u>Component/ Activity</u>	<u>Method of Implementation</u>	<u>Financing Method</u>	<u>LOP Amount</u>
TA, Training, Commodities, Imp. Mgmt.	Competitive Inst. Contract	Direct Reimbursement	43,663
<i>TA, CDC</i>	<i>PASA</i>		400
Basic Package Service Del.	HB 13 IO Grant to UNICEF	FRLC	900
EPI/DRUGS, TA, Operations	HB 13 IO Grant to PAHO	FRLC	2,450
Contraceptives	Dir. Procurement	OYB Transfer	1,750
USAID Mgmt	PSCs, POs, etc.	Dir. Payment	1,000
Audit		Dir. payment	137
Evaluation	Direct Contract	Dir. Payment	120

The grants to PAHO and UNICEF, the CDC PASA and the contraceptive procurement are standard procedures at USAID Haiti and will take little time or effort. Currently, CDC has been funded through PASA. Actual funding level under this PASA will be obligated to provide for the CDC's activities under HS2004. The USAID management costs are also standard procurement, and

for project monitoring, the purchase of one computer for project data analysis, and miscellaneous supplies. The 1998 evaluation will either be through an IQC or local procurement, but is not considered complicated. The only complicated procurement will be the institutional contract.

This project paper has determined that the best implementation strategy is through an institutional contractor or consortium to manage the service delivery mechanisms for the SPOs. There are several reasons why the project is designed this way:

1. The project strategy with regard to service delivery is to move from level-of-effort funding tied to inputs to service delivery based on outputs, i.e., a per capita payment for basic services or cluster of services. A Minimum Coverage Threshold would have to be achieved by the SPO for payment. There would be a two-year phase-in period where some grants would continue, but where other procurement mechanisms, including probably sub-contracting, would be used. The project is designed so that by FY 1997, the new funding mechanisms will cover SPOs in 20 UCSSs, or over 2 million people.

2. The project is an integrated primary health care project and needs to keep the technical assistance and all other components integrated under one contract to assure that integration is effective. To implement the project any other way would defeat the purpose of integration, thus the thrust of the project.

3. The project is clearly trying to do more with less resources and is being innovative in so doing. This project will enable the Mission to streamline its management while getting a higher population coverage in basic health services and more efficiently monitor all aspects of the project.

The contract will be competitively bid among US companies, with standard requirements for not less than 10 percent, and preferably more, of the total award to Gray amendment concerns. Given the probable size of the award, and the depth and breadth of services required, it is likely that offerors will form large consortia in order to meet the needs. The Request for Proposals will be structured so as to encourage offerors to demonstrate simple and direct management structures -- such as the use of one lead firm -- for such multiple-institution groupings. The number and relationships of actors in Haiti is complex enough without being compounded by an unwieldy contractor management structure.

In order to accommodate the varied requirements for procuring goods and services under the contract, it will be

structured to provide for grants to SPOS that are not yet able to manage the output-based mechanisms, and consequently to provide for advances to organizations that cannot pre-finance activities on their own. It is hoped that use of both of these modes of operation can be phased out over the LOP. However, the contract must be structured to provide at least half of the US\$19.5 million for service delivery, or up to \$9.75 million over the LOP, on a grant basis.

The methods of implementation and financing are appropriate and are within the preferred methods as defined by the payment verification policy. On the basis of the above, the USAID Haiti Controller has approved the methods of implementation and financing under the auspices of the payment verification policy.

7. MANAGEMENT PROCEDURES

Overall responsibility for the project will rest with the Chief of the USAID Population, Health, Nutrition Office (PHNO). The Chief, PHNO, will directly supervise the following structure:

Deputy & HS2004
Project Manager

USDH Posno.	FSN-DH Project Coord.	PSC IEC/Comm. Participation	PSC Pop/FP Specialist	Sr. PHN Advisor
	Program Specialist	Program Asst.	Secretary	

In keeping with USAID re-engineering policies, this staffing represents a net decrease of two PSC positions by the end of FY 1996 due to anticipated decreased management load. During that period, a USAID International Development Intern (IDI) will join the office, and will fill the FTE of the CDC TAACS Advisor when his tour ends. Two local drivers will also be hired but will be managed out of the USAID motor pool.

The PHNO staff will be assisted on an as-needed basis by other offices of USAID/Haiti, i.e. the Controller, Contracts, and Program Coordination and Project Support (PCPS). As recommended in a recent Mission Management Assessment, a Project Committee will be maintained to consult and advise on project issues and progress on a periodic basis. The institutional contractor COP may be asked to sit in committee meetings as an observer from time to time.

Although the project design presented in this document is based on precise contracting modes and budget estimates, it must be emphasized that one of the Project Committee's primary roles will be to assure that the project stays flexible and responsive to changes in the environment. Project flexibility will be assured through regularly scheduled Annual Implementation Reviews during the second quarter of each fiscal year. The purpose of the reviews will be to identify changes in the Haitian context, including entry of new donors, progress under existing project components, and changes necessary to meet the new environment.

It is likely that, due to the rapidly changing environment and possible entry of new donors in Haiti, these annual reviews will result in formal project design adjustments, such as change in focus of activities under a specific project component, or addition of new activities or components consistent with project purpose or goal. Annual design adjustments will be carefully reviewed by the Committee and formalized through Action Memoranda signed by the Director.

One evaluation is planned, in FY 1998. The evaluation will address the progress of project implementation as measured against stated indicators, and the experience to date with the output-based financing scheme. The Scope of Work will be prepared by USAID Haiti. A total of 6 pm of TA is provided for in the budget.

As described in previous sections, the project as currently planned will be implemented through one major institutional contract and a small amount of direct USAID procurement. Given USAID staffing and management constraints, this is believed to be the most effective means of assuring technical and administrative efficiencies and effectiveness over time.

ANNEX A
LOGICAL FRAMEWORK MATRIX

ANNEX A
LOGICAL FRAMEWORK MATRIX

ANNEX A: LOGICAL FRAMEWORK
PROJECT NO. 521-0248: HEALTH SYSTEMS 2004

<u>Goal</u>	<u>Indicators of Goal Achievement</u>	<u>Means of Verification</u>	<u>Critical Assumptions</u>
to protect and develop Haiti's human resource base	Infant Mortality Rate decline by 50% to 50 per 1,000 live births by 2004. Total Fertility Rate decline by 33% to 4.5 by 2004.	1. On-going project monitoring 2. Demographic Health/Contraceptive Prevalence Survey conducted in FY 98 will provide detail on progress.	Health, smaller families are essential to productive human capital. The restoration of democracy and political stability will foster development and economic growth.

<u>Purpose:</u>	<u>End of Project Status (EOPS)</u>	<u>Means of Verification</u>	<u>Critical Assumptions</u>
to ensure equitable access to basic and reproductive health services to Haitian families in a manner that can be sustained over time.	1) One million Haitian families (5 million people) have regular access to immunizations, family planning, and AIDS prevention services. 2) 400,000 Haitian families (2 million people) have regular access to full range of basic preventive and curative services. 3) Public and private sector health institutions collaborating to provide more effective supervisory, support and direct services, on a cost recovery basis where appropriate.	1. Project reports (quarterly from lead contractor and periodic health surveys). 2. Project reports, as above. 3. USAID monitoring, project reports.	There is unmet demand for basic and reproductive health services nationwide. The public sector will reassume its role in policy and service delivery. Haiti's PYO/NGO health service organizations will continue to provide services throughout the country in collaboration with government. Socially and economically feasible mechanisms for financing health care can be developed and implemented over time.

1/2

<u>Outputs</u>	<u>Objectively Verifiable Indicators</u>	<u>Means of Verification</u>	<u>Critical Assumptions</u>
Component 1: Policy & Inst. Strengthening			
1.1 National-level <u>health policy agenda</u> formulated and providing policy framework for improved service delivery.	1.1.a) First National Consensus Workshop held and preliminary policy areas identified by 6/95; National Commission established by 9/95; c) Sequenced workplan for policy reform identified and more detailed benchmarks agreed by 6/96.	1.1. Contractor reports, USAID monitoring.	MSPP and other relevant MOH agencies willing and interested in establishing national policy.
1.2 Improved macro-level national and decentralized <u>planning and service delivery</u> undertaken by the MSPP and relevant private sector partners.	1.2.a) Institutional audit/needs assessment in center and provinces completed by 12/95; b) Strategic plan for decentralized service delivery drafted by 3/96; c) New systems developed and training plans initiated by 6/96; d) 30 - 60 persons per year trained in new systems; e) MSPP qualifies for direct USAID funding by 6/98.	1.2. Contractor reports, USAID monitoring.	GOH continues to promote decentralization according to 1987 Constitution.
1.3 MSPP staffed, functioning and monitoring service delivery from center and in 9 departmental management units.	1.3.a) 9 dept. units assigned essential staff by 6/95, staff deployed by 9/95; b) departmental units equipped and functioning by 3/96; c) 30 - 60 persons/year trained in basic service delivery monitoring and support.	1.3. Contractor reports, USAID monitoring.	GOH central budget will be able to provide salaries adequate to pay qualified staff. MSPP is committed to restoring basic and appropriate public sector functions.
1.4 Improved Health Information System(s) functioning and providing essential data for decision making.	1.4 a) Consensus on indicators to be measured established by 3/96; b) protocols with NGOs and other providers for provision of data established by 9/96; c) HIS providing essential data by 9/97; d) 40 pm training completed and system fully operational by 9/99.	1.4 Contractor reports, USAID monitoring.	Health services NGOs will collaborate in MSPP-led HIS.

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Outputs -- Continued

Component 2. Direct Service Delivery

2.1 Critical MSPP facilities, including laboratory, radiology, and communications facilities, rehabilitated and operational.

2.1. a) Institutional audit determines commodity/equipment needs of targetted facilities by 2/96; b) detailed specifications developed 4/96; c) equipment in country 9/96; d) training delivered to LC and radio operators by 9/97, e) targetted facilities operational by 9/97.

2.1 Contractor reports, USAID field verification.

MSPP will obtain and allocate adequate operating budget for facilities to function.

2.2 400,000 Haitian families receiving basic package of health services in approximately 20 defined locations.

2.2 a) 60,000 families receiving full package thru HS2004 SPOs by 3/96; b) 240,000 families receiving full package by 3/97; c) 400,000 families on full package by 3/98.

2.2 Contractor reports.

MSPP retains emphasis on basic package in defined geographic units with registered populations.

NGO/PVO partners remain interested in participating in USAID-financed projects, even with different financing mechanisms.

2.3 1 million Haitian families receiving more limited but essential coverage from national programs in reproductive health, immunizations, and nutrition.

2.3.a) National modern contraceptive prevalence increased to 20 percent by 1999; b) socially marketed condoms increased to 500,000 per month; c) immunization coverage rate 60% by 1999; d) Vitamin A coverage rate 60% by 1999.

2.3 MSPP HIS, contractor reports, 1998 demographic health survey.

Unmet demand for immunizations, FP and AIDS awareness activities exists/can be stimulated nationwide.

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Outputs - Continued

Component 3: Support Services

3.1 Risk behaviors reduced due to more effective IEC.

3.1. a) IEC committee and DES initiate integrated marketing communication plan by 3/96, with benchmarks to be determined; b) 4 new products introduced thru social marketing which remain on market in the absence of USAID funding by 9/98.

3.1. Contractor reports, USAID monitoring.

Effective IEC will reduce high risk behavior.

Various public, NGO, and commercial private sector organizations will collaborate to develop more cohesive IEC messages.

3.2 Operations and evaluative research to promote participation and improve service delivery providing information to improve efficiencies and effectiveness overall.

3.2. a) Sub-committee for Operations Research established by 3/96; b) Criteria and mechanisms to encourage operations research established by 9/96; c) grant program stimulating research underway by 12/96; d) DHS undertaken 3/98.

3.2. Contractor reports, USAID monitoring.

Well selected and designed operations research will increase demand for and utilization of basic and reproductive health services.

Inputs -- see following page for type and magnitude of inputs.

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Line Item	Unit	FY 1995				FY 1996				FY 1997				FY 1998				FY 1999				LIFE OF PROJECT TOTALS			
		Unit Cost	No Units	USAID	GOH	No Units	USAID	GOH	No Units	USAID	GOH	No Units	USAID	GOH	No Units	USAID	GOH	No Units	USAID	GOH	No Units	USAID	GOH		
			FX	LC	LC	FX	LC	LC	FX	LC	LC	FX	LC	LC	FX	LC	LC	FX	LC	LC	FX	LC	LC		
I. TECHNICAL ASSISTANCE																									
***NOTE: LISTING SPECIFIC POSITIONS AS "EXPATRIATE" OR "LOCAL" IS ARBITRARY FOR BUDGET PURPOSES												CONTRACTORS ARE ENCOURAGED TO PROPOSE THEIR OWN MIX													
LONG TERM EXPATRIATE																									
COF/Health Admin	py 326	06	160	13	0	1	300	26	0	1	300	26	0	1	300	26	0	06	160	13	0	4	1200	100	0
Contracts Administrator	py 300	06	138	13	0	1	276	26	0	06	1376	13	0	0	0	0	0	0	0	0	0	2	660	60	0
Health Policy Advisor	py 326	06	160	13	0	1	300	26	0	1	300	26	0	1	300	26	0	06	160	13	0	4	1200	100	0
Financial Mgmt	py 300	06	138	13	0	1	276	26	0	1	276	26	0	1	276	26	0	06	1376	13	0	4	1100	100	0
IEC Specialist	py 300	03	69	63	0	1	276	26	0	08	2063	19	0	0	0	0	0	0	0	0	0	2	660	60	0
Reproductive Health	py 300	03	69	63	0	1	276	26	0	08	2063	19	0	0	0	0	0	0	0	0	0	2	660	60	0
LONG TERM LOCAL																									
Contracts Administrator	py 80	C-6	0	40	0	1	0	80	0	1	0	80	0	1	0	80	0	06	0	40	0	4	0	320	0
Financial Mgmt	py 80	C-6	0	40	0	1	0	80	0	1	0	80	0	1	0	80	0	06	0	40	0	4	0	320	0
Commodities/Logistics	py 80	C-6	0	40	0	1	0	80	0	1	0	80	0	1	0	80	0	06	0	40	0	4	0	320	0
Facilities/Maintenance	py 80	C-6	0	40	0	1	0	80	0	1	0	80	0	1	0	80	0	06	0	40	0	4	0	320	0
Research/Evaluation	py 80	C-6	0	40	0	1	0	80	0	1	0	80	0	1	0	80	0	06	0	40	0	4	0	320	0
HIS Advisor	py 80	C-6	0	40	0	1	0	80	0	1	0	80	0	1	0	80	0	06	0	40	0	4	0	320	0
Human Res/Training	py 80	C-6	0	40	0	1	0	80	0	1	0	80	0	1	0	80	0	06	0	40	0	4	0	320	0
ILLUSTRATIVE SHORT TERM EXPATRIATE																									
Health Policy	pm 20		2	40	0	0	2	40	0	0	2	40	0	0	2	40	0	0	0	0	0	8	160	0	0
Regulations/Legislation	pm 20		0	0	0	0	1	20	0	0	1	20	0	0	1	20	0	0	0	0	0	3	60	0	0
Institutional Dev	pm 20		1	20	0	0	1	20	0	0	1	20	0	0	1	20	0	0	0	0	0	4	80	0	0
MSPP Training Curious	pm 20		0	0	0	0	2	40	0	0	0	0	0	0	0	0	0	0	0	0	0	2	40	0	0
Reproductive Health	pm 20		0	0	0	0	2	40	0	0	2	40	0	0	2	40	0	0	0	0	0	6	120	0	0
Others TBD	pm 20		1	20	0	0	2	40	0	0	2	40	0	0	2	40	0	0	0	0	0	7	140	0	0
ILLUSTRATIVE - SHORT TERM LOCAL																									
Health Policy/Regulators	pm 6		3	0	18	0	1	0	6	0	1	0	6	0	1	0	6	0	0	0	0	6	0	36	0
Institutional Audit & Follow	pm 6		8	0	48	0	3	0	18	0	3	0	18	0	1	0	6	0	0	0	0	15	0	90	0
MSPP Training Curriculum	pm 6		0	0	0	0	2	0	12	0	0	0	12	0	0	0	0	0	0	0	0	4	0	24	0
Reproductive Health	pm 6		1	0	6	0	2	0	12	0	2	0	12	0	0	0	0	0	0	0	0	6	0	30	0
HIS/Statistics	pm 6		1	0	6	0	3	0	18	0	3	0	18	0	3	0	18	0	0	0	0	10	0	60	0
Equipment Maintenance	pm 6		2	0	12	0	2	0	12	0	2	0	12	0	2	0	12	0	2	0	12	10	0	60	0
Facilities Maintenance	pm 6		2	0	12	0	2	0	12	0	2	0	12	0	2	0	12	0	2	0	12	10	0	60	0
Others TBD	pm 6		1	0	6	0	1	0	6	0	3	0	18	0	3	0	18	0	2	0	12	10	0	60	0
MID TERM EVALUATION	pm 20		0	0	0	0	0	0	0	0	0	0	0	0	6	120	0	0	0	0	0	6	120	0	0
SUB TOTAL TECH ASSISTANCE			793	461	0		1900	808	0		1686	793	0		1166	707	0		4376	364	0		6870	3110	0

