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

CHILE

PROJECT PAPER

PROGRAM FOR PRIMARY HEALTH CARE

AID/LAC/P-588

PROJECT NUMBER: 513-0351
GRANT NUMBER: 513-K-601

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AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT DATA SHEET		1 TRANSACTION CODE <input type="checkbox"/> A = Add <input type="checkbox"/> C = Change <input type="checkbox"/> D = Delete	Amendment Number	DOCUMENT CODE 3
2 COUNTRY/ENTITY Chile		3 PROJECT NUMBER 513-0351		
4 BUREAU/OFFICE LAC/DR/SA		5 PROJECT TITLE (maximum 40 characters) Program for Primary Health Care		
6 PROJECT ASSISTANCE COMPLETION DATE (PACD) MM DD YY 1 2 3 0 9 2		7 ESTIMATED DATE OF OBLIGATION (Under 'B', below, enter 1, 2, 3, or 4) A Initial FY <input type="checkbox"/> 9 <input type="checkbox"/> 1 B. Quarter <input type="checkbox"/> 2 C Final FY <input type="checkbox"/> 9 <input type="checkbox"/> 1		

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

A FUNDING SOURCE	FIRST FY 91			LIFE OF PROJECT		
	B FX	C. L/C	D. TOTAL	E FX	F L/C	G TOTAL
AID Appropriated Total	700	--	700	700	--	700
(Grant)	(700)	(--)	(700)	(700)	(--)	(700)
(Loan)	(--)	(--)	(--)	(--)	(--)	(--)
Other						
U S						
Host Country		6150	6150		16,700	6150
Other Donor(s)						
TOTALS	700	6150	6850	700	16,700	17,400

9 SCHEDULE OF AID FUNDING (\$000)

A APPROPRIATION	B PRIMARY PURPOSE CODE	C PRIMARY TECH CODE		D OBLIGATION 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) HE	534	510		0		700		700	
(2)									
(3)									
(4)									
TOTALS									

10 SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)
520 | 530 | 570 | 580

11. SECONDARY PURPOSE CODE

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

A Code	BRW	BMW	TNG
B Amount			

13 PROJECT PURPOSE (maximum 480 characters)

To provide technical assistance to support the implementation of the Program for the Immediate Improvement of Primary Health Care in Chile.

14 SCHEDULED EVALUATIONS

Interim	MM YY	MM YY	Final	MM YY
	0 6 9 1			1 2 9 2

15 SOURCE/ORIGIN OF GOODS AND SERVICES
 000 941 Local Other (specify)

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

17 APPROVED BY

Signature <i>Pete J. [Signature]</i>	18 DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION MM DD YY
Title Director, LAC/DR	
Date Signed MM DD YY 0 6 9 2	

B

CLASSIFICATION

AGENCY FOR INTERNATIONAL DEVELOPMENT PROGRAM ASSISTANCE APPROVAL DOCUMENT (PAAD)	1 PAAD Number 513-R-801		
	2 Country Chile		
	3 Category Development Assistance - Non-Project		
	4 Date November 16, 1990		
5 To AA/LAC: James Michel	6 OYB Change Number N/A		
7 From LAC/DR, Peter Bloom <i>PB</i>	8 OYB Increase To be taken from N/A		
9 Approval Requested for Commitment of \$ 9,300,000	10 Appropriation Budget Plan Code LDH091-25513-IG15		
11 Type Funding <input type="checkbox"/> Loan <input checked="" type="checkbox"/> Grant	12 Local Currency Arrangement <input type="checkbox"/> Informal <input checked="" type="checkbox"/> Formal <input type="checkbox"/> None	13 Estimated Delivery Period N/A	14 Transaction Eligibility Date N/A

15. Commodities Financed
N/A

16. Permitted Source	17 Estimated Source
U.S. only	U.S. \$9,300,000
Limited F W	Industrialized Countries
Free World	Local
Cash \$9,300,000	Other

18. Summary Description
 This program will assist the Government of Chile (GOC) to implement its two-year Program for the Immediate Improvement of Primary Health Care. This program consists of DA Section 104 non-project assistance of \$9.3 million to be provided in two tranches (conditioned upon benchmarks and progress made in achieving outputs as specified in this PAAD) and a technical assistance project component of \$700,000 which will fund program coordination, financial reviews and audits and technical assistance. The non-project dollar funds will be used by the GOC to finance (via reimbursement) public or private sector imports from the U.S. destined for the health sector. Local currency will be generated once dollars are released from the Separate Account and will be deposited into a Special Account. Local currency will help finance short-term costs of restructuring the primary health care system, and will be managed by the Ministry of Health.

"I certify that the methods of payment and audit plan are in compliance with payment verification policy."

[Signature]
LAC/Controller

19. Clearances	Date	20 Action
LAC/DPP:BSchouten <i>BS</i>	12/20/90	<input checked="" type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED Authorized Signature: <i>[Signature]</i> Title: _____ Date: 11/3/91
GC/LAC:PSullivan <i>PWS</i>	12/18/90	
LAC/SAM:RNelson <i>RN</i>	12/12/90	
LAC/DPP:CADams <i>CA</i>	12/13/90	
PPC/PB:TBarker <i>TB</i>	12/20/90	

C

PROJECT AUTHORIZATION

Country: Chile
Project Name: Immediate Improvement of Primary Health Care
Project Number: 513-0351

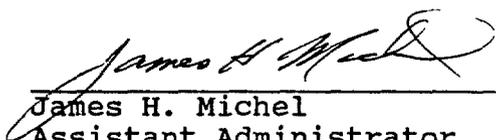
1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Immediate Improvement of Primary Health Care Project for Chile (the "Cooperating Country") involving planned obligations of not to exceed \$700,000 in grant funds in fiscal year 1991, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange costs and, to the extent permissible under A.I.D. "Buy America" policy, local currency costs for the project. The planned life of the project is two years from the date of initial obligation.

2. The project consists of support for the Cooperating Country's Program for the Immediate Improvement of Primary Health Care, which program will be partially financed by non-project assistance provided by A.I.D. Project activities will include technical assistance pursuant to buy-ins to A.I.D. centrally-funded projects, financial reviews and audits, and provision of a Program Coordinator.

3. The project agreements which may be negotiated and executed by the officers to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority shall be subject to the terms and conditions stated herein, together with such other terms and conditions as A.I.D. may deem appropriate.

4. Except as A.I.D. may otherwise agree in writing, commodities financed by A.I.D. under the project shall have their source and origin in the United States or, to the extent permissible under A.I.D. "Buy America" policy, the Cooperating Country. Except as A.I.D. may otherwise agree in writing, the suppliers of commodities or services (other than ocean and air shipping) shall have the United States or, to the extent permissible under A.I.D. "Buy America" policy, the Cooperating Country as their place of nationality. Except as A.I.D. may otherwise agree in writing, ocean and air shipping under the project shall be financed only on flag vessels of the United States.

1/3/91
Date


James H. Michel
Assistant Administrator
Bureau for Latin America
and the Caribbean

J

Clearances:

SA/AA/LAC:KHarbert	_____	Date	_____
LAC/DR:PBloom	<u>sgz</u>	Date	_____
LAC/DR/SA:PLapera	<u>sgz</u>	Date	<u>12/5/90</u>
LAC/SAM:NParker	<u>sgz</u>	Date	<u>12/19/90</u>
LAC/DPP:BSchouten	<u>MS</u>	Date	<u>12/20/90</u>
LAC/DPP:CAdams	<u>e</u>	Date	<u>12/13/90</u>

Drafted: GC/LAC:PSullivan:12/3/90:x79182

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Chile
Program for Immediate Improvement
of Primary Health Care
(513-0350)

Program Assistance Approval Document

Table of Contents

	<u>Page</u>
Summary and Recommendation	i
I. Introduction	1
A. Background and General Overview	1
B. Importance of Health Sector	3
II Description of the Problem	3
A. Current Health Care System	3
B. Current Primary Health Care System	5
C. Problems of the Health Care System	7
D. Specific Constraints and Bottlenecks of the Primary Health Care System	11
E. GOC Strategies for Overcoming Identified Constraints and Bottlenecks	13
III. Other Donors	15
IV. Program Rationale	17
V. A.I.D. Sector Assistance Program	18
A. Goal and Purpose	18
B. Strategies	19
C. Structure of the Program	19
D. Program Outputs	21
E. Program Inputs and Budget	23
F. Benchmarks/Conditions Precedent	25
VI. Program Implementation and Management	26
A. Implementation of Institutional and Policy Reform	27
B. Dollar Transfer and Local Currency Procedures and Management	28
C. Monitoring and Reporting	31
D. Implementation Plan	35
E. Audit Plan	37

F

VII. Ministry of Health Monitoring/Evaluation System	38
A. Monitoring "Performance" of Institutional and Policy Reform Efforts	40
B. Monitoring "Impact" at the Program Level	40
VIII. Compliance with Cash Transfer and Local Currency Guidance	40
IX. Conditions Precedent and Covenants	43

Annexes:

- A. GOC Program for the Immediate Improvement of Primary Health Care
- B. Logical Framework
- C. 611(e) Certification
- D. Statutory Checklist
- E. Initial Environmental Examination
- F. Letter of Request for Assistance
- G. Technical Assistance Project
- H. PID Approval Cable
- I. Program Analyses
- J. Letter to Minister of Health Conveying Financial Procedures and Requirements of Program

Summary and Recommendation

During the 1980s, Chile moved towards an open economy. In line with this goal, the military government began to privatize many of the existing social programs, including health care. It is acknowledged that the structural changes made to the health care system during the 1980s were important and unique in Chile. However, the reforms were incomplete or poorly implemented. Consequently, significant operational problems remain. The GOC recognizes the following constraints to an effectively operating primary health care system: 1) the health financing system gives preference to curative services, distorts the training of health personnel, and discriminates against health education and preventive care; 2) success in decentralization efforts has lagged in many municipalities because of inadequate technical and administrative capacities; 3) there is a lack of social and community participation in the management of primary health care service delivery; 4) the morale of health personnel is very low; 5) access to primary health services is impeded by limited facility hours, inadequate infrastructure, insufficient staff, etc.; 6) the lack of capacity to diagnose and treat health problems at the primary care level gives rise to other problems; 7) primary health services are not sufficiently focussed on the family; 8) serious mental health problems afflict the population and are not being addressed; and 9) PVO primary health care services are not effective due to lack of coordination.

Over the next two years (1991 and 1992), the Government of Chile (GOC), through the Ministry of Health (MOH) is undertaking the Program for the Immediate Improvement of Primary Health Care ("the Program") to address the constraints listed above. The GOC's Program will include five strategies: expansion of core primary level health services to areas not adequately covered; development of improved management, administrative, personnel and resource allocation measures to improve service delivery; improvement of technical problem-solving capacity in primary health care centers through the provision of equipment, training and other resources; improvement of access to primary health care through the use of extended hours, mobile units, and cooperative public/NGO service delivery; and development of innovative primary health care programs to improve quality for underserved groups. The GOC's Program for the Immediate Improvement of Primary Health Care will be an expeditiously implemented, two year effort which will later be subsumed under larger projects backed by the IBRD and the IDB.