2

Line Item	Unit	FY 1995				FY 1996				FY 1997				FY 1998				FY 1999				LIFE OF PROJECT					
		No.	USAID		GOH	No.	USAID		GOH	TOTALS																	
			Units	FX			LC	LC			Units	FX			LC	LC			Units	FX		LC	LC	Units	FX	LC	LC
II. TRAINING																											
S-T PARTICIPANT - US																											
- Policy	pm	12	0	0	0	0	6	72	0	0	3	36	0	0	3	36	0	0	0	0	0	0	0	12	144	0	0
- Decentralized Systems	pm	12	0	0	0	0	6	72	0	0	3	36	0	0	3	36	0	0	0	0	0	0	0	12	144	0	0
- Reproductive Health	pm	12	0	0	0	0	3	36	0	0	3	36	0	0	3	36	0	0	0	0	0	0	0	9	108	0	0
- Other TBD	pm	12	3	36	0	0	3	36	0	0	3	36	0	0	3	36	0	0	0	0	0	0	0	12	144	0	0
S-T PARTICIPANT - TC																											
- Policy Observation Vis	pm	7	6	42	0	0	3	21	0	0	3	21	0	0	3	21	0	0	0	0	0	0	0	15	105	0	0
- Decentralized Systems	pm	7	0	0	0	0	3	21	0	0	3	21	0	0	3	21	0	0	0	0	0	0	0	9	63	0	0
- Nutrition	pm	7	6	42	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	42	0	0
- Other conferences, etc	pm	7	0	0	0	0	3	21	0	0	3	21	0	0	3	21	0	0	0	0	0	0	0	9	63	0	0
IN-COUNTRY																											
- Consensus Roundtable	ls	-	0	50	5	-	0	25	2	-	0	25	2	-	0	25	2	-	0	15	1	NA	NA	140	12		
- Decentralized Systems	pm	2	15	0	30	15	30	0	60	30	30	0	60	30	30	0	60	30	30	0	60	30	135	0	270	135	
- Departmental Teams	pm	2	15	0	30	15	15	0	30	15	15	0	30	15	15	0	30	15	15	0	30	15	75	0	150	75	
- HIS	pm	2	5	0	10	5	10	0	20	10	10	0	20	10	10	0	20	10	5	0	10	5	40	0	80	40	
- Lab/Radiology Equip M	pm	2	30	0	60	30	50	0	100	50	50	0	100	50	0	0	0	0	0	0	0	0	130	0	260	130	
- Radio Commo Mtnce	pm	2	50	0	100	50	50	0	100	50	0	0	0	0	0	0	0	0	0	0	0	0	100	0	200	100	
- Reproductive Health	pm	2	50	0	100	50	50	0	100	50	50	0	100	50	50	0	100	50	50	0	100	50	250	0	500	250	
- Nutrition	pm	2	50	0	100	50	50	0	100	50	50	0	100	50	50	0	100	50	50	0	100	50	250	0	500	250	
- Other TBD	pm	2	0	0	0	0	10	0	20	10	10	0	20	10	10	0	20	10	0	0	0	0	30	0	60	30	
NOTE																											
1 pm = 1 person in a one month course, or																											
2 persons in a 2 week course, or																											
4 persons in a 1 week course, or																											
30 persons in a 1 day course																											
SUB TOTAL TRAINING																											
			230	120	480	220	292	279	556	287	238	207	455	217	186	207	355	167	150	0	315	151	////	813	2160	////	

Line Item	Unit	Qty	FY 1998		FY 1998		FY 1997		FY 1998		FY 1998		FY 1998		FY 1998		TOTALS			
			USAID	GOVT	USAID	GOVT	USAID	GOVT												
VEHICLES																				
TA Team	car	27	10	270	0	0	0	0	0	0	0	0	0	0	0	0	0	10	270	
For General Mobility	car	27	10	270	0	0	0	0	0	0	0	0	0	0	0	0	0	10	270	
For Department Teams	car	27	11	361	0	0	0	0	0	0	0	0	0	0	0	0	0	11	361	
MOTORCICLES																				
For TA Team	bike	2	5	18	0	0	0	0	0	0	0	0	0	0	0	0	0	5	18	
For General Mobility	bike	2	10	20	0	0	0	0	0	0	0	0	0	0	0	0	0	10	20	
For Department Teams	bike	2	18	78	0	0	0	0	0	0	0	0	0	0	0	0	0	18	78	
LATINAM OFFICE																				
FURNITURE & EQUIPMENT																				
Computers/Peripherals	set	4	10	40	0	0	0	0	0	0	0	0	0	0	0	0	0	10	40	
Phone/Fax/Printer	lot	2	4	8	0	0	0	0	0	0	0	0	0	0	0	0	0	4	8	
Desk Chair/Fair Cab	lot	15	20	30	0	0	0	0	0	0	0	0	0	0	0	0	0	20	30	
Power System	lot	10	1	10	0	0	0	0	0	0	0	0	0	0	0	0	0	1	10	
Office Equipment	lot	3	0.5	1.5	0	0	0	0	0	0	0	0	0	0	0	0	0	0.5	1.5	
Basic Supplies	lot	0.2	6	0.6	0.6	0	0	0	0	0	0	0	0	0	0	0	0	6	0.6	
OFFICIAL RESIDENCY																				
FURNITURE & EQUIPMENT																				
Computers/Peripherals	set	4	15	60	0	0	0	0	0	0	0	0	0	0	0	0	0	15	60	
Phone/Fax/Printer	lot	2	18	20	0	0	0	0	0	0	0	0	0	0	0	0	0	18	20	
Desk Chair/Fair Cab	lot	15	25	37.5	0	0	0	0	0	0	0	0	0	0	0	0	0	25	37.5	
Power System	lot	10	2	20	0	0	0	0	0	0	0	0	0	0	0	0	0	2	20	
Basic Supplies	lot	0.2	25	5	0	0	0	0	0	0	0	0	0	0	0	0	0	25	5	
DEPT TEAMS																				
FURNITURE & EQUIPMENT																				
Computers/Peripherals	set	4	30	156	0	0	0	0	0	0	0	0	0	0	0	0	0	30	156	
Phone/Fax/Printer	lot	2	12	26	0	0	0	0	0	0	0	0	0	0	0	0	0	12	26	
Desk Chair/Fair Cab	lot	16	52	78	0	0	0	0	0	0	0	0	0	0	0	0	0	52	78	
Power System	lot	10	13	130	0	0	0	0	0	0	0	0	0	0	0	0	0	13	130	
Basic Supplies	lot	0.6	13	0	28	0	0	0	0	0	0	0	0	0	0	0	0	13	0	
HEALTH FACILITIES																				
EQUIPMENT SPECS TBD																				
LAB & DIAGNOSIS																				
FURNITURE & EQUIPMENT																				
For TA Team	set	1	20	20	0	0	0	0	0	0	0	0	0	0	0	0	0	20	20	
MSCT to be determined	lot	300	TBD	60	0	0	TBD	200	0	0	TBD	75	0	0	0	0	0	TBD	100	
USAID (ON TRACK) PT																				
Social Meeting Course	lot	TBD	0	0	0	0	lot	600	0	0	lot	500	0	0	lot	600	0	0	0	
SUBTOTAL COMMODITIES																				
			1282	84	0	0	1895	2	15	275	1240	16	275	395	2	19	15	466	159	
																		6558	743	568

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Line Item	Unit	FY 1996				FY 1996				FY 1997				FY 1998				FY 1999				LIFE OF PROJECT TOTALS				
		Unit Cost	No Units	USAID FX	GOM LC	No Units	USAID FX	GOM LC	No Units	USAID FX	GOM LC	No Units	USAID FX	GOM LC	No Units	USAID FX	GOM LC	No Units	USAID FX	GOM LC	No Units	USAID FX	GOM LC			
IV OTHER																										
INSTITUTIONAL CONTRACTOR																										
NOTE ALL LT TA SUPPORTS COSTS INCLUDED IN WEIGHTED TA COSTS																										
NOTE ALL LT AND ST TRAVEL & PER DIEM INCLUDED IN WEIGHTED TA COSTS																										
Home Office Direct	col/yr	200	05	100	0	0	1	200	0	0	1	200	0	0	1	200	0	0	05	100	0	0	4	800	0	0
PAP Office Rental	yr	60	05	30	0	0	1	60	0	0	1	60	0	0	1	60	0	0	05	30	0	0	4	240	0	0
PAP Office Ops Costs	yr	180	05	0	90	0	1	0	180	0	1	0	180	0	1	0	180	0	05	0	90	0	4	0	720	0
PAP Office Local Staff	yr	180	05	0	90	0	1	0	180	0	1	0	180	0	1	0	180	0	05	0	90	0	4	0	720	0
COMM HEALTH UNITS																										
US\$3/person/year																										
one UCS = 100 000 per																										
therefore 300 000/UCS/yr																										
of which 200 000 LC	yr	200	3	0	600	0	12	0	2400	0	20	0	4000	0	20	0	4000	0	10	0	2000	0	65	0	13000	0
& 100 000 FX	yr	100	3	300	0	0	12	1200	0	0	20	2000	0	0	20	2000	0	0	10	1000	0	0	65	6500	0	0
(includes UNICEF grant)																										
NATIONAL PROGRAMS																										
Family Planning	yr	750	0	0	0	0	1	750	0	0	1	750	0	0	1	750	0	0	05	375	0	0	35	2825	0	0
EPI/DRUGS PAHO	yr	700	0	0	0	0	1	700	0	0	1	700	0	0	1	700	0	0	05	350	0	0	35	2450	0	0
Micronutrients	yr	200	0	0	0	0	1	200	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	200	0	0
SUPPORT SERVICES																										
IEC public education	yr	200	0	0	0	0	1	0	200	0	1	0	200	0	1	0	200	0	05	0	100	0	35	0	700	0
IEC social marketing	prod	260	0	0	0	0	2	0	500	0	2	0	500	0	1	0	250	0	0	0	0	0	5	0	1250	0
RESEARCH																										
Operations Research	stud	50	0	0	0	0	4	0	200	0	4	0	200	0	4	0	200	0	0	0	0	0	12	0	600	0
1998 DHS	stud	500	0	0	0	0	0	0	0	0	0	0	0	0	1	0	500	0	0	0	0	0	1	0	500	0
USAID MGMT																										
Vehicles	car	27	2	54	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	54	0	0
Computers	unit	2	2	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	4	0	0
Local staff (average)	py	30	0	0	0	0	5	150	0	0	5	150	0	0	5	150	0	0	25	75	0	0	175	525	0	0
Internat PSC	py	150	0	0	0	0	1	150	0	0	1	150	0	0	1	150	0	0	05	75	0	0	35	525	0	0
Vehicle Ops/Mtnce	yr	6	05	3	0	0	1	6	0	0	1	6	0	0	1	6	0	0	05	3	0	0	4	24	0	0
Misc Supplies	yr	12	05	06	0	0	1	12	0	0	1	12	0	0	1	12	0	0	05	06	0	0	4	48	0	0
SUB TOTAL OTHER																										
			492	780	0		3417	3660	0		4017	5260	0		4017	5510	0		2009	2280	0		13952	17490	0	

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MISSION LOP BUDGET

16

Line Item	Unit Unit Cost	FY 1985			FY 1986			FY 1987			FY 1988			FY 1989			LIFE OF PROJECT TOTALS			
		No	USAID	GOH	No	USAID	GOH	No	USAID	GOH	No	USAID	GOH	No	USAID	GOH	No	USAID	GOH	
		Units	FY	LC	LC	Units	FY	LC	LC	Units	FY	LC	LC	Units	FY	LC	LC	Units	FY	LC
GRAND TOTALS		3106	1719	220	7291	6036	642	7660	6624	492	6714	6691	182	2932	2964	164	27194	2,834	10,000	
TOTAL USAID		4026			12327			14074			1,2006			6897			60029			

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ANNEX B

ILLUSTRATIVE BASIC PACKAGE PAYMENT MECHANISM

ANNEX B ILLUSTRATIVE BASIC PACKAGE PAYMENT MECHANISM

The purpose of the HS2004 project is to ensure equitable access to basic and reproductive health services to Haitian families in a manner that can be sustained over time. Part of the emphasis on sustainability is to support the MSPP policy to foster increased collaboration between the public and private sector in delivery of services to defined populations. One of the many ways the project will do so is through use of an output-based payment mechanism that promotes and rewards results.

It must be emphasized that not all Service Provider Organizations (SPOs) will move to use of the output-based mechanism at the same time. Use of the mechanism, as described below, will require relatively sophisticated cost-centered accounting which not all SPOs can accommodate. Some will be able to move quickly, and will benefit from the relative freedom the mechanism affords. Others will need to retain grant (or sub-grant) financing until such time as they are able to move to a cost centered basis. The institutional contract will be structured to allow for both types of financing, and includes provision for long-term TA to help SPOs in this regard.

The basic package of services will be delivered by SPOs throughout the country. Many of these are PVOs/NGOs who have received USAID funds in the past, and many have existing formal arrangements with the MSPP to provide care to defined populations in defined geographic areas. The HS2004 institutional contractor will enter into agreements with SPOs to provide a multiple-component package of health care services to registered families.

An illustrative model of how such an agreement might work is described in the following pages.

The Basic Health Care Package

The full package consists of a set of activities grouped around four clusters or components. These clusters are: childhood immunizations and nutrition, family planning, pre-natal and maternity care, and, treatment of childhood illnesses. The package is shown on the next page.

BASIC BENEFITS PACKAGE

1. * CHILDHOOD IMMUNIZATIONS AND NUTRITION

- DPT 3 Doses
- Polio 3 Doses
- Measles 1 dose
- BCG 1 dose

- Identify low birth weight infants
- Periodic weighing of infants and children
- Distribution of cups and spoons for breastmilk
- Identification of growth faltering
- Distribution of vitamin A - Ages 6 months - 7 years
- Food supplementation & nutritional rehabilitation
- Deworming

2. * FAMILY PLANNING

- Family Planning counselling and services
- Family life education for adolescents
- STD counseling and condom promotion/distribution

3 * PRE-NATAL, MATERNITY CARE AND STDS

- Pre-natal consultations, risk assessment and referral
- T Toxoid 5 doses (women 15 - 49 years)
- Iron, folic acid, malaria prophylaxis, syphilis diagnosis and treatment
- Attended birth, maternity care
- Newborn resuscitation, postpartum care including vitamin A, physical assessment
- Post partum family planning, STD, child survival counseling

4. * TREATMENT OF THE SICK CHILD

- Diagnose, refer or properly treat cases of diarrhea, malaria, pneumonia, measles, and intestinal parasites using WHO algorithm and approved products.

Accredited SPOs

In order to qualify for support for any cluster under this program, an institution must demonstrate (a) that it maintains adequate financial, personnel and material resource management systems to adequately account for the institutional contractor's funds; (b) that it is aware of and will abide by the institutional contractor's rules and regulations as to the use of its funds; (c) that it serves a population for which it has an accurate and current registration.

An accredited organization may apply to participate in any or all of the four clusters. In order to qualify for funding under any of the clusters, the organization must demonstrate that it possesses the necessary structures and competent human resources to carry out the activities of the cluster at an acceptable level of coverage and quality.

Payment to Accredited SPOs

Based on the registered population and based on the service statistics of the organization, the SPO will receive a per capita payment for each cluster in which it participates in order to and ... uming that it provides a minimum acceptable threshold level of care.

For example, an SPO participates in the Childhood Immunizations and Nutrition cluster. It has registered 1,000 children aged less than two years. This cluster includes immunizations, growth monitoring, vitamin A distribution and deworming. It's minimum coverage threshold is 80%. This means that least 80% of these children will have received, prior to their third birthday, all vaccines, seven weighings, four vitamin A capsules, and two dewormings. Each of the four clusters will have coverage thresholds and outputs appropriate to the cluster.

Payment will be made quarterly and based primarily on the service statistics provided by the SPO. An activity level factor will be calculated for each SPO that will determine for each SPO's registered population the number of procured services (vaccinations, weighings, vitamin A capsules, etc.) that should be provided by the SPO on a monthly basis in order to achieve the Minimum Coverage Threshold.

Minimum Coverage Thresholds

Childhood Immunizations and Nutrition

80% of children will, prior to their second birthday, have received all immunizations, seven weighings, four doses of vitamin A and two dewormings.

Pre-natal and Maternity Care

80% of the women registered by accredited SPOs who give birth during the year will receive complete pre-natal and obstetric care. This is defined as: at least three pre-natal consultations at which weight gain and risk is assessed and referral -- as necessary -- is made. Pre-natal women should receive the following: Tetanus Toxoid as needed, iron, folic acid, chloroquine (two treatments), syphilis (diagnosis and treatment), attended birth (by a trained and equipped TBA or at a maternity), post-partum Vitamin A, breastfeeding, and birth spacing education.

Family Planning

As to ensure free choice, minimum levels for family planning will not be set in terms of outputs but in terms of access, continuity of acceptors and community knowledge of family planning options.

Access: Voluntary Surgical Contraception available once per month per 40,000 population; Norplant, IUD, Depo-provera and pills available weekly per 20,000 population; spermicides and condoms available daily per 5,000 population. Information is available for modern and natural methods daily per 2,000 population.

Continuity: 80% of those who choose depo-provera, pills, spermicides or condoms will use a method for at least one year; 80% of IUD users will maintain their IUD or opt for Norplant or VSC by the end of year two; 80% of those choosing Norplant will maintain their Norplant at the end of year three.

Knowledge: 80% of Women of Reproductive Age will be able to identify three modern methods of birth spacing and will be able to identify at least one source for each of these methods.

Care of the Sick Child

80% of the population 0-5 has access (is within 5 kilometers) to a facility with a personnel trained in the application of the sick child algorithm AND a facility with the necessary equipment and supplies (ORS, Cotrimoxazole, Chloroquine, Albendazole, Acetaminophen) to treat children ill with diarrhea, pneumonia, malaria, intestinal worms and fever.

SPOs that do not provide this quantity of services will not be paid the entire per capita payment for the particular cluster. SPOs that perform above the minimum standards may qualify for annual "Quality Premium Payments".

Package Costs

While additional analyses will be performed to better estimate the exact reimbursement price USAID will provide to organizations that provide this package of care to a registered population, for budgetary purposes \$3.00 per capita will be used. Assuming an average family size of five, the per family reimbursement price for this package of services is estimated at US\$15 per family.

USAID intends to support the health care of two million Haitians, or 400,000 families through this program. This is approximately the same number of families covered by the PVOs supported currently through the EUHS, VACS and/or PSFP projects. While some of these families may not be supported immediately through this particular financing scheme, they will continue to receive support through some other scheme until they are able to adopt this "output based contract" approach.

Start Up Investments

There are three categories of start-up investments the project will support. First, the institutional contractor will assist SPOs to be "accreditable" by providing technical assistance to help potentially creditable organizations to develop the management systems necessary to account for USG funds. Second, it will fund population registration surveys. Third, it will assist with and finance the training and structure development costs necessary such that an organization can qualify to apply one of the four clusters of the Basic Services Package.

The institutional contractor will provide financial assistance (\$X per family) to register new populations and (\$Y per family) to update population registrations. Assuming that one third of the target two million population is currently registered but will require an updating, 120,000 families will be registered and 280,000 families will have their registrations updated. It will cost a fixed level of investment to bring up to a usable level the registration of 400,000 families to be served under this program. Further annual updates will be required and will be considered as covered under the monies provided for the package of services.

The institutional contractor will provide training, equipments and supplies to start up a new cluster in an organization. In order for an organization to qualify for a cluster, the SPO must demonstrate that it has an adequate number of persons trained and competent to provide the level and quality of care expected under the terms of the contract. For instance, if an SPO wishes to qualify for funding under the Childhood Immunizations and Nutrition cluster, it must demonstrate that it

ANNEX C
SOCIAL SOUNDNESS ANALYSIS

ANNEX C
SOCIAL SOUNDNESS ANALYSIS

1.0 Description

The purpose of this Social Soundness Analysis is to discuss how the proposed HS 2004 Project will interact with the various relevant Haitian sociocultural and institutional systems it proposes to serve: that of predominately poor and rural households, villages and other local communities, the Ministry of Public Health and Population (MSPP), and nongovernmental organizations (NGOs) and private voluntary organizations (PVOs). Five separate but related issues will be discussed in detail:

- What is the sociocultural feasibility of the proposed project and its interventions?
- What is the distribution of its benefits and burdens?
- What are the sociocultural obstacles to implementation and how have they been addressed?
- What is the potential spread effect?
- What would be the potential demographic impact by the year 2004?

2.0 Cultural Feasibility

For the purposes of this paper, cultural feasibility includes analyses of internal and external power relationships, beliefs and behaviors related to illness and the appropriate interventions to ameliorate them, and motivating factors for applying personal effort into activities. The analyses will be applied for four different levels of social grouping:

1. MSPP
2. PVO/NGO
3. Village/neighborhood
4. Household

2.1 MSPP vis a vis USAID and Bilateral agencies

The culture of the Haiti's Ministry of Public Health and Population is presently typified by disorganization, lack of continuity, lack of funds creating fragmentation, and lack of documented sets of norms and standards that could define the national health system in a clear way. Since 1987, for example, there have been 13 Ministers of Health and Population and, in some cases, their terms in office were as short as one month.

The culture of the MSPP at the central level cannot be described as one set of belief or behaviors. Rather, there is a factionalization of personalities in response to international ideologies, goals and funding priorities. Behaviors often reflect a reactive stance rather than a proactive one. The members of this culture are divided into various levels of engagement with the "outside". At the present time, the majority of MSPP employees is comfortable with the status quo, waits for outside projects to be planned, determines where the action is and gets while the getting is good. They are jealous of PVO power, high funding levels, outputs and research. The culture may say "yes" to changes in policy, execution and process for health care, but when observed, not show any of the behavior changes expected by donors. A minority of the culture welcomes innovation, adapts to changing international health priorities, engages and internalizes projects and works with PVOs in a collaborative fashion so that both might benefit.

During the past ten years, the central level of the MSPP has tried to exert its power in the planning, execution and evaluation of health care delivery but has largely remained impotent. It has neither the power base or the means to execute service delivery throughout the republic. The credibility of the system is low within the country and externally as well.

Since 1987, virtually all recent USAID assistance to the health/population/nutrition sector has been through the private sector, primarily NGOs but also the commercial private sector in the successful social marketing activities. U.S. government policy has permitted direct bilateral or indirect assistance to the Government of Haiti (GOH) only twice in the last eight years, in 1987 for a brief time just after the VACS and PSFP were authorized, and in 1990-1991, just prior to and during President Aristide's first in-country tenure. At most other times, USAID has been prohibited from direct bilateral assistance by law. Anger and mistrust at the level of MSPP developed as private NGOs proliferated. Well-stocked private organizations accomplished many of the MSPP health objectives while nearby MSPP facilities floundered and staff went unpaid for months at a time.

A major component of the new project is the establishment of support to the MSPP in its proposed decentralized departmental form. Overcoming nine years of severed relationships and uneven resource distribution will require application of clear lines of financial and logistical support as outlined in the project paper. A large degree of coordination is also required among all of the international donors interested in working in concert with the MSPP. Planning for these new initiatives needs to be accomplished in collaboration with responsible members of the Ministry and all financial actors. International priorities for health needs to be realistically adapted to the needs and capacity of the MSPP.

This project will provide technical assistance to the MSPP to help it do a number of things. During the first months of the project, an institutional audit is planned, which will result in a decentralization plan for the MSPP and an action plan. Specific technical assistance will be provided to the MSPP for:

1. The establishment of a National Commission on Health Policy, to provide a forum for discussion of important health policy issues of the day;
2. Assistance to the MSPP to carry out health policy reform initiatives;
3. Help with decentralization and decentralized systems development, which will include assistance with financial management, logistics support and administration.
4. Assistance with monitoring service delivery of health care; and
5. Planning and implementing health and management information systems.

2.2 NGO/PVO: Institutional Culture

The institutional culture of NGOs and PVOs generally includes the following characteristics, each of which could be a strength or weakness for the organization.

- * High commitment to the delivery of holistic care;
- * Willingness to accept and integrate new ideas and approaches to health care delivery;
- * Willingness to work at the field level in remote areas;
- * Willingness to integrate other development activities into health work;
- * Highly individualistic;
- * Not particularly prone to share resources, information, etc.;
- * Are usually more interested in processes and less in outcomes.

Furthermore, PVOs are often forced to respond to various donor priorities and requirements which means they often have many vertical programs operating simultaneously. This tends to be very inefficient.

The HS2004 Project intends to support processes that increase PVO and local MSPP institutional capability to respond to the health needs of the population in a more integrated fashion with success measured by output indicators, and not process inputs. This will require a change in orientation and in some cases,

reorganization of the manner in which services have been delivered in the past. Whereas some private local and national level institutions have had primarily vertical approaches to primary health care, a shift will occur towards integration at the community level. While this may be problematic at the beginning, the project is sure to reap many benefits of integration which will be felt at all levels.

To date, evaluation of NGO/PVO progress at the institutional level has been primarily in the area of financial accountability. The monitoring of the quality of services provided, therefore, has taken a secondary role for the institution. Although quality of care and sensitivity for the recipients of care are often basic to the Mission statements of PVOs, this is not explicitly stated as a desired outcome of project activities. More attention will be paid to these processes in the HS2004 Project.

This project proposes an integration of preventive and curative health services allowing for institutional variation in the implementation. The positive aspects of the PVO culture, i.e., local adaptation depending on need and resources and willingness to try new approaches, intersectoral development will thus be enhanced. The weak point, process input versus output criteria will demand a change in the operations at the field level to, in some cases, a more efficient model.

2.2.1 Inter-institutional cultural exchange

The culture of inter-institutional health relationships is typified by local determination. As mentioned above, coordination of care is not a routine part of the mission of the majority of PVOs. Sharing of technical information, successful techniques, research findings and failures has been limited to the effort of individuals. These are not integrated inter-institutional processes.

By the creation of a centralized resource center, the dissemination of technical information and the adoption of subject-specific informational seminars among MSPP and PVO institutions and personnel, more standardized case management of care of the sick child and other interventions would be realized, as well as other aspects of health cultural exchange.

In addition, one model suggested in the Project Paper is that evaluation teams will include local experts (often field-experiences PVO managers). They will be a part of other UCS institutions. This may create a spread of usable and successful ideas and solutions to problems encountered in the process of integrating the Project into daily operations.

2.4 Household level beliefs and health seeking behaviors

Health workers in community health have come to understand the distinct classifications of diseases made by many rural Haitians in terms of sicknesses of God or natural illnesses (Maladi Bondyea), and supernatural illnesses (Maladi Lwa). Each type of illness is viewed as having distinct causality and often specific treatments. The use of both traditional systems for supernatural illnesses and western treatments for natural sicknesses have existed simultaneously for many years.

Mothers and other female family members are the primary caretakers of the children of Haiti. In addition to their role as caretakers, they are responsible for commerce of one type or another, household chores, marketing, membership in church groups and, to a lesser extent, agricultural labor. Since the mother-child dyad is the fundamental target group for the HS2004 Project, care needs to be taken not to further overburden women. By providing preventive and curative care in an integrated fashion at the community level, it is expected that mothers will actually have to make fewer trips to the health provider. Missed opportunities for vaccination, for example, will be decreased as the health workers consider these preventive needs when consulting a child with a non-critical illness. This will be the project approach using the WHO "Care of the Sick Child" algorithms.

In addition, the interventions proposed by the HS2004 Project are not inconsistent with the perceived needs of the populace. The preventive interventions that have been in place for many years (vaccination, prenatal care, nutrition activities, monitoring the growth and development of children and distribution of vitamin A) have existed in concert with the traditional system of health care (traditional birth attendants, herbalists).

Traditional herbal treatments as well as modern ones are already prescribed in some programs, and a chapter on traditional treatments was included in the recent Creole translation of "Where there is No Doctor". Another example of traditional/modern health system blending is the training of traditional birth attendants (TBAs, many of whom are also herbalists). TBAs have been and will continue under the new project to be trained in improved sterile delivery techniques and referral for high risk pregnancies. In the new project, TBAs should be encouraged to continue their use of herbal massage for example, while learning to incorporate modern neonatal eye care.

The integration or blending of traditionally held beliefs and scientifically based actions has been successful at the family level in the case of the use of colostrum. Traditionally, a castor oil mixture was given to newborns as a purgative to expel meconium.