The GOC will cover the Program's total value of \$26.7 million with \$16.7 million of its own resources and has asked

the USG to contribute \$10.0 million towards the program: \$9.3 million in local currency (general sector support to the program) and \$700,000 in dollar-funded technical assistance.

Given the maturity of GOC institutions, and the fact that the Program is a GOC initiative which the MOH is certainly capable of implementing, the assistance will be provided through Non-Project Assistance (NPA), with the exception of the technical assistance which will be authorized as a project. Under the NPA, a cash transfer of \$9.3 million will be provided in two tranches to finance health related, private and public imports from the U.S. An equivalent amount of local currency will be placed in a special account and will enter MOH budget accounts to support the Program.

Conditions Precedent to the first disbursement (\$5.8 million cash transfer and \$700,000 Technical Assistance Project), in addition to standard conditions, will include four key benchmarks related to the signing of agreements between the MOH and municipalities, establishment of emergency services, extension of service hours in clinics and hiring of additional medical professionals. Accomplishment of these benchmarks is well in hand and it is expected that the first disbursement will be made shortly after the Program Agreement is signed. The second and final disbursement is planned for one year after the agreement is signed, i.e. December, 1991. The second tranche will be disbursed subsequent to a determination that the GOC has attained progress in implementing the Program. The determination will be based on a joint review by the MOH and the Office of the A.I.D. Representative, which will examine progress made towards achieving key program outputs in: re-establishment and reinforcement of a functional system of technical supervision of the municipalized primary care system; establishment of a new system for resource allocation for the Primary Health Care system; implementation of a management information system in primary health service areas; and improvement in the morale of Primary Health Care personnel. The outputs are straightforward and the MOH believes that it will easily attain progress in meeting them. Therefore, the final disbursement should occur in one year, as scheduled.

In addition to the program assistance summarized above, the GOC has requested technical assistance to be provided in the form of a project. The Technical Assistance Project, described in detail in Annex G, will deliver the following types of technical assistance: TA to help implement the GOC's program; TA for program management, i.e. a project coordinator within the MOH; and TA for audit and financial reviews. Most of the funding (\$500,000) will be for short term TA to

implement the program. This will be arranged through buy-ins to several ongoing centrally funded projects.

Management of the Program, while consistent with dollar cash transfer and local currency guidance, as well as non-project, sector assistance guidance, will not be burdensome for the A.I.D. Representative. Key management events for the first year will be: review of the report which contains the information indicating that the benchmarks have been satisfied, and other documentation for conditions precedent to initial disbursement; validation of reimbursement documentation for imports from the U.S.; and, review of progress to effect second disbursement, based on program report from the Ministry of Health. During the second year, key events will be: validation of reimbursement documentation for imports from the U.S.; and, review of semi-annual progress reports prepared by the Ministry of Health. For the most part, program monitoring will consist of review of the semi-annual progress reports. As mentioned above, this management/monitoring system is consistent with relevant guidance and agency experience in non-project, sector assistance while addressing the need for a "jump-start", i.e. a quickly disbursing program which is not management intensive. To make sure that program management will not be burdensome to the A.I.D. Representative, and to assure effective technical implementation and financial management, a Project Coordinator working in the Ministry of Health will be funded by Technical Assistance funds. One major responsibility of the coordinator will be making logistical arrangements for short term technical assistance.

Based on the description on the GOC's Program for the Immediate Improvement of Primary Health Care and the proposed mechanisms for A.I.D.'s contribution to this program, as contained in the PAAD and summarized above, the A.I.D. Representative recommends that the Assistant Administrator, LAC, authorize program assistance in the amount of \$9.3 million and the Technical Assistance Project in the amount of \$700,000.

I. Introduction

A. Background and General Overview

Although Chile is classified among the lower middle-income economies, with a Gross National Product (GNP) per capita of approximately US\$1,510 in 1988, substantial progress has been made in enhancing the social welfare of its inhabitants during the previous 50 years. From 1923 to 1973, Chile experimented with various economic models, but the general trend was towards increasing state intervention in the economy based on an import substitution economic model. In the early 1970s, this trend became pronounced, and led to macro-economic distortions and social conflict.

After the military government assumed power in 1973, it began introducing a new economic philosophy of open markets. In mid-1975, despite a severe international recession, lower copper prices, and a quadrupling of oil prices, Chile began to seriously implement the free market-oriented policies. During 1974-75, GDP fell by 2.9%, but recuperated in the 1976-81 period, although with high unemployment rates.

Chile's GDP and fiscal spending fluctuated sharply in 1982-83 due to international economic slowdowns in 1981. Total GDP fell by 14.1% in 1982. Fiscal restrictions affected the social reforms. Even though the government attempted to protect per capita social spending relative to other fiscal spending with special regulatory and social safety net relief to help the most needy, social spending was reduced. In 1983, renegotiation of the large foreign debt was undertaken. A two-year International Monetary Fund (IMF) macroeconomic program helped to stabilize the economy.

Chile continued to move towards an open economy. In line with this goal, the military government began to privatize many of the existing social programs, including health care. The popularity of health care, and the concept that it was a social responsibility made changes in the National Health System (SNS) a politically difficult task. The restructuring, although begun in 1979 and nearly completed by 1988, resulted in negative developments in some areas, especially in primary health care.

The military sought to weaken the political influence of the MOH and the health care delivery system. This agenda was partially accomplished through the expansion of privatized health care, through a total restructuring of the SNS, and through the process of health care decentralization. As discussed in detail below, two negative results of the way in which decentralization occurred were that technical control and supervision were weakened and differences in administrative capacity and health care costs were not addressed.

It is acknowledged that the structural changes made to the health care system during the 1980s were important and unique in Chile. However, the reforms were incomplete or poorly implemented. Consequently, significant operational problems remain. The current democratically elected government of Patricio Aylwin has made a commitment to increasing efficiency and the access of the population to health care, and to addressing the issues of equity in service delivery. The implementation of the primary health care system is expected to play a key role in achieving these objectives.

The extent and speed of Chile's health development have been remarkable. Infant and child mortality and morbidity rates are among the lowest in the developing world; average life expectancy at birth is among the highest. Moreover, the health development process has been relatively rapid, with wide-ranging demographic and health status impact. In a span of twenty years, the demographic structure of the population has changed from that of a typical developing country with 39.1 percent of its population under 15 years and 7.7 percent over 60 years of age (1970) to one more typical of a developed country, with 30.6 percent of the 13.2 million people under 15 years of age and 8.9 percent over 60 years of age (1990).

These demographic changes together with major improvements in the quality of life, which include increases in access to maternal and child health care, improved housing, and potable water and sanitation (especially in the urban areas), and to education have contributed to major shifts in the overall mortality and morbidity patterns.

Unlike most developing countries, Chile has moved steadily from a predominantly infectious and parasitic disease pattern to one of "modern diseases" including cardiovascular illnesses (27.9 percent), cancers (18.0 percent), and accidents/traumas (12.1 percent) which were the major causes of mortality for all age groups in 1988. Additional demands on the health system to address adult and adolescent health problems, such as prevalent chronic diseases (including diabetes, epilepsy, and hypertension) are rapidly increasing. Concurrently, already there are indications of development-related health problems, including those associated with water and air pollutants, and with social illnesses including drug and alcohol addiction problems, psychoses, delinquency and prostitution among adolescents, and both individual and community trauma. These newly emerging health problems are far more complex and require more costly approaches than the maternal and child health interventions which traditionally have been the focus of primary health care programs.

However, it is important to recognize that the epidemiologic transition process is incomplete, with elements of

earlier stages of this process remaining. For example, infectious and parasitic diseases are still prevalent among the urban and rural poor, while the incidence of other infectious diseases, including food-borne illnesses, such as typhoid, are relatively high in the population at large.

B. Importance of the Health Sector

Chile has had a long tradition of health care delivery to its general population. The constitutional right to health care is guaranteed by Section 9 of Article 19 of the current (1980) Constitucion Politica de la Republica de Chile.

Numerous independent systems of delivery evolved early in this century, some within heavy industry and mining, some within civil service systems, others within professional associations, etc. These various forms of health care delivery were subsequently combined into a National Health System (SNS) in 1953. There is also a long history of independent private health care providers. The development of these systems of care reflects a widespread attitude among Chileans that health care is a social responsibility of the government.

The universal health care tax, initially 1% of every employees' salary in 1968, 2% in 1975/76, 4 to 6% in 1980, was raised to 7% by 1981. The employee could decide if this tax would go to the public or private system. The tax reinforced the sense that the provision of health care was a responsibility of the government.

The challenge facing the current government is to attain further health improvements in light of shifting demographic profiles, and changing morbidity and mortality patterns. This requires defining and maintaining the necessary balance between adequate national health resources and other competing national priorities. The government task is to: determine the optimal resource allocation pattern, and the appropriate roles of the public and private sectors in financing and delivering health care; increase the efficiency of the public health system; and encourage private sector involvement in the provision of services as well as community responsibility and participation in health decision-making.

II. Description of the Problem

A. Current Health Care System

Chile's strong social development performance demonstrated by rapid decrease in mortality and morbidity rates beginning in the 1950s, especially among infants and children, was supported by the social reforms instituted in the late 1970s and early

1980s. Despite depressed economic conditions and a decline in per capita income, these improvements were largely maintained in the 1980s.

The reforms of the health care system had two main objectives: 1) to improve the targeting of health services to the at-risk groups; and 2) to increase the efficiency of the public health care system. In order to improve targeting, the government expanded and improved primary health care, emphasizing the most vulnerable groups - mothers and young children in rural areas.

In order to improve efficiency, the government undertook major institutional and financial reforms of the health care system. They included: 1) creating a financial institution for the public health sector (FONASA), charged with collecting all revenue for health services from the national budget and the payroll deductions for health care, and for distributing these funds, including paying the providers of services; 2) continuing the role of the Ministry of Health (MOH) as the policy-making, normative, supervisory, and evaluating agent; 3) decentralizing the National Health Service (SNS) into 27 autonomous Health Service Areas (HSAs) of the National Health Service System (SNSS) capable of providing preventive and curative services in 26 specified geographical areas in addition to an Environmental Care Unit based in Santiago; 4) transferring responsibility for primary health care services and infrastructure to the municipalities; and 5) allowing workers to choose whether to have their payroll deductions for health applied to FONASA or to the private health insurance companies (ISAPREs) which were established in 1981.

As the decade of the 1980s unfolded, it became clear that the theory of how the SNSS and private sectors were to operate was quite different from reality. The decentralization of the MOH and SNS frequently resulted in confusion. The expectation that the private sector could expand rapidly, to absorb many previously covered by the public sector, was not met. Initially, the rate at which the ISAPREs grew in number and membership was much less than hoped. The premiums and fees charged for membership by ISAPREs were too high for the vast majority of the Chilean population, and for those people whose only recourse was the public system, another problem arose. As the military government enacted laws to foster expansion of the private health care sector, it simultaneously reduced funding for the public sector. There was no budget for maintenance and facilities were allowed to deteriorate; salaries of health professionals were reduced, the provision of supplies and technology were insufficient, and operating funds and supervision were crippled. The relatively higher salaries available in the private sector attracted away many physicians and other auxiliary personnel. In short, the public health

care system was allowed to languish while the private sector was encouraged to grow.