The initial breast milk, colostrum, was expressed and discarded. The practice of giving a "purgative" to newborns was kept, but the new message developed was to use colostrum as a better purgative. This updated practice has been adopted by many Haitian women.

Many recent health interventions have been based on anthropological investigations undertaken in order to understand the emic perspective of Haitian mothers. Care has been taken to avoid labeling caretakers as inadequate or thrusting a new treatment modality into a household without a sensitive approach to understanding current home care. An example of this was the recent WHO pilot study (1990) that was undertaken before the ARI standard case management was adapted for Haiti. An important objective of this study was to determine the explanatory model of pneumonia used by rural mothers. Based on the information gained e.g., pneumonia does not have a supernatural cause; home treatment is given for the initial three days of the illness, etc., appropriate modifications were made in the adaptation of the materials to the reality of the Haitian experience.

3.0 Distribution of Benefits and Burdens

3.1 MSPP

The problems created since the rupture of formal resolution with the MSPP in 1987 require clear, practical resolutions. Specific plans in the HS2004 project will be adapted in the early years of the project to re-establish working relationships. Specifically the benefits to the MSPP include the diagnostic audit and resulting institutional assistance, including financial and administrative assistance to resume selective, appropriate service delivery in areas throughout the country where there are no operational PVOs. Through training of nationals and collaborative planning between MSPP and bilateral organizations, there may be motivation for a closer integration of service delivery systems (PVO and MSPP) at the departmental levels. Sharing of expertise and resources will re-establish more standardized care and disseminate norms and standards for treatment at all levels of health practitioners. New opportunities for trained health providers will be created.

3.2 PVO/NGO Level

The variation in the methods of project implementation provide the flexibility necessary to adapt interventions to the local sociocultural environment. For local health systems the UCS concept will encourage more integration of services and better sharing of human and material resources. The institutions will have the liberty to design interventions independently, to utilize financial

resources as they determine, and to apply community participation principles as they decide.

New organizations will have a more difficult time providing integrated care. It will take years of technical assistance, cooperative planning and process evaluations to establish a minimal level of services and quality of care. This is why the project paper outlines a period or phase of transition from input-driven to output-driven indicators. The burden is carried by the organization to maintain a high degree of management capability. If the minimal standards are not met and sufficient technical assistance has been provided, the organization may find that assistance will be reduced.

The burdens at the level of the mature institutions will be the challenge of adjusting staff responsibilities, demonstrating clinical capability at all levels, documenting services provided and cooperating with periodic quantitative and qualitative evaluations.

3.3 Village/Neighborhood Level

The benefits at the village/neighborhood level are reflected throughout the Project paper. The services will come to the villagers through community-selected health workers. For the first time, integrated curative care will join the preventive educational and service inputs provided on-site. Not only will more members of communities have access to care, but they will participate in the delivery of that care. Opportunities for women as health workers, and as members of active and productive mothers' groups and other activities may be catalysts for community development in sectors other than health. The empowerment of women to participate in their own development will have a greater potential for realization through the IEC and community participation components of the Project.

Some current USAID projects have demonstrated that community participation has created a demand for preventive services. Examples include a demand for family planning and high utilization rates in immunizations. In many villages, community groups have written letters requesting vaccines for their children, assistance with sanitation and water. They have formed health committees on their own and have facilitated weekend vaccine efforts. Many village members have observed that fewer women and children die in places where there are on-site health workers, and have requested to be a part of these systems.

Those community members who would not directly participate in the implementation of the project except for in the case of STD/AIDS prevention are voodoo priests. These men and women are the spiritual/political power brokers located throughout the country. Basically, their area of diagnosis and treatment involves

supernaturally caused illnesses so that efforts in primary preventive and curative care does not directly involve them. Also, emergent healer-businessman called injectionists (pikirists) as well as local drug-sellers will not be integrated into the service delivery system. Injectionists are contracted for a small fee to administer injections of various liquids (milk, water, expired PCN, etc) into multiple sites on the body. Often the syringe is used multiple times. If integrated curative services spread to a large portion of the population through a community-based system, these itinerant health workers would stand to lose business. Through educational campaigns and the availability of essential medications at the village level, there is the possibility that the practice of buying one or two pills for illnesses will cease. There is no plan to train these people and integrate them in to the HS2004 project.

3.4 Household level

Mothers will be motivated to participate in the activities as they have in the past through utilization of culture-specific key messages. The benefit to them are healthy children and healthier pregnancies. Fathers will be involved but to a lesser degree. They will have access to some of the preventive educational and curative services. Adolescents are a target group for preventive education, particularly family planning and STD/AIDS prevention.

Communication of key health messages will be tested and implemented at the national, regional and household levels through tested IEC strategies and the use of radios. These include one-on-one communication and centrally designed mass media messages. Long term commitment to the increase in the knowledge base of caretakers, including fathers, is a method for sustainability of demand for the basic health services. The end point of positive behavior change will be evident at the level of the household.

4.0 Obstacles to Implementation

4.1 Lopsided coverage

Some areas of the country have inadequate coverage of the basic preventive and curative services, or extraordinary distances for patients to walk to get to health providers. At the same time, the West Department has the vast majority of practitioners, services, resources and referral facilities. The MSPP concept of UCS by geographical boundaries and the implementation of the new policy agenda may, in time, diminish some of these inadequacies. In other cases where the UCS concept will not be initially implemented, national level programs for preventive health in the areas of immunizations, nutrition, STD/AIDS prevention, and family planning will reach more of these underserved areas. Planning with the MSPP at the central level will be coordinated in the consensus process of the final HS2004 Project Paper.

4.2 Extreme poverty

There are many cases of families unable to pay for services because of the many demands for money and time that compete within the family. In the case of the inability to pay for curative services, the PVO organizations will most likely subsidize care for the extremely poor. In most cases, however, nominal payments will be required for services but not to the degree to maintain financial sustainability. In terms of the opportunity cost of time, the location of services in the community will help provide access. This integration of services in the HS2004 will actually reduce some of the other "costs" required of the family and, specifically, the mother.

4.3 Institutional demands

A considerable obstacle to the implementation of the integrated program will be the real adjustments that will have to be made at the field level. There will have to be a shift away from vertical orientation. The institutions will come to view the services they provide to their catchment area as integrated. This may require additional training for all levels of health personnel and a reorientation to the provision of care. The institutions will have to undertake self-assessments of current levels of care and complexities of implementation. They will be required to project into the future, taking into consideration all possible contingencies. They will have to fine-tune their health service information system to provide the required documentation. Institutions will simultaneously have to continue to provide services during this period of transition, according to their internal goals, objectives, commitments to the people and mission statements. These changes will be difficult to implement.

In addition, care has to be taken not to overburden the workers at the community or neighborhood level. If they are required to perform many distinct tasks in both the preventive and curative arenas, they will not be able to provide the level of quality that planners determine is the minimally acceptable level. Let us look at what the complement of services will be for a community health worker:

1. Coordinate community activities/ groups meetings
2. Provide group and individual education
3. Provide vaccines for all children and women 15-49
4. Train family members in oral rehydration therapy
5. Provide family planning counseling
6. Distribute contraceptives and follow-up
7. Learn how to use algorithms for curative care
8. Register pregnant women for prenatal care
9. Assess pregnant women for risk and refer
10. Distribute prenatal vitamins
11. Distribute and document children receiving vitamin A

12. Provide first aid
13. Detect and refer TB cases
14. Provide chemoprophylaxis for malaria to children and pregnant women
15. Diagnose, treat and follow-up children with GRI
16. Treat cases of malaria
17. Provide education for STD prevention and family life
18. Detect and coordinate institutional response or epidemics
19. Register births and deaths
20. Participate in continuing education
21. Weigh children, record and counsel mothers
22. Keep the water source clean/protected
23. Participate in nutritional rehabilitation
24. Maintain a minimal quality of care as defined by the institution

This overwhelming array of activities can only be performed if at least two conditions are present:

- * phasing-in of interventions - less complex to most complex
- * consistent planned clinical supervision

In the HS2004 Project, institutions have the flexibility to provide services in the manner most appropriate to the area and the designated population. These considerations, however, are a critical aspect that will, in large part, determine the clinical sustainability of a family centered approach to health care.

4.4 Atmosphere of distrust

Due to the years of political violence, uncertainty about the future, disruption of schooling for children, unemployment, lack of public/private discourse, and other circumstances the potential for people to form trusting relationships in the health sector has been small. Fortunately, many of the organizations that will be involved in the HS2004 Project have spent years developing trust relationships with the recipients. Trust at the level of the region, among institutions, between the public and private sector and between the central level and international donors have not been attained. A reestablishment of trust will depend on clear lines of support, clarification of expectations, and well defined requirements for results. The process of "keeping promises" for health posts applies also to higher levels. The HS2004 Project will use a process of consensus and recapitulation to clarify operational points for all levels of funding over the period of eight years. It will initially be a fluid process that will strive to clarify roles and relationships, expectations and results required.

4.5 Already overburdened mothers

The HS2004 Project must be careful to avoid making more

demands of their time and efforts. By integrating multiple services into each health contact, the overall number of contacts with health care providers will decrease, for example, by giving vaccines during non-urgent illness care visits or during regular health "rally posts". A major obstacle to consistent preventive and early illness care has been the tremendous commitment of time by mothers and other caretakers. The project acknowledges these constraints which is why the promotion of family centered services is now replacing vertical implementation strategies.

4.6 Illiteracy

The relationship between a decrease in infant mortality and the literacy of mothers has been strongly suggested internationally and in Haiti as well. This is also an obstacle to the realization of success in the HS2004 Project since it is not in the basic integrated package. However, attention to the education and empowerment of women will continue to be promoted as an adjunct to the work of health institutions. Interface with educators at the local and national levels will be encouraged during the period of the project.

4.7 Religious considerations

These must be considered in relation to STD/AIDS prevention and contraception. Particularly in some Catholic parishes, it is unacceptable to promote these activities and the distribution of condoms is prohibited. Some religious leaders have actively campaigned against the use of condoms for any reason, including prevention of AIDS/STDs.

The project will offer the full menu of family planning alternatives including natural family planning in the basic package. So, in cases where modern methods are not welcome, natural family planning will be promoted. However, there is no place for interface with activities designed to prevent the spread of sexually transmitted diseases including AIDS through the use of condoms. The messages related to monogamy offered by some Church leaders is the only point that is included as a part of wider educational messages.

4.8 Lack of infrastructure Integrity

The rugged mountain terrain of the country, inconsistent or lacking telephone communication, lack of sufficient local transportation, and inadequate public works all contribute to problems with rupture of stocks of materials, repair and service delivery, referral, training and continuing education. Recipients of care at the extreme must walk hours to the nearest health worker or facility. In the past, surveys suggested that 50% of the rural population have access to radios. Due to the present high cost of

batteries, the actual proportion of working radios is most likely substantially lower.

One example of a way to overcome logistical problems is the use of solar-powered radio communication. This would be a way to reach remote villages for the delivery of health messages e.g., soap operas for modeling behavior change; for assistance with differential diagnosis for physicians and nurses in remote regions; for facilitating medical referral from the provinces to advanced medical facilities, and others. This type of medium will be applied in concert with other forms of communication at all levels of health delivery. Of course, the medium will be used as well to advertise low-cost contraceptives and where to get them, as well as other products and services appropriate to integrated family health.

At the regional and institutional level, communication strategies will include joint seminars for technical information exchange. The radios mentioned above can be used to provide scheduled continuing education lessons for staff members in remote areas which could decrease the number of trips to central locations for training. In addition, given the diverse number of activities that health workers must perform, this methodology may improve productivity and efficiency within in the HS2004 Project.

The development of an inter-agency resource center will stimulate the exchange of new medical information, suggestions for public health administration improvement and other topics germane to the operations of the UCS. Another broad communication strategy is the creation of a research summary exchange. Written summaries of operations and other research with suggestions for implementation would be widely distributed to staff and program managers.

At the level of the village/neighborhood and household, communication strategies will include tested communication packages that can be integrated into the delivery of health services. Integration of IEC (face-to-face communication) using non-formal techniques for key health messages will be offered to institutions at the UCS level in the HS2004 Project. In addition, institutional and village level activities to enhance community participation will be promoted. A key step in these processes is feedback on progress of health activities with village members on a periodic basis.

5.0 Potential Spread Effects

The capacity of the poor to participate in some aspects of the implementation in this Project has already been demonstrated in other USAID-funded projects e.g., Family Planning in satisfied client groups, PHC in Jeremie, women's groups in Maissade, even though it had been thought unlikely within a climate of political

instability and mistrust. When health projects are approached as an "association" between the organization and the recipient clusters (neighborhoods or villages), participation is realized, and "success" not only in health interventions but in other types of development (latrines, roads, commerce groups) has been realized. The spread is not only to unplanned individuals who receive the benefits of increased knowledge but in terms of other development efforts in other sectors (E. Eng: WASH Project, 1987)

At the institutional level, the spread effect will be evident in the dissemination of new information and approaches to implementation. The HS2004 consortia will innovate new approaches to reach reasonable health outputs. These data and the results of operations research will be disseminated through the cooperative alliance among PVOs, bilateral organizations, professional organizations and the MSPP.

It has been shown that, in areas where there are scheduled "well child" rally posts, people living in non-registered areas receive the benefits of the intervention. Pregnant women are also the beneficiaries in these interventions. Also, in non-UCS funded interventions, all interested individuals will have access to family planning, STD/HIV prevention and practical, culturally appropriate messages related to exclusive breast feeding.

This project does not intend that there be widespread behavior changes on all fronts in the area of family health. However, access to the basic packages of services will improve. These interventions will be incorporated into the behavior patterns of Haitians and a demand will be created for the services. An important consideration is the assimilation of activities that will cement both institutional and clinical sustainability. Through these and other specific strategies at the UCS and non-UCS levels, the intermediate goals of reduction in child and maternal mortality will be achieved. A decentralized model of program implementation will permit each UCS to determine its scope and reach within the limits of the geographical and human resource limits.

The impact of the project can be realized in increments. Changes in health behaviors can be identified qualitatively. Institutional cohesion will evolve with resulting flow of health services to the neediest of Haitian households. Sustained and dynamic community participation in the development and maintenance of health delivery systems will be promoted.

The beneficiaries of the project are families - specifically women and their partners and their children. The project plans that at the end of the project:

One million Haitian families (5 million people) will have regular access to immunization, family planning, and HIV/AIDS prevention, and nutrition services.

400,000 Haitian families (2 million people) will have regular access to a full range of basic preventive and curative services.

5.1 Non-participants

Those who will not benefit from this project are people in need of advanced tertiary care. While these services may be available in the capital of PAP, highly technical health care will remain out of the reach of those too distant or too ill to travel, and to the very poor. However, the UCS service providers will work as efficiently as possible to establish realistic referral points and follow-up processes to serve these people. Handicapped children will receive the basic preventive and limited curative care. Extraordinary care will not be available to them in this package. Individuals in need of eye surgery will need to garner their own resources for cataract and other corrective eye surgery. Clearly, this project is not intended to provide comprehensive care to all registered within the UCS service areas. Additional tertiary care systems will need to be supported from other sources.

Local merchants may be adversely affected if the program of breast feeding changes the current behavior of women in the postpartum period. Local farmers may have problems in those instances where locally available foods (corn and beans) are substituted by the introduction of imported foods in feeding programs.

6.0 Demographic Impact by 2004

Haiti's population of 6.7 million is nearly double what it was in 1960. It could grow to 27 million in just 50 years at its present rate of natural increase (2.9%). The demographic transition in Haiti is characterized by decreased mortality and continued high fertility of about 6 children per woman. Emigration has tended to serve as a major factor in adjusting population pressure, is estimated to have fallen since 1980.

However, demography need not be destiny: nearly half of Haitian women in union in 1989 wanted to limit or postpone childbearing by at least two years, even though only 10% of them were using contraception. If the HS2004 project did nothing more than help hundreds of thousands of women and men achieve their own personal reproductive goals, the country's population would be far less than it might otherwise reach in 50 years.

Therefore, an indicator of progress toward the goal of the HS 2004 project will be the decrease in fertility rates resulting from both an improvement in maternal and child health status and accessible, quality reproductive health services. Services will include availability of a wide range of contraceptive methods in the public, private voluntary and commercial sectors.

A distinction should be made, however, between the impact of the project on fertility rates and the impact on overall population growth rates. While fertility among women of reproductive age can be affected in the near and medium term, there will be less noticeable change in the rate of population growth in the same period; current and past high fertility rates have produced a large number of Haitians age 0 - 15 years. Thus the size of the reproductive aged segment of the population cannot be affected for the next fifteen years.

Furthermore, the changes in fertility rates that can also be brought about through socio-economic development, improved quality of life, and changes in the status of the women, will not become evident until the medium or long term and are unlikely to be measurable until late in the HS2004 project.

Nonetheless, critical, measurable changes can be secured in the immediate future regarding the numbers of children that women will bear, and therefore the size of the population by 2004. There is strong evidence of high levels of need and demand reflected in responses to surveys of desired versus actual fertility, the response to quality services when they are provided, the numbers of abortions, the high maternal mortality rate, and the success of commercial condom and pill sales even during the hardest periods of the recent economic embargo. The most recent national survey (1989 CPS) reveals that in addition to 10% of women in union who use contraception, an additional 33% have a need for such services.

The project has been conceptualized to ensure maximum response to meeting these reproductive health needs. It will fill a major vacuum to access and quality of services: the organized private voluntary sector serves only a third of the country's population; the remaining two-thirds have very little access to any kind of service. The Project's approach to integrated preventive and curative interventions ensures that family planning will be highly complementary to other reproductive services, and is consistent with Haitian beliefs and practices. The project has incorporated flexibility for implementation of interventions at the community level through a decentralized MSPP system. Cultural considerations have been taken into account, and obstacles have been weighed and strategies recommended to address them.

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Interventions leading to increased use of family planning, maternal health, and child survival services would affect population estimates by the year 2004 as follows:

Scenario of Population Growth by 2004
With Improved Family Planning, Maternal Health,
and Child Survival Services

	1995	2005
Total Fertility Rate ¹	6.5	4.04
Life Expectancy at Birth ²	58.5	61.7
Annual Emigration ³	22,000	20,200
Total Population ⁴	6,899,000	
8,540,000		

¹. Current method mix (1989 CPS) stays the same; prevalence rises to 43.5%, which is 1989 CP (10%) and unmet need (33.3%)

². Futures Group (J. May) 1990

³. Futures Group (J. May) 1990

⁴. Futures Group (J.P. Guengant, R. Berg, E. Ade) 1993

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Listed below are statutory criteria applicable to the eligibility of countries to receive the following categories of assistance: (A) both Development Assistance and Economic Support Funds; (B) Development Assistance funds only; or (C) Economic Support Funds only.

A. COUNTRY ELIGIBILITY
CRITERIA APPLICABLE TO
BOTH DEVELOPMENT
ASSISTANCE AND ECONOMIC
SUPPORT FUND ASSISTANCE

1. **Narcotics
Certification**

(FAA Sec. 490): (This provision applies to assistance provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance relating to international narcotics control, disaster and refugee relief assistance, narcotics related assistance, or the provision of food (including the monetization of food) or medicine, and the provision of non-agricultural commodities under P.L. 480. This provision also does not apply to assistance for child survival and AIDS programs which can, under section 522 of the FY 1994 Appropriations Act, be made available notwithstanding any provision of law that restricts assistance to foreign countries.) If

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the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government):

(1) has the President in the April 1 International Narcotics Control Strategy Report (INCSR) determined and certified to the Congress (without Congressional enactment, within 45 calendar days, of a resolution disapproving such a certification), that (a) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to satisfy the goals and objectives established by the U.N. Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, or that (b) the vital national interests of the United States require the provision of such assistance?

yes

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(2) with regard to a major illicit drug producing or drug-transit country for which the President has not certified on April 1, has the President determined and certified to Congress on any other date (with enactment by Congress of a resolution approving such certification) that the vital national interests of the United States require the provision of assistance, and has also certified that (a) the country has undergone a fundamental change in government, or (b) there has been a fundamental change in the conditions that were the reason why the President had not made a "fully cooperating" certification.

Recipient is not defined as either a major illicit drug producing or a major drug transit country.

2. **Indebtedness to U.S. citizens** (FAA Sec. 620(c): If assistance is to a government, is the government indebted to any U.S. citizen for goods or services furnished or ordered where: (a) such citizen has exhausted available legal remedies, (b) the debt is not denied or contested by such government, or (c) the indebtedness arises under an unconditional guaranty of payment given by such government or controlled entity?

No

3. **Seizure of U.S. Property** (FAA Sec. 620(e)(1)): If assistance is to a

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government, has it
(including any government
agencies or subdivisions)
taken any action which
has the effect of
nationalizing,
expropriating, or
otherwise seizing
ownership or control of
property of U.S. citizens
or entities beneficially
owned by them without
taking steps to discharge
its obligations toward
such citizens or
entities?

No

4. Communist
countries (FAA Secs.
620(a), 620(f), 620D; FY
1994 Appropriations Act
Secs. 507, 523): Is
recipient country a
Communist country? If
so, has the President:
(a) determined that
assistance to the country
is vital to the security
of the United States,
that the recipient
country is not controlled
by
the international
Communist conspiracy, and
that such assistance will
further promote the
independence of the
recipient country from
international communism,
or (b) removed a country
from applicable
restrictions on
assistance to communist
countries upon a
determination and report
to Congress that such
action is important to
the national interest of
the United States? Will
assistance be provided
either directly or
indirectly to Angola,

No

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Cambodia, Cuba, Iraq, Libya, Vietnam, Iran or Syria? Will assistance be provided to Afghanistan without a certification, or will assistance be provided inside Afghanistan through the Soviet-controlled government of Afghanistan?

5. Mob Action (FAA Sec. 620(j)): Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property? No

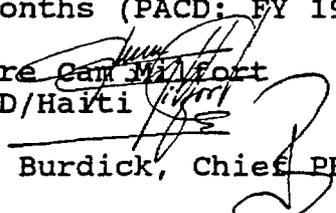
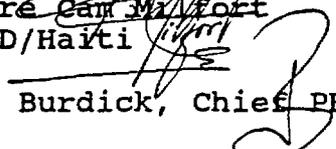
6. OPIC Investment Guaranty (FAA Sec. 620(l)): Has the country failed to enter into an investment guaranty agreement with OPIC? No

7. Seizure of U.S. Fishing Vessels (FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5): (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? No
(b) If so, has any deduction required by the Fishermen's Protective Act been made?

8. Loan Default (FAA Sec. 620(q); FY 1994 Appropriations Act Sec. 512 (Brooke Amendment)): (a) Has the government of the

ANNEX D
INITIAL ENVIRONMENTAL EXAMINATION

INITIAL ENVIRONMENTAL EXAMINATION

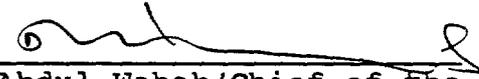
Project Location : Haiti
Project Title : Health System 2004
Project Number : 521-0248
Funding : 50,000,000
Life of Project : 54 months (PACD: FY 1999)
IEE Prepared by : Pierre Cam ~~Wort~~ 
USAID/Haiti
Concurrence : John Burdick, Chief PHN 

Recommended Threshold Decision

(a) **Categorical Exclusion** [(22 CFR 216.2) (c) (viii)] for Programs involving nutrition, health care or population and family planning services except to the extent designed to include activities directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment etc..)

(b) **Negative Determination** for the Direct Service Delivery component which will involve re-construction of health facilities.

CONCURRENCE


Abdul Wahab/Chief of the
Economic Growth Office
USAID/Haiti

**MISSION DIRECTOR'S
DECISION**

Approved: 
Date: Apr 3, 95

**LAC ENVIRONMENTAL
OFFICER'S DECISION**

Approved: _____
Date: _____

Project Description

The Health Systems 2004 project's purpose is to provide basic and reproductive health services to Haitian families in a sustainable manner.

The project is proposed for a two-phase 10 year implementation period beginning in FY 1995 and ending in FY 1999. It encompasses several components such as:

1. Policy Development and Institution Strengthening

The project seeks to ensure equitable access to basic and reproductive health services to Haitian families that can be sustained over time.

Public sector policy and institutional strengthening for the Ministry of Public Health (MSPP) will be available to support new decentralized health care delivery systems nationwide.

2. Direct Service Delivery

This component comprises direct service delivery by MSPP, NGO and commercial providers which operate both through community health units (UCS) with registered population as well as through selected national level programs in immunization, family planning, HIV / AIDS prevention and nutrition. This will be accomplished through the rehabilitation of MSPP hospitals, clinics, dispensaries and training institutions.

3. Support Services

This component includes information, education, and communication (IEC), social marketing, operations and evaluation research as well as USAID management and oversight.

Description of the Environmental Impact

The environmental impact of the project will be particularly felt in the health area.

The achievement of the project objectives will be especially expressed in increased access of Haitian families to basic and reproductive health services, such as immunizations, birth spacing, pre-natal care, ORT, nutrition including supplementation of women and children with micronutrient (vitamin A, iodine, iron etc..).

From the immunization activities planned to be carried out on a national basis, a certain amount of bio-hazardous wastes will be generated, which may not only contribute to the pollution of the environment, but also may be harmful to the population.

However, this must be balanced against the positive impact the project will have on various sectors through the day-to-day

activities of the population. Healthy workers will perform a better job than sick ones. Better performance in the farming sector will be translated into an increase in the agricultural production. That increase will in turn augment farmers income.

Mitigation Measures

The following mitigation measures focus especially on the reactivation of the essential MSSP health facilities:

1. The project will supply local dispensaries and clinics with appropriate equipment such as solar-powered stoves or incinerators to allow the health centers to incinerate needles and other bio-hazardous waste.

Mission Environmental Officer (MEO) will develop a list of materials that may likely show up as medical waste at the clinics, but that may not be incinerated due to potential air pollution/health concerns. MEO should use US Environmental Protection Agency regulations regarding incineration to develop this list. In addition, MEO should provide alternative disposal methods for materials that are not allowed to be incinerated. MEO will ensure that safety instructions accompany delivery of incinerators and stoves, and the appropriate workers are aware of proper use.

2. For most health centers, reconstruction will take place only within the footprint of the present structures.
3. Where a building may be expanded, there will be no construction in sensitive habitats.
4. Construction material will not be placed temporarily or permanently in waterways or wetlands.
5. There will be minimal vegetation clearing for reconstruction activities; and forested areas will be avoided during reconstruction.
6. Where there is any question regarding the potential impact of reconstruction activities on the environment, Mission Environmental Officer shall be contracted, and from a site visit, shall design additional site-specific mitigation, or require an amendment to this IEE, requesting a positive determination for that specific case, and an EA shall be conducted.

ANNEX E
STATUTORY CHECKLIST

A.I.D. PROJECT STATUTORY
CHECKLIST

Introduction

The statutory checklist is divided into two parts:
5C(1) - Country Checklist; and
5C(2) - Assistance Checklist.

The Country Checklist, composed of items affecting the eligibility for foreign assistance of a country as a whole, is to be reviewed and completed by AID/W at the beginning of each fiscal year. In most cases responsibility for preparation of responses to the Country Checklist is assigned to the desk officers, who would work with the Assistant General Counsel for their region. The responsible officer should ensure that this part of the Checklist is updated periodically. The Checklist should be attached to the first PP of the fiscal year and then referenced in subsequent PPs.

The Assistance Checklist focuses on statutory items that directly concern assistance resources. The Assistance Checklist should be reviewed and completed in the field, but information should be requested from Washington whenever necessary. A completed Assistance Checklist should be included with each PP; however, the list should also be reviewed at the time a PID is prepared so that legal issues that bear on project design are identified early.

The Country and Assistance Checklists are organized according to categories of items relating

to Development Assistance, the Economic Support Fund, or both.

These Checklists include the applicable statutory criteria from the Foreign Assistance Act of 1961 ("FAA"); various foreign assistance, foreign relations, anti-narcotics and international trade authorization enactments; and the FY 1994 Foreign Assistance Appropriations Act ("FY 1994 Appropriations Act").

These Checklists do not list every statutory provision that might be relevant. For example, they do not include country-specific limitations enacted, usually for a single year, in a foreign assistance appropriations act. Instead, the Checklists are intended to provide a convenient reference for provisions of relatively great importance and general applicability.

Prior to an actual obligation of funds, Missions are encouraged to review any Checklist completed at an earlier phase in a project or program cycle to determine whether more recently enacted provisions of law included on the most recent Checklist may now apply. Because of the reorganization and consolidation of checklists reflected here, such review may be particularly important this year. Space has been provided at the right of the Checklist questions for responses and notes.

recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1990 Appropriations Act appropriates funds?

Yes, the President signed an FAA Section 614(a) determination permitting this assistance, despite GOH arrears.
Also, PUB. L. 103-306, Section 541, permits assistance to Haiti notwithstanding any other provision of law.

9. Military

Equipment (FAA Sec. 620(s)): If contemplated assistance is development loan or to come from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment?

N/A

(Reference may be made to the annual "Taking Into Consideration" memo:
"Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

10. Diplomatic Relations with U.S. (FAA Sec. 620(t)): Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new

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bilateral assistance agreements been negotiated and entered into since such resumption?

No

11. U.N. Obligations (FAA Sec. 620(u)): What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operational Year Budget? (Reference may be made to the "Taking into Consideration" memo.)

The President signed an FAA Section 614(a) determination permitting this assistance, despite GOH arrears. See also question 8 on pages 7 and 8.

12. International Terrorism

a. Sanctuary and support (FY 1994 Appropriations Act Sec. 529; FAA Sec. 620A): Has the country been determined by the President to: (a) grant sanctuary from prosecution to any individual or group which has committed an act of international terrorism, or (b) otherwise support international terrorism, unless the President has waived this restriction on grounds of national security or for humanitarian reasons?

No

b. Airport Security (ISDCA of 1985 Sec. 552(b)). Has the Secretary of State determined that the country is a high

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terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures?

No

13. **Countries that Export Lethal Military Equipment (FY 1994 Appropriations Act Sec. 573).** Is assistance being made available to a government which provides lethal military equipment to a country the government of which the Secretary of State has determined is a terrorist government for purposes of section 40(d) of the Arms Export Control Act?

No

14. **Discrimination (FAA Sec. 666(b)):** Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA?

15. **Nuclear Technology (FAA Secs. 669, 670):** Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or

No

safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.)

No

16. **Algiers Meeting** (ISDCA of 1981, Sec. 720): Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and did it fail to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the "Taking into Consideration" memo.)