The financial mechanism for collection of health revenues, the FONASA, collects 7 percent of the income earned by working Chileans who are not ISAPRE members and distributes these revenues to the public sector. These funds are used to pay for health care services provided within the SNSS to lower middle income families and the working poor. The upper-middle and high income people pay their 7 percent directly to the ISAPRE of their choice. The non-working poor pay nothing for their care, which is provided primarily by the SNSS.

In the final months of the military government, the overall condition of the total combined health care systems of Chile could be described as very uneven in the provision of health care services. The ISAPRES appear to provide ample, high quality curative care to their clients, with the best facilities, equipment, and health care personnel in Chile. However, their services have been limited to the 15% of the population which is well-to-do or fortunate enough to belong to an employment association which has contracted with an ISAPRE. In addition, some ISAPRES have been known to terminate contracts with clients who become afflicted with a costly illness. The ISAPRES have also tended to avoid contracts with elderly Chileans. Furthermore, most ISAPRES do not have their own hospitals, but rather use public facilities on a cost reimbursable basis, a system which carries hidden subsidies from the public to the private sector because of inaccurate or incomplete cost estimates. Preventive care has remained largely the responsibility of the public health system for all Chileans.

B. Current Primary Health Care System

The primary care system that was transferred to the municipalities in a process begun in 1981 consists of four basic types of health facilities: urban and rural clinics (consultorios), rural health posts, and rural medical stations. Urban and rural clinics are responsible for provision of integrated, outpatient/ambulatory care in the basic specialty areas of internal medicine, pediatrics, obstetrics and gynecology, as well as dental care, for which they employ a health team comprised of medical and health professionals and auxiliaries.

Rural clinics are located in communities of between 2,000 and 5,000 inhabitants. However, in reality they provide care to larger geographically defined or catchment areas of approximately 40,000 persons, including both preventive and curative services provided on an outpatient basis for general health problems of limited complexity. In the urban areas the

reality is somewhat different with several consultorios with assigned populations of 100,000 to 175,000 persons.

Rural health posts staffed by resident health auxiliaries provide rudimentary primary care, including curative treatment, and theoretically, health prevention and promotion-oriented activities to catchment areas of approximately 1,000 persons. As an integral part of health promotion, auxiliaries were to be responsible for community outreach activities, including maintenance of a ledger of the health and nutrition status of each family residing within their area of responsibility. However, these outreach and preventive health activities are largely non-functional today.

Rural medical stations (EMR), in contrast, are buildings used only on a temporary basis within given communities to provide a site for periodic visits or "rounds" made by medical teams based in the rural clinics to provide outpatient care to the local populace. They have no permanent medical or health staff in residence.

As an integral component of PHC services, municipalities assumed responsibility for provision of a basic set of pharmaceuticals, as needed, according to a sliding scale defined by socioeconomic levels (ability to pay). The majority of the people served by the system claim to be from the poorest category, skewing the municipalities' pharmacy budgets and resulting in insufficient supplies to meet demand. In delivering all primary services, each municipality agrees to comply with service-specific norms and regulations established by the MOH, and to carry out its responsibilities under the overall technical supervision of, and performance evaluation by, the local HSA to which it corresponds.

Health personnel employed in primary care facilities and services were transferred from the Ministry of Health payroll with "civil service" status to municipalities as contract employees. They lost their longevity and retirement rights with the public health system and became subject to private sector equivalent labor laws, including what most PHC workers viewed as much more tenuous employment protection, given municipal governments right to hire and fire staff at their own discretion.

The 27 Health Service Areas (HSAs), part of the public health system, are responsible for all secondary and tertiary care services. Cases that the primary health care level cannot adequately handle are to be referred to these higher care levels. The Director of Primary Care (DAP) of the HSA is responsible for technical supervision of all municipal PHC activities within their HSA, which includes assuring that MOH standards and norms are maintained. However, in reality this role is difficult to fulfill because the municipalities do not depend either financially or administratively on the HSA.

The importance of the process of municipalization of health services goes beyond the actual numbers of facilities and staff. Primary care services are the first entry point into the more extensive health care system, and therefore may be the only type of care much of the population receives. Consequently, the quality of the primary health care services strongly influences the health status of the population as well as the system's image. If the public health system, particularly primary health care, is to function efficiently and effectively, financial adequacy must be ensured.

Concomitant with decentralization, and in order to enhance the overall effectiveness of the municipal PHC program in addressing priority health needs, a core set of interventions were identified. This core program includes the following: 1) infant health, 2) maternal health, 3) adult and elderly health, and 4) dental health. In addition to this basic core set of interventions, the municipalities were to develop special PHC programs which were responsive to specific local needs. Some examples of these specific, targeted interventions might have included activities for mental health and adolescents. Unfortunately, these specific, locally relevant interventions were never realized, as has been the case with adult and elderly groups.

C. Problems of the Health Care System

Most public health specialists agree that Chile's extraordinary progress in expanding coverage of basic health services, particularly preventive services for high-risk, low-income populations, has been one of the key elements of the dramatic improvement in health status. Of particular importance from a public health perspective has been the success in expanding maternal and child health services coverage, especially among children under two years of age among all income groups, and maternal access to prenatal, delivery, and postnatal services. Further improvements in traditional health status indicators (i.e., Infant Mortality Rate, Maternal Death Rate, Life Expectancy) are possible if those women and children at highest risk who because of access problems are not receiving adequate care are identified and given preferential treatment.

However, for the vast majority of the population the availability and quality of health care services has deteriorated. In most cases, a visit to a public facility means waiting in long lines, facing the possibility of being rejected for service (especially if you are an adult), possibly going to the emergency room of a hospital because the local clinic is closed and facing a high probability of being treated by a different physician with each visit. If attended at either the consultorio or the hospital, the time spent waiting is usually

several hours, the quality of the facility and equipment is low, the availability of pharmaceuticals and medical supplies is uncertain, and several visits are often required to diagnose and resolve a problem. The information systems that support the public health care system are antiquated, for the most part hard-copy manual systems. The morale of the staff and physicians at such facilities is low and their level of frustration is high. Because of chronic underfunding, conditions in rural health facilities and in some densely populated urban slum neighborhoods are worse than in other areas of the public system; often there is insufficient personnel to fully staff the facility. The shortage of physicians who are willing to work for the SNSS at the primary level is especially acute and most who do work for the SNSS work a half day, as well as maintain a private practice.

Faced with these conditions, it is not surprising that confusion sometimes arises as to the effectiveness of this new, dual health care system and the apparent inconsistency between the problems noted and certain positive indicators of Chilean health status. For example, the low level of infant mortality in Chile is well recognized, as are several other measures of improved infant and maternal health. To put these results in perspective, it should be recognized that early on the military government implemented strong programs which targeted feeding and health care resources to the infant and maternal populations in response to international criticism of a deterioration in infant and child health. The programs were highly successful: the Infant Mortality Rate was 18.5 per 1,000 live births in 1987, dramatically decreasing from 63 per 1,000 in 1974 and 120 per 1,000 in 1960. Likewise, the Maternal Mortality Rate has dropped dramatically from 35 per 10,000 live births in 1961 to 4.6 per 10,000 in 1987.

Unfortunately, the rest of the Chilean population was not targeted for such programs. Partially as a result of new disease distribution patterns as well as cuts in financial resources available to the system, some studies have shown that the working poor and the lower middle class have experienced a deterioration of their health care utilization patterns and health status. The military government was not inclined to reveal these results to the international health care community. The utilization patterns and health status of the upper income groups probably have improved as a result of their coverage under the ISAPRES.

Another complication which must be considered in any discussion of current health care and health status patterns in Chile is the trend towards modern industrial morbidity and mortality patterns. Under the military government, the limited resources that were made available through the SNSS were resources traditionally utilized to fight the bacterial diseases

commonly found in underdeveloped countries. For some time this has not been the significant illness pattern relevant to Chile. As a country in the intermediate range of economic development, Chile has, nevertheless, already joined the advanced industrialized countries in its pattern of illness categories. Chileans, of just about all income groups, suffer from heart disease, hypertension, cancer, and mental health problems. The public health care system passed to the new democratic government is poorly designed to address these modern health care problems. Even the ISAPRES, as currently structured, are not prepared to confront the costs and resource utilization patterns typically associated with these illnesses.

Notwithstanding the substantial achievements that have been made in expanding access to services (especially among the poorest groups), serious gaps in service coverage remain. There is evidence that the overall quantity of health services - particularly primary care provided at the municipal level - is below actual demand. Relatively high rejection rates at the municipal level (estimated at 10-20%) reflect the inability of many clinics to cope with the current demand for care due to both staffing constraints, inadequacy of supplies (including pharmaceuticals), and limited facility hours. Estimates are that at least 2.5 million persons may not be adequately served by either the public health or organized private health system (this may be especially true for the upper low-income and lower middle-income workers).

Further, continuing gaps in access to primary care exist among the poorest groups, for which virtually no alternatives to publicly financed health care exist. The data seem to suggest that certain geographic areas of the country still have not achieved Chile's overall standard level of health development. A major underlying cause of the wide discrepancies in morbidity and mortality both across regions and between municipalities within the same region appears to be highly variable coverage of individual population groups with primary health services, especially with regard to maternal and child health programs. Coverage of other "core" public health programs is still unsatisfactory throughout the system, particularly dental care, and adult and adolescent health services.

Moreover, gaps in health system coverage are not necessarily a phenomenon of isolated rural municipalities. New or poor municipalities in urban areas often have insufficient funds to establish and support a clinic. The GOC has identified 104 rural municipalities and 28 urban ones using health status and poverty indicators where the PHC system needs to be strengthened on a priority basis.

There is a strong curative bias in the health system which is demonstrated by the fact that one of every three (29 percent)

medical consultations provided by the MOH in 1987 was for emergency care. The majority of these consultations were by adults who are rejected from the primary care system often because priority is given to maternal and child health care. Also, this pattern highlights the continuing problem at the municipal level of long waiting periods and the inability to receive non-emergency services (often due to limited facility hours) which forces people to higher level health facilities for emergency care. In addition, the scarcity of health education pertaining to disease prevention and health promotion reinforces curative care.

The gaps in preventive health care are well documented. Data reveal that two out of every three (64.9 percent) of all household members have never had a preventive health visit. This lack of attention is particularly high among households in the lowest income groups.

The present system is essentially an urban-based one which assumes geographic accessibility of the population; the model has limited applicability for the rural areas. It also is a largely "passive" health care approach in which interventions depend on the conscious decision of the patient to seek care. The rural outreach system which existed in the 1970s, and was effective in facilitating the rapid decrease in infant mortality rates during this period, is largely non-existent now.

Widespread deterioration of the public health hospital sector is also believed to adversely affect medical education, as hospitals are the locus of medical school training. Moreover, the increasingly highly specialized orientation of medical education contrasts sharply with the more family-oriented practice required for primary health services.

There is a serious maldistribution of medical professionals throughout the country because of low salaries, poor working conditions (inadequate facilities and equipment), lack of opportunities for advancement or training, and geographical isolation. In addition, shortages of trained rural health manpower are a continuous obstacle to optimal operation of the system. The incentive structure for rural health providers has deteriorated; salaries are low and the ability to obtain additional work is limited.