No

17. **Military Coup** (FY 1994 Appropriations Act Sec. 508): Has the duly elected Head of Government of the country been deposed by military

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coup or decrease? If assistance has been terminated, was the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance?

No

18. **Exploitation of Children** (FIM Sec. 116(b)): Does the recipient government fail to take appropriate and adequate measures, within its means, to protect children from exploitation, abuse or forced conscription into military or paramilitary services?

19. **Planning Fines** (FY 1994 Appropriations Act Sec. 571): Has the overall assistance allocation of funds for a country taken into account the requirements of this section to reduce assistance by 10 percent of the amount of unpaid parking fines owed to the District of Columbia as of September 30, 1993?

No

B. **COUNTRY ELIGIBILITY CRITERIA APPLICABLE ONLY TO DEVELOPMENT ASSISTANCE ("DA")**

Yes

Human Rights Violations (FIM Sec. 116): Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally

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recognized human rights?
If so, can it be
demonstrated that
contemplated assistance
will directly benefit the
needy? No

C. COUNTRY ELIGIBILITY
CRITERIA APPLICABLE ONLY
TO ECONOMIC SUPPORT FUNDS
("ESF")

**Human Rights
Violations (FAA Sec.
502B):** Has it been
determined that the
country has engaged in a
consistent pattern of
gross violations of
internationally
recognized human rights?
If so, has the President
found that the country
made such significant
improvement in its human
rights record that
furnishing such
assistance is in the U.S.
national interest?

Funding for Haiti in FY 1994
and 1995 exempts the program
from these prohibitions.

5C(2) - ASSISTANCE CHECKLIST

Listed below are
statutory criteria applicable
to the assistance resources
themselves, rather than to the
eligibility of a country to
receive assistance. This
section is divided into three
parts. Part A includes
criteria applicable to both
Development Assistance and
Economic Support Fund
resources. Part B includes
criteria applicable only to
Development Assistance
resources. Part C includes
criteria applicable only to
Economic Support Funds.

CROSS REFERENCE: IS COUNTRY
CHECKLIST UP TO DATE?

A. CRITERIA APPLICABLE TO
BOTH DEVELOPMENT
ASSISTANCE AND ECONOMIC
SUPPORT FUNDS

1. **Host Country
Development Efforts (FAA
Sec. 601(a)):**
Information and
conclusions on whether
assistance will encourage
efforts of the country
to: (a) increase the
flow of international
trade; (b) foster private
initiative and
competition; (c)
encourage development and
use of cooperatives,
credit unions, and
savings and loan
associations;
(d) discourage
monopolistic practices;
(e) improve technical
efficiency of industry,
agriculture, and
commerce; and (f)
strengthen free labor
unions.

This project responds to all
three of the mission strategic
objectives articulated in
september 1991 Country
Development Strategy Statement
(CDSS) and reconfirmed in the
Mission's FY 1995-2000 program
Objectives Document (POD) of
April 1993.

2. **U.S. Private
Trade and Investment (FAA
Sec. 601(b)):**
Information and
conclusions on how
assistance will encourage
U.S. private trade and
investment abroad and
encourage private U.S.
participation in foreign
assistance programs
(including use of private
trade channels and the
services of U.S. private
enterprise).

Services and commodities of
U.S. source, origin and
nationality will be used.

3. **Congressional**

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Notification

a. **General requirement** (FY 1994 Appropriations Act Sec. 515; FAA Sec. 634A): If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified (unless the Appropriations Act notification requirement has been waived because of substantial risk to human health or welfare)?

Yes

b. **Special notification requirement** (FY 1994 Appropriations Act Sec. 520): Are all activities proposed for obligation subject to prior congressional notification?

c. **Notice of account transfer** (FY 1994 Appropriations Act Sec. 509): If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures?

Yes

N/A

c. **Cash transfers and nonproject sector assistance** (FY 1994 Appropriations Act Sec. 537(b)(3)): If funds

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are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted?

N/A

4. **Engineering and Financial Plans** (FAA Sec. 611(a)): Prior to an obligation in excess of \$500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

Yes

5. **Legislative Action** (FAA Sec. 611(a)(2)): If legislative action is required within recipient country with respect to an obligation in excess of \$500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?

N/A

6. **Water Resources** (FAA Sec. 611(b)): If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in

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accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)

N/A

7. Cash Transfer/Nonproject Sector Assistance Requirements (FY 1994 Appropriations Act Sec. 537). If assistance is in the form of a cash transfer or nonproject sector assistance:

a. Separate account: Are all such cash payments to be maintained by the country in a separate account and not commingled with any other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)?

N/A

b. Local currencies: If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:

(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms

N/A

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and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?

(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?

N/A

(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?

N/A

N/A

8. Capital Assistance (FAA Sec. 611(e)): If project is capital assistance (e.g.,

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12c

construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively?

N/A

9. Multiple Country Objectives (FAA Sec. 601(a)): Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

The goal of this project is to protect and develop Haiti's human resource base. This will help Haitian families remain healthy and well-nourished, and to have the number of children they desire.

10. U.S. Private Trade (FAA Sec. 601(b)): Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

Services and commodities of U.S. source, origin and nationality will be used.

11. Local Currencies

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a. Recipient Contributions (FAA Secs. 612(b), 636(h)):

Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

N/A

b. U.S.-Owned Currency (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

N/A

12. Trade Restrictions

a. Surplus Commodities (FY 1994 Appropriations Act Sec. 513(a)): If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

N/A

b. Textiles (Lautenberg Amendment) (FY 1994 Appropriations Act Sec. 513(c)): Will the assistance (except for programs in Caribbean Basin Initiative

N/A

countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

13. **Tropical Forests** (FY 1991 Appropriations Act Sec. 533(c)(3) (as referenced in section 532(d) of the FY 1993 Appropriations Act): Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas?

N/A

14. **PVO Assistance**

a. **Auditing and registration** (FY 1994 Appropriations Act Sec. 568): If assistance is being made available to a PVO, has that

Yes

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organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?

b. Funding sources (FY 1994 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"): If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?

Yes

15. Project Agreement Documentation (State Authorization Sec. 139 (as interpreted by conference report)): Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).

Yes

16. Metric System (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as

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interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

Yes

17. **Abortions** (FAA Sec. 104(f); FY 1994 Appropriations Act, Title II, under heading "Population, DA," and Sec. 518):

a. Are any of the funds to be used for the performance of abortions as a method of

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family planning or to motivate or coerce any person to practice abortions? No

b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations? No

c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? No

d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? (As a legal matter, DA only.) Yes

e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? (As a legal matter, DA only.) No

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f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

No

g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization?

No

18. **Cooperatives** (FAA Sec. 111): Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life?

N/A

19. **U.S.-Owned Foreign Currencies**

a. **Use of currencies** (FAA Secs. 612(b), 636(h); FY 1994 Appropriations Act Secs. 503, 505): Are steps being taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services.

N/A

b. **Release of currencies** (FAA Sec. 612(d)): Does the U.S.

BS

own excess foreign
currency of the country
and, if so, what
arrangements have been
made for its release? N/A

20. Procurement

**a. Small
business** (FAA Sec.
602(a)): Are there
arrangements to permit
U.S. small business to
participate equitably in
the furnishing of
commodities and services
financed? Yes

**b. U.S.
procurement** (FAA Sec.
604(a)): Will all
procurement be from the
U.S., the recipient
country, or developing
countries except as
otherwise determined in
accordance with the
criteria of this section? Yes

**c. Marine
insurance** (FAA Sec.
604(d)): If the
cooperating country
discriminates against
marine insurance
companies authorized to
do business in the U.S.,
will commodities be
insured in the United
States against marine
risk with such a company? N/A

**d. Non-U.S.
agricultural procurement**
(FAA Sec. 604(e)): If
non-U.S. procurement of
agricultural commodity or
product thereof is to be
financed, is there
provision against such
procurement when the
domestic price of such N/A

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commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)

e.

Construction or engineering services (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)

No

f. Cargo

preference shipping (FAA Sec. 603)): Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are

Yes

available at fair and reasonable rates?

g. **Technical assistance** (FAA Sec. 621(a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

Yes

h. **U.S. air carriers** (International Air Transportation Fair Competitive Practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?

Yes

i. **Consulting services** (FY 1994 Appropriations Act Sec. 567): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)?

N/A

j. **Metric conversion** (Omnibus Trade

and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

Yes

k. **Competitive Selection Procedures** (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable

Yes

procurement rules allow otherwise?

1. **Chemical Weapons** (FY 1994 Appropriations Act Sec. 569): Will the assistance be used to finance the procurement of chemicals that may be used for chemical weapons production? No

21. **Construction**

a. **Capital project** (FAA Sec. 601(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used? N/A

b. **Construction contract** (FAA Sec. 611(c)): If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? N/A

c. **Large projects, Congressional approval** (FAA Sec. 620(k)): If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress? N/A

22. U.S. Audit

Rights (FAA Sec. 301(d)):

If fund is established solely by U.S.

contributions and administered by an international organization, does Comptroller General have audit rights?

Yes

23. Communist

Assistance (FAA Sec.

620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries?

Yes

24. Narcotics

a. Cash

reimbursements (FAA Sec. 483): Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated?

Yes

b. Assistance

to narcotics traffickers (FAA Sec. 487): Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other

Yes

controlled substances);
or (2) been an illicit
trafficker in, or
otherwise involved in the
illicit trafficking of,
any such controlled
substance?

**25. Expropriation
and Land Reform (FAA Sec.
620(g)):** Will assistance
preclude use of financing
to compensate owners for
expropriated or
nationalized property,
except to compensate
foreign nationals in
accordance with a land
reform program certified
by the President?

N/A

**26. Police and
Prisons (FAA Sec. 660):**
Will assistance preclude
use of financing to
provide training, advice,
or any financial support
for police, prisons, or
other law enforcement
forces, except for
narcotics programs?

N/A

**27. CIA Activities
(FAA Sec. 662):** Will
assistance preclude use
of financing for CIA
activities?

Yes

**28. Motor Vehicles
(FAA Sec. 636(i)):** Will
assistance preclude use
of financing for
purchase, sale, long-term
lease, exchange or
guaranty of the sale of
motor vehicles
manufactured outside
U.S., unless a waiver is
obtained?

Yes

**29. Export of
Nuclear Resources (FY**

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1994 Appropriations Act
Sec. 506): Will
assistance preclude use
of financing to finance
the export of nuclear
equipment, fuel, or
technology? No

**30. Publicity or
Propaganda (FY 1994
Appropriations Act Sec.
557): Will assistance be
used for publicity or
propaganda purposes
designed to support or
defeat legislation
pending before Congress,
to influence in any way
the outcome of a
political election in the
United States, or for any
publicity or propaganda
purposes not authorized
by Congress?** No

**31. Marine
Insurance (FY 1994
Appropriations Act Sec.
531): Will any A.I.D.
contract and
solicitation, and
subcontract entered into
under such contract,
include a clause
requiring that U.S.
marine insurance
companies have a fair
opportunity to bid for
marine insurance when
such insurance is
necessary or appropriate?** Yes

**32. Exchange for
Prohibited Act (FY 1994
Appropriations Act Sec.
533): Will any
assistance be provided to
any foreign government
(including any
instrumentality or agency
thereof), foreign person,
or United States person** No

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in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law?

33. Commitment of Funds (FAA Sec. 635(h)):

Does a contract or agreement entail a commitment for the expenditure of funds during a period in excess of 5 years from the date of the contract or agreement?

No

34. Impact on U.S. Jobs (FY 1994 Appropriations Act, Sec. 547):

a. Will any financial incentive be provided to a business located in the U.S. for the purpose of inducing that business to relocate outside the U.S. in a manner that would likely reduce the number of U.S. employees of that business?

No

b. Will assistance be provided for the purpose of establishing or developing an export processing zone or designated area in which the country's tax, tariff, labor, environment, and safety laws do not apply? If so, has the President determined and certified

No

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that such assistance is not likely to cause a loss of jobs within the U.S.?

c. Will assistance be provided for a project or activity that contributes to the violation of internationally recognized workers rights, as defined in section 502(a)(4) of the Trade Act of 1974, of workers in the recipient country, or will assistance be for the informal sector, micro or small-scale enterprise, or smallholder agriculture? No

B. CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY

1. Agricultural Exports (Bumpers Amendment) (FY 1994 Appropriations Act Sec. 513(b), as interpreted by conference report for original enactment): If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export N/A

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would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?

2. Tied Aid Credits (FY 1994 Appropriations Act, Title II, under heading "Economic Support Fund"): Will DA funds be used for tied aid credits?

N/A

3. Appropriate Technology (FAA Sec. 107): Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

N/A

4. Indigenous Needs and Resources (FAA Sec. 281(b)): Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills

A large portion of contract award will go to indigenous organizations which promote capacity building and encourage institutional development.

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required for effective participation in governmental and political processes essential to self-government.

5. **Economic Development** (FAA Sec. 101(a)): Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

Yes

6. **Special Development Emphases** (FAA Secs. 102(b), 113, 281(a)): Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing

N/A

countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

7. **Recipient Country Contribution** (FAA Secs. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

Waived

8. **Benefit to Poor Majority** (FAA Sec. 128(b)): If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?

Yes

9. **Contract Awards** (FAA Sec. 601(e)): Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes

10. **Disadvantaged Enterprises** (FY 1994

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Appropriations Act Sec. 558): What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

PP provides for at least 10 percent preferably more of total contract award for Gray amendment concerns.

11. Biological Diversity (FAA Sec. 119(g): Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

N/A

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12. Tropical Forests
(FAA Sec. 118; FY 1991
Appropriations Act Sec.
533(c) as referenced in
section 532(d) of the FY
1993 Appropriations Act):

N/A

a. A.I.D.

Regulation 16: Does the
assistance comply with
the environmental
procedures set forth in
A.I.D. Regulation 16?

Yes

b.

Conservation: Does the
assistance place a high
priority on conservation
and sustainable
management of tropical
forests? Specifically,
does the assistance, to
the fullest extent
feasible: (1) stress the
importance of conserving
and sustainably managing
forest resources; (2)
support activities which
offer employment and
income alternatives to
those who otherwise would
cause destruction and
loss of forests, and help
countries identify and
implement alternatives to
colonizing forested
areas; (3) support
training programs,
educational efforts, and
the establishment or
strengthening of
institutions to improve
forest management; (4)
help end destructive
slash-and-burn
agriculture by supporting
stable and productive
farming practices; (5)
help conserve forests
which have not yet been
degraded by helping to

N/A

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increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies;

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(12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

c. Forest degradation: Will assistance be used for:
(1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control

No

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structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

d. **Sustainable forestry:** If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry?

N/A

e. **Environmental impact statements:** Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment?

Yes

13. **Energy (FY 1991 Appropriations Act Sec. 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act):** If assistance relates to energy, will such assistance focus on:

N/A

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(a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases?

14. Debt-for-Nature Exchange (FAA Sec. 463):

If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management.

N/A

15.

Deobligation/Reobligation

(FY 1994 Appropriations Act Sec. 510): If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate

N/A

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Appropriations Committees
been properly notified?

16. Loans

a. Repayment
capacity (FAA Sec.
122(b)): Information and
conclusion on capacity of
the country to repay the
loan at a reasonable rate
of interest.

N/A

b. Long-range
plans (FAA Sec. 122(b)):
Does the activity give
reasonable promise of
assisting long-range
plans and programs
designed to develop
economic resources and
increase productive
capacities?

c. Interest
rate (FAA Sec. 122(b)):
If development loan is
repayable in dollars, is
interest rate at least 2
percent per annum during
a grace period which is
not to exceed ten years,
and at least 3 percent
per annum thereafter?

d. Exports to
United States (FAA Sec.
620(d)): If assistance
is for any productive
enterprise which will
compete with U.S.
enterprises, is there an
agreement by the
recipient country to
prevent export to the
U.S. of more than 20
percent of the
enterprise's annual
production during the
life of the loan, or has
the requirement to enter
into such an agreement

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been waived by the President because of a national security interest?

17. Development Objectives (FAA Secs. 102(a), 111, 113, 281(a)): Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

N/A

18. Agriculture, Rural Development and

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**Nutrition, and
Agricultural Research
(FAA Secs. 103 and 103A):**

a. **Rural poor and small farmers:** If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made.

N/A

b. **Nutrition:**
Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition

Nutrition is a major focus of the project. It will be addressed through various mechanisms including education and encouragement of the use of indigenously produced foodstuffs as well as through the opportunity for pilot projects and operational research to address malnutrition.

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of poor and vulnerable people.

c. Food security: Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

N/A

19. Population and Health (FAA Secs. 104(b) and (c)): If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

This is an integrated family health project with special focus on the provision of basic health services to the poor, particularly mothers and young children. The project will be implemented through PVOs/NGOs and the Ministry of Public Health, both of which greatly rely on Colvols, health and rally posts and other outreach mechanism.

20. Education and Human Resources Development (FAA Sec. 105): If assistance is

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being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

A major component of this project is information, education and communication (IEC) as well as social marketing and training. Short-term training will be provided for over 1,000 people from both NGO and public sector. Most of the training will be provided in country.

21. Energy, Private Voluntary Organizations, and Selected Development Activities (FAA Sec. 106): If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is:

a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of

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research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international organizations;

N/A

c. research into, and evaluation of, economic development processes and techniques;

d. reconstruction after natural or manmade disaster and programs of disaster preparedness;

e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;

f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor

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participate in economic and social development.

22. Capital Projects (Jobs Through Export Act of 1992, Secs. 303 and 306(d)): If assistance is being provided for a capital project, is the project developmentally sound and will the project measurably alleviate the worst manifestations of poverty or directly promote environmental safety and sustainability at the community level?

N/A

C. CRITERIA APPLICABLE TO ECONOMIC SUPPORT FUNDS ONLY

1. Economic and Political Stability (FAA Sec. 531(a)): Will this assistance promote economic and political stability?
To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA?

2. Military Purposes (FAA Sec. 531(e)): Will this assistance be used for military or paramilitary purposes?

N/A

3. Commodity Grants/Separate Accounts (FAA Sec. 609): If commodities are to be granted so that sale proceeds will accrue to the recipient country,

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have Special Account
(counterpart)
arrangements been made?
(For FY 1994, this
provision is superseded
by the separate account
requirements of FY 1994
Appropriations Act Sec.
537(a), see Sec.
537(a)(5).)

4. **Generation and
Use of Local Currencies**
(FAA Sec. 531(d)): Will
ESF funds made available
for commodity import
programs or other program
assistance be used to
generate local
currencies? If so, will
at least 50 percent of
such local currencies be
available to support
activities consistent
with the objectives of
FAA sections 103 through
106? (For FY 1994, this
provision is superseded
by the separate account
requirements of FY 1994
Appropriations Act Sec.
537(a), see Sec.
537(a)(5).)

No

5. **Capital Projects**
(Jobs Through Exports Act
of 1992, Sec. 306, FY
1993 Appropriations Act,
Sec. 595): If assistance
is being provided for a
capital project, will the
project be
developmentally-sound and
sustainable, i.e., one
that is (a)
environmentally
sustainable, (b) within
the financial capacity of
the government or
recipient to maintain
from its own resources,
and (c) responsive to a

N/A

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significant development
priority initiated by the
country to which
assistance is being
provided. (Please note
the definition of
"capital project"
contained in section 595
of the FY 1993
Appropriations Act.
Note, as well, that
although a comparable
provision does not appear
in the FY 94
Appropriations Act, the
FY 93 provision applies
to, among other things,
2-year ESF funds which
could be obligated in FY
94.)

N/A

ANNEX F

WAIVERS

Action Requested: Waiver of A.I.D. Requirement for Host Government Funding of International Travel.

Discussion: A.I.D. policy, as stated in Handbook 10, Participant Training, Chapter 16, would require that the Government of Haiti, or the non-A.I.D. funding source cover the cost of individuals selected for participant training under the HS 2004 project. To demonstrate the U.S. Government's support for the restoration of democratic governance with the return of Haiti's first freely elected President Jean-Bertrand Aristide, USAID/Haiti will launch a two-phase, 10-year Health Systems 2004 project. The goal of this project is to protect and develop Haiti's human resource base. The project's purpose is to provide basic and reproductive services to poor urban and rural families in a manner that can be sustained over time.

The success of this project depends upon the competencies of the personnel involved in the provision of quality services and/or the management of various facets of service delivery. A major emphasis is placed on training, both in-country and abroad to ensure the development of NGO's and GOH's personnel competencies under this project.

Funds are budgeted to finance participant training abroad. Short and long-term courses covering a wide range of disciplines relevant to project implementation but focussing primarily on management and policy development will be designed particularly for public sector candidates. AID's requirement that the cost of international travel be paid by the host country or other non-AID funding source might put such candidates at disadvantage, at least during the first phase of the project implementation.

After three years of increasingly harsher internationally-mandated sanctions combined with ever more irresponsible fiscal and monetary mismanagement, the restored democratically-elected government inherited very heavily encumbered public finances. USAID estimates that the consolidated public sector deficit for FY 1994 should exceed 2.5 billion gourdes. The implementation of a policy oriented toward reducing and even eliminating this enormous public deficit, as recently announced by the new Prime Minister in his general policy statement to both houses of the Haitian Parliament, will leave the GOH with almost no funding available to cover the airfare costs of public sector participant trainees.

We believe that it is essential to waive this requirement to give both NGO's and public sector candidates the same opportunity to participate in the training courses necessary for the success of the implementation of this project.

Authority: A.I.D. Handbook 10 , Chapter 16, Section 16C (1) provides the Mission Director with the authority to justify and authorize a general country waiver in full, or in part, of the host

11/16/05

government's or other sponsoring entity's responsibility to fund the cost of round-trip international travel, including incidental costs enroute as well as the cost of travel between the participant's home city and the point of departure and return provided that the Regional Assistant Administrator and OIT are informed.

Recommendation

Based on the discussion above, it is recommended, that the Project Authorization document include a waiver of the requirement for host country funding participant trainees of international travel under the Health Systems 2004 project.

**JUSTIFICATION TO EXEMPT THE GOVERNMENT OF HAITI FROM THE
RECIPIENT COUNTRY CONTRIBUTION REQUIREMENTS OF SECTION 110
OF THE FOREIGN ASSISTANCE ACT**

Action Requested: An exemption, pursuant to Section 547 of the Foreign Operations, Export Financing, and Related Programs 1995 Appropriations Act, Pub. L. 103-306, of the recipient country contribution requirement of FHA Section 110, for the Health Systems 2004 Project.

Discussion: To support the U.S. Government's post-resolution strategy for the restoration of democratic governance with the return of Haiti's first freely elected President Jean-Bertrand Aristide, USAID/Haiti will launch a two-phase, 10-year Integrated Family Health project called Health Systems 2004 (or HS 2004). The goal of this project is to protect and develop Haiti's human resource base. The project's purpose is to provide basic and reproductive services to poor urban and rural families in a manner that can be sustained over time.

The success of this project depends upon our ability to move ahead quickly to complete the pre-implementation arrangements for this project. The objective of the project is to improve efficiency in Haiti's health delivery services and maximize the impact of scarce development resources by fostering close collaboration between USAID and the Public Sector. The Mission will negotiate a bilateral agreement with the restored democratically-elected government shortly. Section 110 of the Foreign Assistance Act, Cost-Sharing and Funding Limits, states the following:

No assistance shall be furnished by the United States Government to a country under Sections 103 through 106 of this Act until the country provides assurances to the President, and the President is satisfied that such country provide at least 25 per centum of the costs of the entire program, project or activity with respect to which such assistance is to be furnished, except that such costs borne by such country may be provided on an "in kind" basis.

Haiti, the poorest nation in the Western Hemisphere, is the only country in Latin America to appear in both the United Nations (U.N.)-designated list of "relatively least developed countries" and the Development Assistance Committee (DAC) list of "low income countries". In 1991, Haiti's per capita gross domestic product (GDP) totalled about \$275 per year. The vast majority of its 6.7 million people lived below an absolute poverty level of \$150 annually. Moreover, coupled with political and economic instability, overpopulation and the consequent pressures on Haiti's resources have escalated rapidly the rate of environmental degradation and depletion, completing the vicious circle of missed opportunities, deprivation and despair.

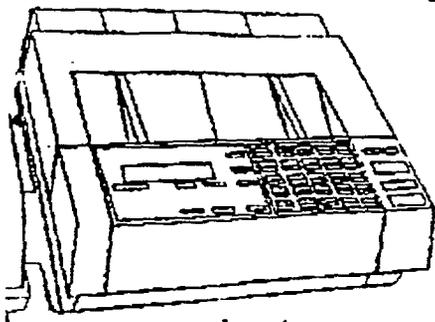
After three years of increasingly harsher internationally-mandated sanctions combined with ever more irresponsible fiscal and monetary mismanagement, the restored democratically-elected government inherited very heavily encumbered public finances. USAID estimates that the consolidated public sector deficit for FY 1994 would exceed 2.5 billion gourdes (U.S. \$167.0 million). The implementation of a sound macro economic policy eschewing foreign exchange control, price controls, and other policy induced distortions, as recently announced by the new Prime Minister in his general policy statement to both houses of the Haitian Parliament, will leave the GOH with very little resources available to provide firm assurance that the contribution could be provided in compliance with the subject policy requirement.

Primary justification: The Governemnt of Haiti simply does not have the funds to meet a 25% host country contribution for this project. The Government will be able to contribute minimal amounts which we estimate to be \$1,590,000.

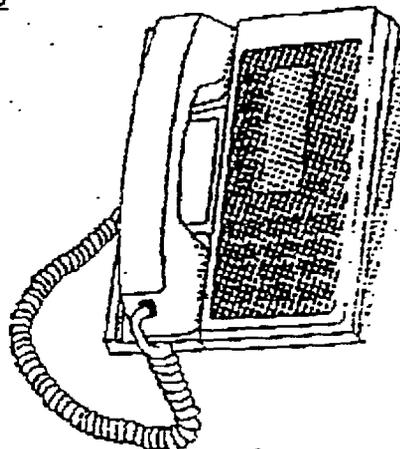
Authority: Section 547 of the Foreign Operations 1995 Appropriations Acts provides that funds appropriated in Title II of the Act that are made available for Haiti, may be made available notwithstanding any other provision of law. In a memorandum dated October 24, 1994, the Assistant Administrator for Latin America and the Caribbean approved the use of the Section 547 authority by the USAID/Haiti Mission Director to exempt activities from the 25% contribution requirement.

The exemption will be sated in the Project Authorization document.

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**AID/LAC/CAR
FACSIMILE MESSAGE
COVER SHEET**



DATE: 4/13/96

SUBJECT: HAIH HEALTH SYSTEMS 2004 PROJECT
(521-0348) PAPER VIEW

NUMBER OF PAGES
INCLUDING THIS COVER SHEET 3

PLEASE DELIVER THE FOLLOWING PAGES TO:

(NAME) Philipae Vixamat (TITLE)
(OFFICE) USAID/HAIH (FAX #) 509-239603

THIS MESSAGE IS FROM:

(NAME) David Eckerson (TITLE)
(OFFICE) LAC/CAR (PHONE) 202-647-2115

FAX NUMBER: (202) 647-4791

REMARKS:

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PHILIPPE
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TELECOMMUNICATIONS CENTER

OUTGOING
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RSD-03 LADP-03 /223 AZ TR 18/08552

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APPROVED BY: AID/AA/LAC:MSCHNEIDER
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SUBJECT: HAITI HEALTH SYSTEMS 2004 PROJECT (21-0748)
PAPER REVIEW

1. THE DAEC REVIEW OF THE HEALTH SYSTEMS 2004 PROJECT PAPER WAS HELD ON MARCH 10, 1995, CHAIRED BY THE AA/LAC. REPRESENTATIVES FROM LAC (SPM, DPB, RSD, HTF, AND CARI AS WELL AS GC, G/PH, M, AND USAID/HAITI PARTICIPATED IN THE REVIEW.

2. AA/LAC OPENED THE MEETING STATING THAT THIS IS A GOOD DOCUMENT WITH A CLEAR SENSE OF POLICY AND STRATEGY FOR STRENGTHENING THE HEALTH SECTOR IN HAITI. AA/LAC QUESTIONS AND COMMENTS FOCUSED ON VARIOUS ISSUES OF PROJECT SUSTAINABILITY.

3. THE FOLLOWING ISSUES WERE DISCUSSED.

A) PROJECT SUSTAINABILITY. AA/LAC ASKED THE MISSION REPRESENTATIVE THE FOLLOWING QUESTIONS: 1) IS THE PROJECT FEASIBLE IN TERMS OF POLITICAL COMMITMENT AND GIVEN THE MINISTRY'S INSTITUTIONAL CAPABILITY AND RESOURCES? 2) WILL NGOs RESIST A GREATER PUBLIC SECTOR PARTICIPATION,

INVOLVEMENT IN AND CONTROL OF THEM TO DATE MORE INDEPENDENT OPERATIONS? AND, 3) HAS THE DIALOGUE WITH THE MINISTRY INVOLVED ISSUES OF COST RECOVERY AND WHAT HAS BEEN THE MINISTRY'S REACTION TO THESE DISCUSSIONS?

THE MISSION REPRESENTATIVE INDICATED THAT THE PACKAGE OF SERVICES PROPOSED BY THE PROJECT ARE TECHNICALLY CORRECT AND EFFECTIVELY RESPOND TO HAITI'S DOMINANT PUBLIC HEALTH PROBLEMS. THE MISSION REPRESENTATIVE ASSURED THE AA/LAC THAT THIS PROJECT WAS CONSISTENT WITH THE RESULTS OF A MORE THAN ONE YEAR DIALOGUE WITH THE MINISTER OF HEALTH AND THAT HE IS TECHNICALLY AND POLITICALLY COMMITTED TO DOING THOSE THINGS DESCRIBED IN THE PP. AS AN EXAMPLE OF

HIS COMMITMENT, THE MINISTER IS CURRENTLY MAKING NEW DEPARTMENTAL HEALTH DIRECTORS AND ADMINISTRATORS. INITIATING OTHER STAFF ADJUSTMENTS, AND MAKING A CONCERTED EFFORT TO SOLIDIFY AND SEEK SUPPORT FOR HIS SERVICE-

STRENGTHENING HEALTH POLICY REFORM PROGRAM. HOWEVER, THE MISSION REPRESENTATIVE ACKNOWLEDGED THAT HE COULD NOT ENSURE THAT IN THE CURRENT BUDGETARY ENVIRONMENT THE MINISTRY OF PUBLIC HEALTH AND POPULATION (MSPP) WOULD RECEIVE MORE RESOURCES FROM THE GOH.