Based on the evidence provided through recent preparation of an inventory of the present physical status of health facilities within the national health system, observers have indicated that there is need for investment in public sector infrastructure, particularly at the secondary and tertiary levels and in the urban-based primary system. In addition, there seems to be a significant problem with inadequate and inappropriate laboratory and medical equipment in the primary system as well and the inability of the auxiliary staff to

properly utilize equipment. Financial constraints facing municipalities were identified as the primary cause of inadequate maintenance, thus forcing local health administrators to allocate funds to direct more costly service provision.

Pharmaceuticals are an integral part of any health system and serious problems exist with the availability of basic drugs. Throughout the health system, pharmaceuticals are provided according to a sliding socioeconomic scale for payment if prescribed by the health provider. The cost of providing free prescriptions to municipalities, specialized clinics and public hospitals is staggering. Consequently, there are shortages and uneven supplies of basic drugs and medical supplies at all levels.

In summary, the programmatic focus of the public health system no longer responds fully to the priority health needs, particularly not in adult and adolescent care. The strong continuing maternal and child health emphasis does not address many problems that have evolved from the epidemiologic and demographic transition underway. It is not suited to meet the anticipated morbidity and mortality patterns in the future, nor is it efficiently and effectively providing adequate coverage of even maternal and child health services for high risk, low income, and geographically dispersed populations.

D. Specific Constraints and Bottlenecks of the Primary Health System

In order to enable the Primary Health Care system to effectively function in the short term, the following specific constraints and bottlenecks need to be addressed on a priority basis:

1. The uniformly applied "fee-for-service" resource allocation system (FAPEM) gives preference to curative services, distorts the training of health personnel, discriminates against health education and preventive care, and theoretically establishes a service cost "ceiling" which turns out to be about 50% of the cost of primary health care. It also does not take into consideration differential costs of providing services in the rural versus the urban areas. This has resulted in a chronic shortage of personnel, medicines and other inputs, inadequate maintenance of municipal infrastructure, and failure of outreach mechanisms in rural areas.

2. The ability of municipal health organizations to effectively implement administrative and management decentralization efforts has not been uniformly successful due to variable technical and administrative capacities at the municipal level, lack of administrative flexibility for the use

of funds from the National Health Fund (FONASA), the lack of clear guidelines for monitoring the use of funds in accordance with ministerial norms, and the deterioration of technical supervision within the Ministry of Health and at the level of the HSA.

3. There is a current lack of social and community participation in the management of primary health care service delivery.

4. The poor morale of health personnel, leading to rapid turnover and frequent vacancies particularly in rural areas, is due to low salaries at all levels, the absence of a policy of continuous professional training, the absence of a career civil service or opportunities for professional improvement, the lack of participation in key decision making and programming efforts affecting primary health care, and the poor communication mechanisms within the clinical health team.

5. Access to primary health services is impeded by limited and unfavorable facility hours, inadequate infrastructure in high population density, low income urban areas, inadequate rural outreach mechanisms, and insufficient medical staff to cover demand on a daily basis.

6. The lack of capacity to diagnose and treat health problems at the primary care level gives rise to numerous problems, for example, the excessive use of emergency services, multiple appointments for the same problem, and long delays in diagnosis and treatment while test results are returned from the secondary or tertiary level. This results in the loss of confidence in the municipal health system;

7. The focus of activities at the primary level is solely on the individual and not on the family resulting in multiple visits, little knowledge of the patient or his environment and service provision by multiple practitioners to a single patient.

8. The serious mental health problems which afflict the population, especially in those sectors with few resources, are a result of the past systematic violation of human rights, growing alcohol and drug abuse problems, and psychosomatic illnesses. The Primary Health Care system is clogged with such problems, which it does not have the ability to treat; and

9. A network of parallel PVO health services developed during the last fifteen years in response to gaps in the provision of primary health care and other health services. This network is not coordinated, is sometimes duplicative of the public system and is not being used as effectively as it could be to provide preventive health care.

E. GOC Strategies for Overcoming Identified Constraints and Bottlenecks

In order to overcome these identified constraints and bottlenecks, the MOH has developed strategies keyed to the constraints discussed above:

1. The health fund resource distribution system (FAPEM) will be adapted to a dual system including 1) a "capitation system" with a distribution of resources on a per capita basis, indexed by health status (e.g. standardized mortality ratio), and by the proportion of families in extreme poverty, particularly for preventive services and drugs, and 2) an adjusted "fee-for-service" system which takes into consideration variable service delivery costs in urban and rural areas. To do this, additional funds have been requested for 1991.

Primary Care Resources Solicited
from the Ministry of Hacienda for 1991
(Chilean Pesos)

Current fund for primary care	\$ 11,500 mill.
Supplemental funds - tax reform	\$ 2,400 mill.
Requested budget increase	\$ <u>2,800 mill.</u>
Total	\$ 16,700 mill.

This permits one to establish an average of about C\$1,855 per beneficiary at the municipal primary care level (discounting persons affiliated with the ISAPRES or other private systems). This is equivalent to US\$6.18 per capita, which is an increase of 45% from the present level of about US\$4.25. This increase and more rational use of the funds would permit the health system to begin to resolve the problem of chronic under-funding of the primary health care level.

2. New Agreements between the SNSS and the municipalities currently under negotiation with the mayors, will help assure the adequate use and monitoring of financial resources.

Moreover, a process of training for municipal administrative personnel will be developed. Likewise, the DAPs' supervision and support for local management will be improved. Computerized systems for primary care level management, including incorporation of computerized information systems, should be introduced. The feasibility of doing so will be explored. All these management and training efforts will improve the efficient use of resources in the Municipal Corporations.

3. Social participation will be attained by developing SICOS (community systems). They will be formalized through the establishment of Community Councils (in cooperation with other Government entities, such as the Ministry of the Interior).

4. The municipal health corporations should be improved by the creation of a universal career civil service in the municipal system, with progressive advancement levels which are similar and interchangeable throughout the country. This would help reduce competition between municipalities for health care personnel with the resulting rapid turnover and mobility of providers. The feasibility of this will be explored.

The improved motivation of municipal health personnel will be reestablished in part through a program of training. More than two hundred workshops for stress management and participatory diagnosis of problems in the health system will be held in all of the 26 Health Service Areas. This training will be continued during four years. The feasibility of other personnel incentives will be explored.

5. The municipal health service accessibility problem will be resolved with the gradual extension of service hours until 9:00 p.m. and with the availability of 24 hour Emergency Primary Health Care Centers (SAPU) in the most isolated sectors of the city. In addition, mobile health units will be introduced on a short term basis in high population density, low income urban areas lacking sufficient infrastructure until additional clinics can be built.

6. The capacity to resolve problems at the primary care level will increase with the improvement of coordination with the secondary and tertiary levels through the action of the DAPs and the proposed Commissions for Integrated Health, with adequate financial resources, with standardized norms for basic medicines and supplies, and with the development of basic clinic-based diagnostic laboratories and training of personnel in their use.

7. The change from an individual to a family focus will occur through the development of a Family Medicine Specialization. This experiment will be developed first in test areas where a standardized model will be developed in accordance with the results of efficacy and efficiency analyses for later replication.

8. Mental health services will be established at special clinics in the urban areas in order to address the growing problems of alcohol and drug abuse, human rights violations, and psychosomatic illnesses.

9. NGOs will be incorporated into the primary health care system through joint delivery of primary services with the municipal sector, or through public support for the ongoing service delivery activities of the NGOs. This service delivery model is considered to be particularly applicable to, for example, delivery of preventive education and mental health care services.

III. Other Donors

Approximately \$450 million is currently being proposed by multilateral and bilateral donors in support of the Government of Chile's 1990-1995 National Health Program. Donors include the International Bank for Reconstruction and Development - IBRD (\$170-200 million), the Inter-American Development Bank - IDB (\$200 million), and the Governments of Germany (\$17.5 million), France (\$25 million), Spain (\$12 million), Italy (\$10 million), and the United States (\$10 million).

The IBRD and IDB are currently negotiating with the Government of Chile to determine the "areas of concentration" of possible projects to be financed in parallel by the two Development Banks. The IBRD proposes to address macro issues affecting the health sector including: 1) reform of health care financing; 2) incentives systems for health care personnel; 3) procurement and distribution systems for drug and food supplementation programs; 4) quality control of pharmaceuticals and food products for export; 5) strengthening of health management at the national level; 6) establishment of joint ventures between public/private institutions in health care delivery; and 7) innovative programs for environment-related and women's health problems. Additionally, the IBRD proposes to assist in the development of integrated health care systems and physical investments in the low-income areas of metropolitan Santiago, and the Health Service Areas of Antofagasta and Llanchipal.

The IDB will concentrate on the improvement of health care delivery, management capacity, and information and maintenance systems at the local level starting with a pilot project in selected Health Service Areas (Iquique, San Felipe, Valdivia and Maule) - Stage I. The IBRD/IDB projects are slated to begin in mid-1991. A follow-on IDB project proposed for early 1992 will cover the remaining areas not covered by other donors - Stage II. The IDB's current ongoing National Fund for Regional Development project includes \$70 million for the rehabilitation/reconstruction of health posts, clinics, and Level 3 and 4 hospitals in rural areas.

The Office of International Cooperation of the Ministry of Health (OCI/MOH) currently is negotiating with the Governments of the United States, France, Spain, Italy and Germany for funds totalling US\$74.5 million for the health sector. These funds are to be disbursed in the course of the next three years, and are in the form both of donations (US\$25 million) and soft credits (US\$49.5 million). A more detailed description of these contributions follows:

- The US\$17.5 million in soft credits from Germany are to be applied to the rehabilitation of hospitals in four of the 26 Health Service Areas (Valparaiso/San Antonio - Region V, Concepcion - Region VIII, Araucania - Region IX, and Southeast Metropolitan area of Santiago).
- The Government of Italy is donating US\$10 million to be used for a program of improved comprehensive medical care in areas defined as high risk. Specifically, this donation is to be targeted on the three HSAs of Southeast Santiago, and Vina del Mar/Quillota. This program, complementing that of the Government of Germany, will build primary health care centers linked directly to hospital centers.
- France has offered a US\$5 million donation to be used for the purchase of mobile primary health care units for use in urban areas, and ambulances. In addition, the French government is providing US\$20 million in soft credits to improve the medical equipment in hospitals nationwide.
- Another soft credit of US\$12 million from Spain is intended to complement the French funds, and will be used to buy additional medical equipment and medicine for all of Chile's 26 HSAs.
- The United States is donating US\$10 million to the Immediate Improvement of Primary Health Care Program described in Annex A of this document.

The U.S. assistance is designed to lay the early groundwork for policy and institutional reforms which will be continued and expanded with the extensive and substantial multilateral assistance anticipated during the 1990-1995 period. Projects with the multilateral banks are not expected to have resources flowing until after mid 1991. In the meantime, flexible A.I.D. assistance is critical to generating momentum for diagnosing and addressing the immediate problems facing the Primary Health Care System.

IV. Program Rationale

Public interest polls taken shortly before the new democratically elected administration of President Aylwin took office in March of this year showed that over 40% of those polled considered provision of adequate health services to be the single most urgent issue facing the government and the Chilean population. In response, the incoming administration formulated a short and medium-term strategy and action plan and mobilized bilateral and multilateral donor assistance in order to be able to respond immediately to this political imperative and strongly felt need on the part of the Chilean constituency. As part of this effort, President Aylwin asked the U.S. Congress for help in "jump starting" the primary health care system and in providing support services to victims of human rights abuses. Congress obliged, earmarking \$10 million in supplemental appropriations for this purpose.

The Government of Chile is now working with the World Bank, the IDB and several European Governments as well as USAID to develop external assistance agreements in support of Chile's 1990-1995 National Health Program. Projects with the multilateral banks are not likely to have resources flowing until after January 1991 in the case of IDB and summer of 1991 in the case of the World Bank. In the meantime, the Government of Chile has allocated a small emergency supplemental to this year's budget and hopes to use more flexible bilateral assistance, including U.S. assistance, to provide an immediate response in trying to resolve the most pressing service delivery constraints, particularly at the primary level. In addition, starting in 1991 the GOC expects to be able to augment the normal operating budget of the Health Services System at the primary level with revenues from recently approved tax increases.

Multilateral and bilateral assistance is to be used to assist in completing the reform of the sector and to augment the investment budget which has been virtually non-existent over the past decade. The U.S. assistance is designed to lay the early groundwork for policy and institutional reforms which will be continued and expanded with the substantial multilateral assistance coming on stream over the next year.

A sector program approach to provision of U.S. assistance to the Chile health program makes sense for a number of reasons. The Chilean Government, acting through the Ministry of Health, has a clear plan and is carefully coordinating external assistance. The plan is built on basic, in-depth analyses of the health sector which have been completed over the past two years and the GOC is taking a careful analytical approach to proposed changes. Chile's system of public administration is

sound and, although improvements are needed, the public health services system, in fact, works relatively well in comparison to other systems in the hemisphere and particularly in developing countries throughout the world. Chile has a cadre of very sophisticated human resources in terms of health care planning and service delivery in the MOH, many of whom have recently returned to public service and, in some cases, to the country with the advent of a democratically elected government. There is clearly strong political and technical commitment to this program for immediate improvement of the primary health care system, and the technical and administrative capacity to carry out the proposed reforms. What is needed is additional financial resources for investment in the reform process.

A sector program approach would give the GOC the flexibility it needs to effectively coordinate the A.I.D. resources with national resources and with those coming from other external donors. Furthermore, the types of institutional reforms contemplated would be strongly facilitated by a sector program versus a project approach. The kind of special procedures and detailed end use monitoring and control required in a project tend to set up parallel and artificial mechanisms for program implementation which in this case would interfere with the institutional changes, the policy and planning process, and the development of innovative mechanisms for service delivery which are the program objectives. Generalized subsector support for the primary care level would assure that the innovative pilot service delivery mechanisms and programs are consistent with and can function effectively and efficiently under the normal operations of the public health services. Taking a program approach in a country like Chile where implementation capacity and skills are high also would allow the U.S. Government to support the kind of thoughtful institutional reform process the Chileans want to and need to carry out with A.I.D.'s limited personnel resources in Chile.

V. A.I.D. Sector Assistance Program

In effect, A.I.D. will be buying into the Government of Chile's Program for the Immediate Improvement of Primary Health Care (PII/PHC) henceforth referred to as "the Program." The goal, purposes, strategies, components, and outputs described below are derived from the Government of Chile's description of the Program contained in Annex A.

A. Goal and Purpose

The Program has, within the goal of improving the quality of life of the Chilean population, the following general purposes:

a) To improve access to primary health care of the Chilean population, especially the poorest sectors, located in dispersed rural areas and marginal urban concentrations; and

b) To improve the quality of and opportunity for health care services through an increase in the capacity for health care problem resolution at the primary level.

B. Strategies

In order to achieve the stated purposes, the implementation of the Government of Chile's Program will involve the use of the following strategies:

1. Expansion of the core primary level health service activities of proven effectiveness to areas, such as isolated rural populations and newer high density, low income urban areas, not now covered by them;
2. Development of improved management, administrative, personnel and resource allocation measures which facilitate the implementation, coordination, technical supervision, and evaluation of the Primary Health Care Program;
3. Improvement of the technical problem-solving capacity in PHC centers through provision of basic laboratory and diagnostic medical equipment, training, increased resource allocation in chronically underfunded municipalities and improved coordination with the secondary and tertiary levels;
4. Improvement of access to primary health care services through the use of extended hours, mobile units, and the introduction and use of cooperative public/NGO health service delivery; and,
5. Development of innovative primary health care programs to improve quality for underserved groups like those with mental health problems, the elderly, adolescents and families, and to increase preventive health care.

C. Structure of the Program

The Government of Chile's Program has the following components to implement the strategies described above:

1. Strengthening Primary Health Care in the Rural Areas -
this program component will include strengthening the supervisory system in the Directorate of Primary Health Care in each Health Service Area, training and motivational workshops, development of educational materials, revised Agreements between the Ministry of Health and the municipalized health system, establishment of community councils and community support systems, and provision of basic equipment.
2. Studies for Improvement of Planning, Administration and Supervision -
this component will include operations research, special studies, and development of an information system at the primary level to assist with design, implementation, monitoring and evaluation of Primary Health Care system interventions in order to improve the effectiveness and efficiency of primary health service delivery. Examples of these studies include the following:
 - Design and implementation of a system to obtain cost information at the primary care level.
 - Diagnosis and monitoring of the efficiency of the health care delivery system at the regional Health Service Area level.
3. Basic Re-equipment at the Primary Health Level -
this component is designed to improve the capacity of the primary health level facilities to diagnose and treat diseases. It includes efforts to provide standardized, basic, and technologically appropriate equipment (including laboratory and medical equipment, and supplies), and to train the auxiliary staff and provide additional staff to adequately and appropriately use it (including basic servicing and maintenance).
4. Incorporation of Non-governmental Organizations (NGOs) into the Primary Care System -
this component is designed to forge a public-private partnership in providing health care services to populations currently served by NGOs through development of a Grants/Cooperative Program. The assistance of NGOs will be sought in order to provide services to isolated or hard-to-reach populations in urban areas with a high concentration of poverty, and in areas where the public system is currently insufficient.

5. Development of Innovative Models of Care -

this component is designed to assist with improvement of the targeting and access of basic or core primary health care services (i.e., maternal and child health activities) to at-risk populations in isolated rural or marginal urban areas. It will also assist with development and implementation of innovative preventive health care programs and the reorientation of curative health care services to be more consistent with the newer epidemiological profile. Examples of additional types of programs to be considered include the following:

- Mental health care with a focus on community centers and treatment for victims of human rights violations.
- Family health care.
- Chronic disease prevention in adults, emphasizing the identification and treatment of specific groups at high risk, i.e. hypertensives.
- Health care for adolescents with emphasis on teenage pregnancy, and alcohol and drug abuse.

6. External Technical Assistance -

this element is designed to support and advise the Ministry regarding the development of suitable program interventions and other monitoring/evaluation and system management activities.

D. Program Outputs

The GOC's Program will achieve the following institutional and policy reforms aimed at improving the efficiency and effectiveness of health care service delivery at the primary care level by the end of December 1992.

1. Strengthening Primary Health Care (PHC) in Priority Rural and Urban Communities Accompanied by the Improvement of Administrative and Supervisory Capacity of PHC

Reestablishment and reinforcement of a functional system of technical supervision of the municipalized primary care system by the Directorates of Primary Health Care (DAPs) in each Health Service Area including:

- DAPs reconstituted and assigned personnel, vehicles, operating expenses and training resources;
- New Agreements signed between the Health Service Areas and the local Mayors which include agreements on specific

Primary Health Care activities and supervisory responsibilities to be carried out; and

- Personnel of DAPs and municipalized Primary Health Care system trained in implementation of supervisory system.

Establishment of a new system for resource allocation for the Primary Health Care system including:

- Studies of actual costs of each type of primary care service completed in a representative sample of Primary Health Care centers in small urban and metropolitan populations.

A Management Information System (MIS) for the Primary Health Care level designed, tested, and implemented in priority Health Service Areas in order to provide accurate and timely data to support planning and management, the new supervisory role of the DAPs, and resource allocation decisions.

Morale of municipalized Primary Health Care personnel improved through:

- Completion of motivational training;
- Completion of feasibility studies on the potential for establishing a career civil service for Primary Health Care workers in the municipalities; and
- Adequate equipment and supplies available so that personnel can perform their duties.

2. Improvement of Technical Problem-Solving Capacity in Primary Health Care (PHC) Centers

Basic diagnostic equipment available and basic diagnostic laboratories established and equipped in priority Primary Health Care areas.

Design, testing, and implementation of technical training for Primary Health Care personnel in the priority areas in the use and maintenance of basic diagnostic equipment.

3. Improved Access to Primary Health Care (PHC)

Compilation of a list of NGOs providing parallel PHC services; development of an instrument to accredit, select, and contract NGOs to provide PHC services in cooperation with both HSAs and the municipalities.

Pilot programs for PHC service delivery by selected NGOs established and tested in priority urban areas.

Thirteen planned 24-Hour Emergency Services (SAPUs) established and pilot tested for effectiveness and efficiency in low-income urban areas; completion of a model for expansion of SAPUs to additional consultorios.

An additional (third) shift established in at least 38 priority PHC centers; evaluation of the model for expansion to additional consultorios.

4. Innovative Programs in Primary Health Care

A pilot mental health program designed, implemented and tested; establishment of a network of community-based mental health centers.

An evaluation completed of the ongoing University affiliated pilot training program for Family Health Practitioners; extension of this training to actual Primary Health Care service delivery.

A pilot service delivery model for caring for the elderly, including chronic disease monitoring, developed and tested; a refined model for elderly care approved for use and replication in the PHC system.

Community Health Councils and community support systems (SICOS) established and operating in at least 80% of the priority municipalities.

E. Program Inputs and Budget

The grant is organized into three parts:
1) dollar disbursement (cash transfer), 2) local currency equivalent to the dollar transfer, and 3) dollar funded technical assistance project including provisions for evaluation, program coordination, and audit and financial reviews.

1. Dollar Disbursement - Cash Transfer

Dollar disbursements to the Grantee will be made in tranches, on satisfaction of conditions precedent. The conditions precedent define a series of policy and institutional reform measures to be undertaken by the Grantee. The performance benchmarks are defined in detail in Section V.F. (Benchmarks) of this document. Procedures for dollar disbursement are described in Section VI.B. U.S. foreign exchange will be used to finance either public or private sector imports from the USA destined for the health sector.

2. Local Currency Program

The Grantee will deposit local currency, equivalent in value to dollar disbursements, in a separate Special Local Currency Account. The fund thus created will help finance additional costs of developing and restructuring of the Primary Health Care system. Recurrent costs for the restructured systems in the Health Service Areas and municipalities would be included in the normal municipal health system budgets after the initial investments are made. The Program local currency will support implementation of the policy and institutional reform objectives of the Program described above. For example, local currency will be used to support development and execution of training activities and materials required to upgrade the supervision, information and financial management systems, and case resolution capability at the primary level of health care delivery services.

3. Dollar Funded Technical Assistance and Evaluation

Technical assistance will be programmed in such areas as operations research, cost analysis, management information systems, health care financing, procurement, and health systems management to assist the Government to carry out the policy reform and institutional strengthening program of the grant. Details of the proposed Technical Assistance Project requirements and management are identified in Annex G.