ON THE QUESTION OF POSSIBLE RESISTANCE BY NGOS, THE MISSION REPRESENTATIVE INDICATED THAT USAID HAS NOT NOTICED ANY RESISTANCE TO DATE. FURTHER, HE EXPLAINED THAT NGOS HAVE BEEN COLLABORATING WITH THE MINISTRY FOR YEARS, AND THAT CURRENTLY-NUMEROUS ARRANGEMENTS EXIST BETWEEN THE MSPP AND NGOS TO MANAGE SHARED HEALTH FACILITIES. NGOS IN MANY WAYS LOOK FORWARD TO A STRONG AND COHERENT MSPP TO COORDINATE ACTIVITIES IN THE SECTOR AND TO PROVIDE NORMS AND STANDARDS. THE ABSENCE OF THESE HAS CREATED PROBLEMS FOR NGOS. AN INTEGRATED COHERENT APPROACH WILL ALSO LEAD TO IMPROVED HEALTH STATUS IN HAITI.

THE POLICY DISCUSSIONS WITH THE MSPP HAVE NOT TO DATE SPECIFICALLY DEALT WITH COST RECOVERY. MANY PVD PROVIDERS CURRENTLY OPERATE COST RECOVERY SYSTEMS THAT GENERATE REVENUES AND REPRESENT SIGNIFICANT PORTIONS OF THEIR OPERATING COSTS. WITH REGARD TO THE PUBLIC SECTOR, THE MISSION REPRESENTATIVE CONFIRMED THAT THE MINISTER OF

HEALTH IS CONCERNED ABOUT THIS ISSUE. THE MSPP FIRST NEEDS TO DEVELOP SYSTEMS THAT WILL ALLOW FOR THE PROPER ACCOUNTING AND USE OF FUNDS AND PROVIDE SERVICES FOR WHICH PATIENTS WILL BE WILLING TO PAY. ONCE SYSTEMS ARE IN PLACE AND SERVICES ARE BEING OFFERED, COST RECOVERY ISSUES CAN BE MORE EFFECTIVELY ADDRESSED.

IN CONCLUSION, IT WAS AGREED THAT THE EXPECTED COMMITMENTS BY THE GOH TO ENSURE THE SUSTAINABILITY OF THE PROJECT NEEDED TO BE CLEARLY IDENTIFIED AND AGREED TO BY THE GOH. THE DAEC DECIDED THAT THE MISSION WOULD INCLUDE A COVENANT IN THE PROAG THAT: (A) THE GOH WOULD PROVIDE GREATER RESOURCES TO THE HEALTH SECTOR, (B) THE MSPP WOULD PURSUE A PROGRAM OF DECENTRALIZATION AND STRENGTHEN ITS NORMATIVE, POLICY MAKING ROLE, C THAT THE MOH WOULD CONTINUE TO WORK IN COLLABORATION WITH THE PRIVATE NGO PROVIDERS; AND, (D) THAT IT WOULD DEVELOP A COHERENT COST RECOVERY PROGRAM TO INCREASE FINANCIAL SUSTAINABILITY AND ENSURE EQUAL ACCESS.

IT WAS SUGGESTED THAT THE MISSION SHOULD OPERATIONALIZE THIS COVENANT VIA A PROJECT IMPLEMENTATION LETTER (PIL). THIS PIL WOULD PROVIDE GUIDANCE TO THE GOH FOR THE JOINT DEVELOPMENT OF AN OPERATIONAL PLAN WITH AGREED-UPON BASELINES AND BENCHMARKS THAT WOULD BE MONITORED AND ASSESSED DURING THE PROJECT'S ANNUAL IMPLEMENTATION REVIEWS. THE INPUT BUDGET IN THE PP DOES NOT PROVIDE CLEAR INFORMATION ON THE LEVEL OF RESOURCES THAT WOULD BE DEVOTED TO EACH COMPONENT SIGNIFICANT ACTIVITY.

THEREFORE, THE MISSION SHOULD PROVIDE A SUMMARY COMPONENT BUDGET IN THE PP. A MORE DETAILED COMPONENT/ACTIVITY BUDGET SHOULD BE PREPARED AS PART OF THE OPERATIONAL PLAN.

B) COST ANALYSIS AND THE OUTPUT-BASED PAYMENT MODEL.

THE QUESTION WAS RAISED WHETHER THE OUTPUT-BASED PAYMENTS TO HEALTH-CARE PROVIDERS AIM AT COVERING THE TOTAL COST OF VARIOUS PACKAGES OR AT CONTRIBUTING TO THESE COSTS? FOR BUDGETING PURPOSES, THE PP USED A US\$3.00 AVERAGE PER BENEFICIARY PER YEAR COST ESTIMATE FOR THE ENTIRE PROPOSED

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PACKAGE OF CARE. THIS FIGURE WAS THEN USED TO CALCULATE THE AMOUNT NECESSARY TO ACCOMPLISH THE SERVICE DELIVERY OBJECTIVES OF THE PROJECT. THE MISSION REPRESENTATIVE EXPLAINED THAT THIS MAY OR MAY NOT COVER THE ENTIRE COST OF SERVICES FOR A PARTICULAR ORGANIZATION. IN ANY CASE, IT IS NOT INTENDED TO COVER ALL COSTS, RATHER TO CONTRIBUTE TO THESE COSTS. USAID DOES NOT WISH TO BECOME THE SOLE SOURCE OF FUNDING FOR THESE ACTIVITIES FOR ANY ORGANIZATION. ALL SERVICE PROVIDER ORGANIZATIONS (SPOS) WILL BE EXPECTED TO CONTRIBUTE ADDITIONAL RESOURCES, EITHER FINANCIAL OR IN-KIND. THE MISSION AGREED TO MAKE CHANGES IN THE PROJECT PAPER AND EVENTUAL INSTITUTIONAL CONTRACT TO REFLECT THE FACT THAT USAID PROJECT FUNDS WILL CONTRIBUTE TO COVERING THE COSTS OF SERVICE DELIVERY BY SPOS, AND NOT COVER THEM COMPLETELY.

FURTHERMORE, IT WAS SUGGESTED THAT THE CONTRACTOR BE OBLIGED UNDER THE TERMS OF THE AGREEMENT WITH USAID/HAITI TO INSTITUTIONALIZE THE COST-FINDING AND CONTROL SYSTEMS WHICH YIELD AN UNDERSTANDING OF THE RELEVANT COST FUNCTIONS PERTAINING TO HEALTH SERVICES DELIVERY IN HAITEI

THIS WOULD INVOLVE SELECTED SPOS, AND SEEN WAYS TO MAXIMIZE THE EFFICIENCY OF ALL SPOS. IT WILL BE NECESSARY TO UNDERSTAND THESE COSTS IN ORDER TO IMPROVE THE EFFICIENCY OF SERVICES DELIVERY AS CONTEMPLATED IN THE PROJECT, AND TO LAY A FOUNDATION FOR REALISTIC BUDGETING OF REVENUES TO THE HEALTH SECTOR BY THE CENTRAL GOVERNMENT.

C) ROLE OF THE GLOBAL BUREAU PHN CENTER IN THE IMPLEMENTATION OF THE HEALTH SYSTEM 2004 PROJECT.

THE DRAFT PP MADE NO MENTION OF UTILIZING 6 PROJECTS IN THE PROPOSED PROJECT. THERE WAS CONCERN THAT GIVEN BOTH THE SIZE OF THE PROJECT AND THE RANGE OF ACTIVITIES PROPOSED IN THE PP, IT WOULD MAKE SENSE TO DRAW UPON THE TECHNICAL EXPERTISE AVAILABLE TO USAID/HAITI THROUGH 6 PROJECTS. THE USAID REPRESENTATIVE EXPLAINED THAT 6 SUPPORT WAS NOT INCLUDED IN THE DRAFT PP PRIMARILY BECAUSE THE MISSION UNDERSTOOD THAT 6 FIELD SUPPORT SERVICES WOULD HAVE TO BE FUNDED UNDER THE PROJECT. AS THE NEWLY DEVELOPED FIELD SUPPORT MECHANISM DOES NOT REQUIRE MISSION-DIRECTED BUY-INS, THIS 6 BUREAU SUPPORT WOULD BE PROVIDED IN ADDITION TO HS2004 FUNDS. GIVEN THIS, IT WAS AGREED THAT THE PP WOULD BE MODIFIED TO INCLUDE LANGUAGE TO ALLOW FOR GLOBAL BUREAU FIELD SUPPORT ASSISTANCE AND WOULD INDICATE TECHNICAL AREAS, SUCH AS QUALITY ASSURANCE, EVALUATION, HEALTH FINANCING, AND STD/AIDS WHERE GLOBAL ASSISTANCE MAY BE SOUGHT.

D) THE AA/LAC INDICATED THAT IN THE IMPLEMENTATION STAGE, THE CONTRACTOR SHOULD CONSIDER SUB-CONTRACTING TO INTERNATIONAL ORGANIZATIONS WHERE THEY HAVE EXPERTISE AND PROVEN CAPACITY TO CARRY OUT ACTIVITIES IN A COST-EFFECTIVE FASHION. FURTHER, IN THE IMPLEMENTATION STAGE, THE CONTRACTOR AND USAID NEED TO REVIEW CAREFULLY THE NEED FOR EACH SPECIFIC OPERATIONS RESEARCH PROJECT, RELATIVE TO OVERALL PROJECT FUNDING NEEDS.

E THE FOLLOWING ISSUES/CONCERNS WERE DISCUSSED IN THE ISSUES MEETING. THE MISSION REPRESENTATIVE AGREED TO MAKE ADDITIONS AND CORRECTIONS TO THE PP TO RESOLVE THESE CONCERNS.

A) COMPLEMENTARITY AND INTEGRATION WITH OTHER USAID PROJECTS AND OTHER DONOR ACTIVITIES. THE PP DOES NOT

DISCUSS OTHER USAID PROJECTS AND HOW THESE RELATE TO HS2004, NOR DOES IT ADEQUATELY ADDRESS OTHER DONOR ACTIVITIES IN THE HEALTH FIELD. IT WAS AGREED THAT THE PP WOULD BE REVISED TO PROVIDE A DESCRIPTION OF HOW THIS PROJECT WOULD COMPLEMENT AND RELATE TO OTHER USAID PROJECTS AND PROGRAMS SUCH AS THE PL ARE TITLE II PROGRAM, MISSION AGRICULTURAL ACTIVITIES, PL ARE TITLE III, POLICY REFORM AND PRIVATE SECTOR PROGRAMS. PARTICULAR ATTENTION WILL BE GIVEN TO HOW THESE OTHER ACTIVITIES WILL AFFECT THE PROJECT'S NUTRITION ACTIVITIES. FURTHER, WITH RESPECT TO A CONCERN BY G/PHN, THE PP WILL EXPLAIN WHY THE PROJECT

DOES NOT PROPOSE SPECIFIC ENVIRONMENTAL HEALTH OR WATER AND SANITATION ACTIVITIES AND HOW THESE ISSUES ARE BEING ADDRESSED BY USAID PROJECTS AS WELL AS OTHER DONORS AND HOW COORDINATION IS ENSURED THROUGH VARIOUS MULTI-AGENCY TECHNICAL COMMITTEES.

B) QUALITY OF HEALTH SERVICES: G/PHN EXPRESSED CONCERN THAT THE PP PROVIDES INADEQUATE GUIDANCE FOR IMPROVING THE QUALITY OF HEALTH SERVICES IN HAITEI, NOTING THE IMPORTANCE OF INCORPORATING CURRENT APPROACHES TO DEFINING, ASSESSING AND IMPROVING QUALITY. IT WAS AGREED THAT THE PP WOULD BE REVISED TO INCLUDE DEVELOPMENT OF A QUALITY ASSURANCE PROGRAM BY THE INSTITUTIONAL CONTRACTOR AS PART OF ITS PROPOSAL, AND THAT THE CONTRACTOR'S ADDRESSING THE NEED FOR QUALITY ASSURANCE WOULD CONSTITUTE ONE OF THE PROPOSAL EVALUATION CRITERIA. SPOS WOULD HAVE TO INCORPORATE QUALITY STANDARDS IN THEIR HEALTH SERVICE PROGRAMS. FURTHER, THE PROJECT WILL ASSIST THE MSPP TO DEVELOP THE MANAGEMENT SYSTEMS NEEDED TO ENSURE ADEQUATE MONITORING OF THESE NORMS AND STANDARDS.

5. CONSISTENT WITH MODIFICATIONS TO THE PROJECT PAPER AND PROAG AS DESCRIBED IN SECTIONS 3 AND 4 ABOVE, THE MISSION IS HEREBY DELEGATED AUTHORITY TO AUTHORIZE THE HEALTH SYSTEMS 2004 PROJECT. IN ORDER TO RECORD THE USE OF NOTWITHSTANDING AUTHORITY, THE MISSION SHOULD INCLUDE THE FOLLOWING STATEMENT IN THE PROJECT AUTHORIZATION: QUOTE AA/LAC HAS DELEGATED TO THE USAID/HAITI MISSION DIRECTOR THE AUTHORITY TO UTILIZE THE QUOTE NOTWITHSTANDING UNQUOTE

AUTHORITY OF SECTION 547(a) OF THE FY95 FOREIGN OPERATIONS APPROPRIATIONS ACT TO EXEMPT THIS PROJECT FROM THE REQUIREMENT OF SECTION 110 OF THE FOREIGN ASSISTANCE ACT THAT THE COOPERATING COUNTRY CONTRIBUTE TWENTY FIVE PERCENT OF THE COST OF THE PROJECT UNQUOTE. PLEASE NOTE THAT AUTHORIZATION OF THE PP SHOULD AWAIT EXPIRATION OF THE CONGRESSIONAL NOTIFICATION. SEPTTEL WILL PROVIDE INFORMATION ON CN SUBMISSION AND EXPIRATION DATES. CHRISTOPHER

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REPUBLIQUE D'HAITI

MINISTÈRE DE LA SANTÉ PUBLIQUE
ET DE LA POPULATION

No. 2805

Port-au-Prince, le 28 AVR. 1995 19

Monsieur Larry Crandall
Directeur Agence Americaine
pour le developpement
International (AID)
En ses Bureaux

Monsieur le Directeur,

Le Ministère de la Santé Publique et de la Population vous presente ses compliments et, suite aux réunions de travail entre l'USAID et le MSPP, initiées depuis l'été 1994, a le plaisir de solliciter, au nom du Gouvernement Haïtien, une assistance financière, sous forme de don, de cinquante millions de dollars US (US \$ 50,000.00). Cette assistance servira à financer la première phase d'exécution du projet "Health System 2004" ou "Haïti Santé 2004". Ce projet est destiné à appuyer les efforts déployés par le Gouvernement Haïtien, dans le cadre de la nouvelle orientation des services de Santé, basée sur l'Equité, l'Accessibilité à tous, la Decentralisation et la Participation communautaire.

Vu l'importance de l'amélioration du système sanitaire dans le développement socio-économique du pays, cet office apprécierait que l'USAID réponde favorablement à cette requête.

Le Ministère de la Santé Publique et de la Population vous prie d'agrèer, Monsieur le Directeur, avec ses remerciements, l'expression de ses salutations distinguées.

Dr Jean Joseph MOLIERE
Ministre