There will be a final evaluation prior to program termination. The Evaluation component of the program will be managed directly by USAID. All activities under this component will be planned and carried out with full collaboration of the Government of Chile/Ministry of Health, using procedures established with the Government.

The Technical Assistance Project will provide the services of a technical consultant to develop an evaluation methodology and assist with implementation, if necessary. Also, the final evaluation will be a descriptive report based on technical information provided by the MOH in documents submitted to the A.I.D. Representative/Chile for the semi-annual reports. (Refer to Section VI.C. Monitoring and Reporting)

4. Audits and Financial Reviews

Audits and financial reviews will be phased to provide assurance that procedures and controls are effective in their

application during implementation as well as annual compliance verifications. The timing and content of the audits and financial reviews are described in more detail in Section VI.E. (Audit Plan and Financial Review).

<u>Summary Budget - AID Inputs</u>		<u>(\$000)</u>
<u>Cash Transfer and Equivalent Local</u>		9,300
<u> Currency Program</u>		
<u>Dollar Project*</u>		700
Technical Assistance	(500)	
(including evaluations)		
Program Support (Prog Coord)	(100)	
Audits/Financial Reviews	(100)	
		<hr/>
Total		\$10,000

* - Refer to Annex G - Technical Assistance Project - for a complete description of the components.

F. Benchmarks and Conditions Precedent to Disbursement

The following is a list of benchmarks or measures of progress in the implementation of the institutional and policy reforms of the Program for the Immediate Improvement of Primary Health Care. Disbursements are based on two tranches, initial and final, of which the first is expected to be the most significant. Disbursements are to be US\$5.8 million and US\$3.5 million respectively, with the remaining US\$700,000 to be reserved for Technical Assistance, Program Support, and Audits/Financial Review (as described in Annex G).

Initial Disbursement

- New Agreements will be signed between the Health Service Areas (HSAs) and Mayors in at least 85% of the priority 104 rural and 24 urban municipalities. These Agreements will reflect the agreement between these authorities and the MOH on the goals to be achieved with the increased funding available for Primary Health Care.

- Establishment of at least 11 of the 13 24-Hour Emergency Services planned for selected urban consultorios in the first phase of the Program. Such services will provide previously unavailable emergency health care in underserved areas, reducing congestion both in the consultorios' regular daily hours as well as in the local hospital emergency room.
- Extension of hours in 100% of the 38 consultorios selected to include as third shift during the first phase of the Program. These extended hours will allow greater access to primary health care services by the working public.
- Hiring of at least 50% of the 28 additional medical professionals planned for the first phase of the Program in order to strengthen the technical supervisory capacity of the Directorates of Primary Care (DAPs) of the 18 Health Service Areas (HSAs) which contain the 104 priority rural municipalities.

Final Disbursement

The final disbursement of US\$3.5 million will be made approximately 12 months after the initial disbursement. Prior to release of the final disbursement, a joint review will be held by USAID/Chile and the MOH to discuss the status of the Program and to determine whether substantial progress has been made towards achievement of the institutional and policy reforms aimed at improving the efficiency and effectiveness of health care delivery at the primary level.

The MOH will prepare a formal descriptive report for USAID/Chile which discusses these achievements and the status of the Program. The Program Outputs or End of Project Status (EOPS), as identified in Section V.D. (Program Outputs) of this document, will serve as guidelines for review of the Program and provide an outline of the descriptive report.

VI. Program Implementation and Management

The MOH, through its semi-autonomous Health Service Areas, will be the lead Chilean agency responsible for program implementation. Agreements or contracts with other implementing entities including municipalities, universities, NGOs and private for-profit companies will be made through the MOH. Implementation of the cash transfer foreign exchange component will be through BANESTADO, a subsidiary of the Banco del Estado of Chile, in cooperation with the Ministry of Health. A.I.D. will cooperate with the MOH in implementing the foreign exchange technical assistance component of the Program.

Management responsibilities for the Program exist at several levels, under three main categories: policy and institutional reform, dollar cash transfer and the local currency program. For the first tranche, U.S. dollars will be disbursed to the GOC upon achievement of agreed upon institutional and policy benchmarks necessary in the reform of the Primary Health Care system. For the second tranche, dollars will be disbursed after a joint review has determined that the MOH has made substantial progress in implementing the Program. U.S. dollars will be applied to finance public or private sector imports from the U.S., destined for the health sector. The local currency equivalent to the U.S. dollar disbursements will be used by the MOH to effect reforms in the Primary Health Care system.

A. Implementation of Policy and Institutional Reform Program

1. Government of Chile

The MOH will take the lead for the GOC in coordinating and managing implementation of the institutional and policy reform component of the program. Since many of these reforms will be implemented through the municipalized primary health care system, the MOH will be responsible for coordinating the program at all levels: central, regional and municipal.

Within the MOH, the Department of Primary Care under the Department of Planning and Budget, in coordination with the Office of International Cooperation, will have principal responsibility for overseeing and coordinating the policy and institutional reform components of the program.

The MOH will have the following responsibilities:

- Monitoring and evaluation of the program of institutional and policy reforms;

- Carrying out or ensuring the implementation of the necessary studies, assessments, pilot activities, seminars, workshops and training activities and purchase of commodities and supplies aimed at achieving the intended policy and institutional reforms;

- Ensuring or coordinating the issuance of necessary administrative acts or legal agreements necessary for policy institutional reform implementation from appropriate Ministries or Agencies;

- Coordinating reviews and evaluations of the policy and institutional reform program;

- Identifying required external technical assistance and coordinating with USAID/Chile to obtain the assistance; and
- Reporting to USAID/Chile on program progress and results.

2. USAID

The USAID Representative, with support from his FSN and/or PSC staff and LAC Bureau USDH support staff (specifically LAC/DR/HPN) will be responsible for:

- Monitoring the policy and institutional reform program and preparing report(s) for A.I.D./Washington as required under this program;
- Preparing and reviewing with the GOC any changes or revisions in the Grant Agreement;
- Coordinating and managing requests for external technical assistance to be supplied through buy-ins to Central AID/W or LAC/Regional contracts; and
- Coordinating and carrying out the necessary reviews, evaluations/audits to ensure that the agreed upon institutional and policy reforms have been properly implemented. Assistance from LAC/DR/HPN in the verification of the benchmarks may be required.

B. Dollar Transfer and Local Currency Procedures and Management

The GOC's management of foreign exchange within the financial system is relatively open and "hands-off," compared to other developing countries. Under this system, commercial banks are allowed to hold dollars, but sell dollars exceeding certain established limits to other banks or the Central Bank of Chile. If banks need dollars, they buy from each other or from Central Bank, as long as the amounts which they hold do not exceed the limits established by Central Bank. Thus, Central Bank controls the volume of foreign exchange in the economy. Central Bank can also influence the exchange rate by determining the rate at which it sells dollars. The management and procedures of dollars and local currency takes this foreign exchange management system into account.

As described previously, dollars will be released in two tranches, the first upon satisfaction of conditions precedent to disbursement, including benchmarks of performance, and the

second upon determination that reasonable and substantial progress has been made in the implementation of the Program. Disbursement of the second tranche is expected to take place 12 months after the first disbursement. Dollars will be disbursed into a separate, segregated interest-bearing account at BANESTADO (the agent bank), a subsidiary of Banco del Estado of Chile. Dollars in the separate account will earn interest until they are released as described below.

The U.S. dollar funds will be used to finance health related imports from the U.S., with the exception of pharmaceuticals since pharmaceuticals would require advance FDA approval in order to guarantee quality assurance. In order to minimize the A.I.D. Representative's management burden and to simplify procedures for the Government of Chile (GOC), dollars will be used to finance imports on a reimbursable basis. Only those expenditures for imports made after the date of the Program Agreement shall be deemed eligible for reimbursement. The MOH will be able to obtain supporting documentation for import transactions such as invoices, bills of lading, etc., from commercial banks to support transactions.

Accordingly, release of funds from the separate dollar account will occur after documentation for imports has been gathered by the MOH and verified by A.I.D. and after instructions to release the funds are relayed to BANESTADO. BANESTADO will exchange the released dollars for pesos which will be placed in the special Peso account, also at BANESTADO. BANESTADO will, in effect, buy the pesos on the open market, from commercial banks, at the highest rate which is not unlawful.

The special peso account will also be separate, i.e. will contain only Pesos equivalent to the amount of dollars released from the separate dollar account and the interest earned thereon, since the special peso account will also be interest bearing. As needed and consistent with the budgetary process and GOC funds control, pesos will be released to the MOH's normal accounts for primary health care, and will be commingled with other GOC funds for the Program. A.I.D. will arrange for a financial assessment of the system for managing the local currency prior to the first disbursement of pesos from the Special Account.

1. Procedures for the Separate Dollar Account

- a. The GOC will establish a separate U.S. dollar account in BANESTADO of Chile, containing only dollars disbursed by A.I.D. for this program. This will be an interest bearing account. Dollars will earn interest up to the time that they are released from the separate account.

b. Upon the GOC meeting conditions precedent to disbursement (including benchmarks) for the first tranche, and a determination that substantial progress has been achieved in the program for the second tranche, A.I.D. will disburse dollars to the Central Bank of Chile which will transfer the funds within 48 hours into the separate dollar account.

c. The MOH will review documentation evidencing health imports, the suppliers' invoices of which are dated on or after the date of the program agreement. Imports can be either public or private sector. Lists of individual transactions of health related imports from the U.S. will be backed up by invoices, bills of lading, etc. Imports of pharmaceuticals will not be eligible for reimbursement. Nor will other items prohibited by the U.S. Foreign Assistance Act (military items, abortion equipment, etc.). The MOH will present a report to A.I.D. stating that proper documentation of eligible imports has been collected and is available for A.I.D. review.

d. Once documentation is presented to and verified by A.I.D., A.I.D. will issue a Project Implementation Letter authorizing release of dollars from the Separate Account in an amount equal to the amount of imports verified. MOH will then instruct BANESTADO to release the funds and exchange (sell) them for local currency on the open market to commercial banks, at the highest exchange rate which is not unlawful.

e. BANESTADO will submit monthly reports to A.I.D. and MOH summarizing dollar account transactions.

f. To compensate for import transactions found to be ineligible through audit, or any other post-examination, the GOC will either immediately present documentation for other eligible imports or re-deposit into the separate account any amounts, in dollars, equivalent to erroneous payments, until acceptable documentation for eligible imports can be presented.

2. Procedures for Special Local Currency (Peso) Account

a. The GOC will establish a segregated, special peso account in the name of the Ministry of Public Health, which will contain only those pesos equivalent to disbursement of dollar tranches and earned interest, as described above.

b. The special account will be interest bearing and will be at BANESTADO.

c. As described above, once import transactions are accepted and dollars are released from the separate dollar account, BANESTADO will exchange the dollars for pesos in the banking system and place the pesos into the peso special account.

d. As funds are needed for the Program, they will be disbursed out of the special peso account into the MOH's normal accounts for the Program. At this point, funds from the special peso account will be commingled with the MOH's normal budgetary resources and possibly resources from other donors.

e. MOH will provide financial reports to A.I.D. on a monthly basis. Such reports will evidence all transactions in the local currency account and will provide sufficient documentation to demonstrate that funds from the special account have been deposited into the MOH's accounts for the Program.

f. Such financial reports will be in addition to BANESTADO's monthly reports on the special peso account and technical reports demonstrating progress against planned outputs. The financial reports will demonstrate progress in financial indicators which demonstrate that funds provided from the special account have increased the MOH's budget for the Program by certain increments or percentages.

C. Monitoring and Reporting

The monitoring of implementation under this sector assistance program includes: 1) monitoring the institutional and policy reform program, and 2) monitoring the foreign exchange and local currency program.

1. Monitoring of Institutional and Policy Reform

a. Ministry of Health

The Office of International Cooperation (OIC) in the MOH will be responsible for monitoring and reporting on progress (or problems) toward the implementation of the institutional and policy reforms. To accomplish this, the MOH will contract a program coordinator with funds from the Technical Assistance Project. The coordinator's duties and responsibilities will be agreed upon by the MOH and USAID/Chile. (Refer to Annex G.II. for details).

Semi-annual reports and joint reviews of the Program will be required. The OIC, in collaboration with the Department of Primary Health Care, will have the main tasks of monitoring and evaluating the "performance" and monitoring the "impact" of the

institutional and policy changes (refer to Section VII. MOH Monitoring/Evaluation System). This will be carried out as follows:

- Identify relevant data to be used in the evaluation and determination of progress made in the implementation of the institutional and policy reform program aimed at improving primary health care services;

- Collect the data identified above;

- Assist the Department of Primary Care in the analysis of the data, in the preparation of necessary reports to be used in the review, assessment, and determination of whether the conditions precedent related to institutional and policy reforms have been satisfactorily met;

- Assist the Department of Primary Care to prepare terms of reference of the various studies, assessments, pilot innovative service delivery activities, workshops, training and other activities required to achieve the desired institutional and policy reforms;

- Provide continuing analysis and evaluation of the effects of institutional and policy changes on resource allocation, government finance, organizational and service delivery efficiency and effectiveness, user satisfaction and health status;

- Make recommendations, based on analysis and evaluation, as to the need to modify the institutional and policy reforms to mitigate any unforeseen negative effects of the changes;

- Coordinate and assist other entities involved in the reform program; and

- Prepare required reports for both the Government of Chile and USAID.

b. USAID

The A.I.D. Representative in Chile will carry out A.I.D.'s ongoing monitoring and review responsibilities for the program and will be responsible for reporting to AID/W and other parts of A.I.D. on progress in implementing the primary care institutional and policy reform program.

However, the MOH will assume the major share of the monitoring responsibilities, especially through the Program Coordinator to be hired with Technical Assistance Project funds (refer to Annex G. Section II). Technical assistance

arrangements will provide technical backstopping for USAID and assist with monitoring of the Program's progress.

c. Joint Reviews

Semi-annual reviews between the Government of Chile and the USAID Representative and his staff, with assistance from Washington and the USAID/Peru controller, will be held to discuss the progress made or problems encountered in the Program. The first review will provide the basis for determining subsequent disbursements of funds under this grant. Semi-annual reviews will also provide an opportunity to make necessary adjustments or to correct any errors made during the design or implementation of the program.

The AID Representative, with AID/W assistance mentioned above and the MOH's Office of International Coordination will make the determination as to whether necessary conditions precedent for subsequent dollar disbursements have been met or whether modifications of institutional and policy reform targets are needed. AID/W will be informed of the decision with necessary documentation to support the decision. Any decision involving substantive modifications of the program will be deferred to the LAC Bureau.

d. Reports

Initial Disbursement -

The MOH will prepare a formal descriptive report with supporting documentation for USAID which will present the status/achievement of the major benchmarks identified in Section V.F. (Benchmarks and Conditions Precedent) of this document.

Semi-annual -

The MOH will prepare 4 (four) descriptive reports at six month intervals for presentation to USAID/Chile which discuss the achievements and status of the Program for the Immediate Improvement of Primary Health Care. The Program Outputs/End of Project Status (EOPS) as specified in Section V.D. (Program Outputs) of this document, will serve as a basis for review of the Program and provide the parameters for the descriptive reports. The reports will be reviewed in the semi-annual meetings between MOH and USAID.

The final semi-annual report will serve as the final evaluation document. In addition to presenting an assessment of achievement of the End of Project Status (EOPS) as specified in Section V.D., the MOH will also

present information regarding impact at the program level as described in Section VII (MOH Monitoring/Evaluation System). Technical consultants will assist the MOH with preparation of a simple and quick methodology for "evaluating" the Program and establishing the status of achievements by end of program (December 1992).

Final Disbursement -

The MOH will prepare a formal descriptive report with supporting documentation for USAID/Chile approximately 12 months after the Initial Disbursement Report. The report will discuss the achievements and the status of the Program based on Program Outputs/EOPS. This Final Disbursement Report may fulfill the requirement for preparation of the first or second semi-annual report.

A joint review between USAID and the MOH will be held to discuss the status of the Program and to determine whether substantial progress has been made towards achievement of the institutional and policy reforms aimed at improving the efficiency and effectiveness of health care delivery at the primary care level.

2. Monitoring of Foreign Exchange and Local Currency

a. Ministry of Health

As described above in Section B, Dollar Transfer and Local Currency Procedures and Management, once conditions are met and dollars are disbursed by the U.S. Treasury through the Central Bank of Chile and to the separate account in BANESTADO, the MOH will take charge of the process of getting dollars released from the separate dollar account. The MOH will receive import documentation from the commercial banks, aggregate such documentation and pass it to A.I.D. for final validation. After documentation is validated and dollars can be released, the agent bank will buy pesos from commercial banks and place them in the special peso account.

MOH will prepare monthly reports on the dollar transactions, until such time as the full dollar transfer has been made. Such reports will contain the following: 1) a summary of the current month's requests for dollar transfer by eligible Chilean custom codes; 2) a status of transfers to-date by custom code and separated into public and private sector amounts; 3) identification of the banking institutions financing eligible imports, including information on custom codes and dates of eligible transactions current month, and 4) an itemized accounting of deposits made to the dollar Special Account as well as withdrawals for the purpose of buying local currency for deposit into the host country owned local currency Special Account.

The information will be maintained on a monthly basis and will be submitted to A.I.D.

On the local currency side, the peso account will be maintained at BANESTADO which will receive orders from the MOH to disburse pesos to MOH current accounts for primary health care. BANESTADO will be responsible for providing appropriate documentation to A.I.D. evidencing the withdrawal of funds from the Special Account and the deposit of funds to the MOH's normal account for Primary Health Care. Again, reports will be prepared on a monthly basis, and will contain the following information:

- 1) a summary of the current month host country owned local currency deposits to the Special Account indicating the date of deposit, supported by evidence of the sale of dollars released from the dollar Special Account at the highest rate of exchange legally available from the sale on the commercial money market; and
- 2) a summary of the host country owned local currency withdrawals from the Special Account and evidence of the transfer to the MOH account for the Primary Health Care Program.

b. USAID

The Office of the A.I.D. Representative/ Chile will be responsible for validating the import documentation releasing the dollars from the separate account. The office of the A.I.D. Representative will also review, provide feedback and accept the monthly reports described above.

The import documentation, as well as monthly reports will be subject to post review by the Controller's Office, USAID/Lima as well as independent auditors described under Section VI.E. Audit Plan and Financial Review. The LAC Bureau will not have a role in the review of financial documentation and reports, but will participate in technical reviews, as requested by USAID/Chile.

D. Implementation Plan

1. Institutional and Policy Reform:

The institutional and policy reform implementation schedule

is provided below with the assumption that the sector assistance program will have been authorized in November 1990.

<u>Action</u>	<u>Date</u>
Grant Agreement signed Technical Assistance Project authorized Benchmarks for Initial Tranche submitted Joint meeting held to discuss achievements	December 1990
Phase I Technical Assistance visit Program Coordinator identified and hired	December 1990
Phase I Technical Assistance - Plan of Action presented and reviewed by MOH and USAID	January 1991
Phase II Technical Assistance - PIO/Ts prepared by USAID for buy-ins to central AID/W projects	January 1991
Phase II Technical Assistance - buy-ins completed by USAID	February 1991
Semi-annual Report submitted by MOH Joint MOH/USAID review held	June 1991
Final Tranche prepared, semi-annual Report submitted by MOH and joint review held to discuss progress	December 1991
Semi-annual Report submitted by MOH Joint review held to discuss progress	May 1992
Final Evaluation completed Final Program Report submitted Joint review held to discuss EOPS	December 1992
End of Program	December 1992- January 1993

2. Dollar and Local Currency Implementation

The dollar and local currency implementation plan is presented below:

<u>Action</u>	<u>Date</u>
Financial Analysis of dollar and local currency management system	Dec. 1990

First Disbursement of Dollars to Separate Account	early Dec. 1990
Conditions Precedent for first tranche met	Dec. 1990
Presentation of import documentation to release dollars	Jan. 1991
Dollars released, converted to Pesos and put into non-commingled special account	Jan./Feb. 1991
Pesos withdrawn from special account and enter MOH account, as needed	begin Feb. 1991, continuing
First monthly financial reports presented to A.I.D.	end of Feb. 1991
CPA firm conducts financial review	June 1991
As above, final tranche of dollars disbursed, after joint review of progress	Dec. 1991
Dollars released, converted to Pesos and put into non-commingled special account	Dec/Jan. 1991
Pesos withdrawn from special account and enter MOH account, as needed	begin June 1991, continuing
CPA firm does complete audit after first year of program	Jan. 1992
CPA firm conducts financial review	June 1992
CPA firm does complete audit after second year of program	Jan. 1993

E. Audit and Financial Review Plan

Contracted audits and financial reviews will be performed by an independent CPA firm(s) and will be phased to provide assurance that procedures and controls are effective in their application during implementation. Annual compliance verifications will be included. Financial assessments will be undertaken at the inception of the program to provide financial analyses of the entity managing the dollar separate and local currency special accounts and of the MOH. A covenant in the grant agreement will assure that any recommendations resulting from the financial analysis will be implemented.

The first Non-Federal Audit by a CPA firm will be performed at the end of the first year of operations, which will encompass the dollar transfers. The audit will examine implementation of recommendations of the First Financial Review. A follow-on financial review will be scheduled shortly thereafter to assure the effective application of any necessary remedial actions. Finally, a program close-out, Non-Federal Audit will be performed to coincide with the final program evaluation.

All of the financial reviews and Non-Federal Audits will be contracted by A.I.D. and will be performed by CPA firms in accordance with established criteria, including General Accounting Office and Generally Accepted Auditing Standards. Funding will be provided by the Grant (refer to Annex G. Section III.); the scopes of work for the financial reviews and Non-Federal Audits will be developed and competed according to standard Regional Inspector General (RIG) procedures.

VII. Ministry of Public Health Monitoring and Evaluation System

An information system which establishes a monitoring and evaluation process for both the Program for Immediate Improvement of Primary Health Care and the GOC's overall PHC program should have the following characteristics: be formative, continuous, adapted to the objectives of the Program, participative, and specially suited to development of local health systems.

As a base, a monitoring and evaluation plan will be introduced which is appropriate for the Program for Immediate Improvement of Primary Health Care. This plan will be established with the following objectives:

General Objectives:

- To design and implement a baseline study that describes the actual conditions of Primary Care and which will permit annual monitoring and evaluation of the sector activities; and
- To develop an ongoing monitoring and evaluation system for Primary Care which will be useful in developing plans of action for the different levels of health care.

Specific Objectives:

- To define related indicators which permit the monitoring of the quality of Primary Care;
- To carry out a diagnosis of the problems of the Primary Care situation;
- To promote the joint participation of the relevant sectors with the purpose of working out a diagnosis of the problems;

- To identify the principal problems which are the obstacles to normal delivery of Primary Care;
- To incorporate monitoring and evaluation as permanent activities in the different levels of Primary Care; and
- To develop a process of formative evaluation.

In connection with the Department of Primary Care, the monitoring and evaluation process will provide useful information relative to the following aspects: coverage, impact, resources, access, and outcome. In addition, it is important to measure the degree of user satisfaction with the Primary Care Services, which may be reflected in the degree of community participation in health.

Some of the indicators that may be used to monitor and evaluate the actual status of the Program are as follows:

- Resources -
total health expenditures of the population;
pharmaceutical expenditures per inhabitant; annual doctor hours per inhabitant; annual patient hours per inhabitant; auxiliary personnel hours per inhabitant (these indicators will be analyzed at the community level).
- Coverage -
hypertension, diabetes, alcoholism and epilepsy program coverage; immunization program coverage; screening for uterine cancer coverage; percentage of pregnant women who attend prenatal care during pregnancy (these indicators will be analyzed at the community level).
- Impact -
infant mortality and general mortality rates; principal causes of death; principal causes of morbidity; incidence of infectious diseases; annual number of medical consultations per inhabitant (indicators at the health service level).
- Access -
the number of persons denied service in relation to the number of persons seeking service; number of emergency service consultations versus the total number of consultations at the primary level; the number of emergency service consultations for non-emergency care versus total number of emergency service consultations (indicators at the health service level).

- Outcome -

number of referrals per 100 consultations; number of laboratory examinations per 100 consultations; waiting time for referrals and counter-referrals; waiting time for major laboratory tests (indicators at the community level).

- Satisfaction -

as a baseline, changes in user satisfaction with the services at the primary care facilities.

Developing an ongoing monitoring and evaluation process will allow regular semi-annual review and analysis of the Program. At the same time, this process will be useful for developing a standard "before and after" study model. This will facilitate decision-making and problem resolution processes and permit the timely incorporation of required programmatic changes.

A. Monitoring "Performance" of Institutional and Policy Reform Efforts

The indicators of performance criteria to which the semi-annual reports and final disbursement are tied are given in Section IV.D. These indicators are intended as targets toward which the institutional and policy reform program will move. The concept of "program performance" includes three successive levels of objectives - policy adoption, policy implementation, and direct effects of implementing the policy changes.

B. Monitoring "Impact" at the Program Level

All institutional and policy reform measures can be expected to have their ultimate impact in terms of changes of health status or institutional changes (e.g. the impact on the efficiency and effectiveness of health services). The monitoring and evaluation system described above will provide data sets on these indicators and on the most common intermediate indicators. Examples might include resources, coverage, access, outcome, and/or satisfaction indicators as identified on the previous page. These indicators will provide the information for the Final Evaluation/Reporting required by USAID.

VIII. Compliance with Cash Transfer and Local Currency Guidance

The Program was designed with close attention to existing cash transfer and local currency guidance, and with the draft

local currency guidance expected to be released before December, 1990. Essential dollar transfer guidance is contained in State 050845 (Oct. 1987-incorporated in HB 1 Part IV) and State 194322 issued June, 1990. Local currency guidance is contained in State 327494, Supplemental Guidance on Programming Local Currency (Oct. 1987 also incorporated in HB 1 Part IV) and State 313159, LAC Supplemental Host Country Owned Local Currency Guidance.

A. Compliance with Dollar Guidance

On the dollar side, the Program is consistent with the guidance in the following ways (according to the requirements in State 194322, Financial Management Guidance on Dollar Separate Accounts for ESF Cash Transfers and ESF, DA and DFA-funded Non Project Sector Assistance Cash Disbursements):

-The specific uses of the dollars is identified: the dollars will be used for financing health imports, using reimbursement.

-Dollars will be deposited into an interest bearing, separate account, within 48 hours of disbursement by U.S. Treasury.

-Interest earned will be programmed as principal.

-A financial assessment of the host country agency (BANESTADO) managing the separate dollar account will be completed before obligation of program funds. This assessment will be conducted by the regional financial analyst.

-The GOC will implement any recommendations resulting from the financial assessment.

-The Agent Bank will provide monthly reports on the dollar account.

-Audits will be conducted once a year, with interim financial reviews every six months.

B. Compliance with Local Currency Guidance

Local currency procedures are consistent with the Local Currency Guidance cited above, as follows (following State 313159, LAC Supplemental Guidance):

-Local currency will deposited into an interest bearing separate account.

-Local currency will be programmed according to agreement with the GOC-the program will be described in the grant agreement.

-A.I.D. is satisfied that GOC programming and budgeting systems provide assurance that primary health care objectives of the program will be achieved.

-Programming for primary health care is consistent with the FAA.

-Monitoring procedures have been reviewed with the GOC. A.I.D. will monitor local currency account transactions on a monthly basis, and technical progress, formally on a semi-annual basis.

-As with dollar transactions, A.I.D. will receive monthly reports on local currency account transactions, in addition to semi-annual technical reports.

C. Compliance with Draft Guidance

The draft local currency guidance is similar to the existing guidance, with the exception that the draft guidance requires that the following assessments be performed prior to or during the design stage: 1) general assessment of host country financial management and contracting capabilities and 2) a financial assessment of the institution receiving the local currency. The program, as designed, conforms to the draft guidance: i.e. local currency will be for general sector support, there will be a separate account, reporting and auditing requirements are met, etc.

However, it will not be possible to conduct a general assessment of the Government of Chile's financial management and contracting capabilities prior to the completion of the PAAD. The Office of Financial Management has confirmed that a general assessment need not be performed prior to obligating funds under this program.

Disbursement of funds from the Peso Special Account will be conditioned on completion of a financial assessment of the MOH and of the system for managing the local currency. This financial assessment will be contracted by A.I.D. with technical assistance funds.

D. Other Considerations

Neither the dollar nor the local currency guidance stipulate that local currency must be deposited simultaneously with the disbursement of dollars to the separate dollar account. The GOC has been advised that this is AID's preference, but has expressed some doubt on whether this is possible from a Treasury/budgetary standpoint. At any rate, the government has agreed that local currency will be deposited into the special account at the time dollars are released from the dollar account.

AID's concern is that dollars disbursed from the U.S. Treasury are expeditiously used for their intended purposes. The probability of this occurring is very good since imports for the health sector total some \$200 million per annum and the GOC must present documentation for reimbursement for less than \$10 million worth of imports. The documentation should be presented quickly after each disbursement to the separate dollar account. Similarly, local currency drawdown from the special account should also be expeditious since the program is short term and the GOC expects to expend approximately \$27 million on the program over two years. However, drawdowns from the special peso account will not be made as quickly as from the separate dollar account, since local currency drawdowns will depend on implementation of the program.

IX. Conditions and Covenants

A. Conditions

1. First Tranche: U.S. 5.8 Million

Prior to the disbursement of the first tranche (expected to be effected in December, 1990), the GOC will comply with the standard conditions precedent (legal opinion and authorized representatives), as well as with the conditions described below for the cash transfer portion of the grant. The technical assistance project will have only the standard conditions listed above in order to facilitate expeditious technical assistance, project coordination and auditing services.

- Establishment of a separate account and a special account for the deposit of the U.S. dollar and Chilean Peso proceeds of the grant, respectively;
- Provision to A.I.D. of the procedures governing how the dollars and pesos will be handled;

- Documentation (i.e. a report) evidencing that the following benchmarks have been achieved:
 - New Agreements will be signed between the Health Service Areas (HSAs) and Mayors in at least 85% of the priority 104 rural and 24 urban municipalities. These Agreements would reflect the agreement between these authorities and the MOH on the goals to be achieved with the increased funding available for Primary Health Care.
 - Establishment of at least 11 of the 13 24-Hour Emergency Services planned for selected urban consultorios in the first phase of the PII/PHC Program. Such services will provide previously unavailable emergency health care in underserved areas, reducing congestion both in the consultorios' regular daily hours as well as in the local hospital emergency room.
 - Extension of hours in 100% of the 38 consultorios selected to include as third shift (during the first phase of the PII/PHC Program). These extended hours will allow greater access to primary health care services by the working public.
 - Hiring of at least 50% of the 28 additional medical professionals planned for the first phase of the PII/PHC Program in order to strengthen the technical supervisory capacity of the Directorates of Primary Care (DAPs) of the 18 Health Service Areas (HSAs) which contain the 104 priority rural municipalities

2. Second Tranche: U.S. 3.5 Million

Prior to the disbursement of the second tranche, tentatively scheduled to be effected by Dec., 1991, the GOC will have attained progress, based on joint review by GOC and AID, in implementing the Program for the Immediate Improvement of Primary Health Care. The joint review will measure progress attained in achieving the outputs described in Section V.D. Program Outputs.

B. Covenants

The Government of Chile will covenant to implement recommendations identified in the Non-Federal Audits and Financial Reviews.

The Government of Chile will covenant to implement any recommendations identified and mutually agreed upon in the institutional and policy reform semi-annual reviews.

10/11/90:CHILE

REPUBLICA DE CHILE.
 MINISTERIO DE SALUD.
 DEPTO DE ATENCION PRIMARIA.

PROGRAMA DE ATENCION PRIMARIA - 1991.

I - MARCO CONCEPTUAL :

El marco conceptual del Programa de Atención Primaria (APS) está definido en el documento base " Principios generales y tareas específicas del Primer Año de Atención Primaria ". Sin embargo parece importante hacer énfasis en los siguientes aspectos :

1 - La APS es tarea-objetivo prioritaria del Sistema de Salud dentro de las acciones tendientes al "pago de la deuda social" tal como ha sido definido en los documentos programáticos de la Concertación y en innumerables intervenciones públicas del Presidente Aylwin.

2 - La APS está orientada a toda la población para favorecer una mejor calidad de vida, donde este asegurada la satisfacción de las necesidades de salud de los sectores mas pobres (tradicionalmente postergados)

3 - La APS promueve la programación, gestión y evaluación fundamentalmente en el nivel local, apoyando de esta manera el proceso de descentralización progresiva del sector Salud.

4 - La APS promueve la participación social a través de la creación de los Consejos Comunales en un intento por reforzar el enfoque intersectorial

5 - La APS recoge la problemática de salud mas sentida por la comunidad y orienta sus acciones en la perspectiva de ofrecer soluciones coherentes y realistas

El problema fundamental de APS para 1991 radica en la desproporción que existe aún, a pesar de los recursos asignados durante el 2o semestre de 1990, entre, por un lado, las necesidades sentidas o expresadas por la población, que traducen el considerable daño en salud incluido el medio ambiente y, por otro lado, la disponibilidad de recursos humanos y financieros. Es por ello que nos parece esencial lograr :

- Una expansión del aporte global al Programa de Atención Primaria para 1991 que permita el cumplimiento de los objetivos que se indican mas adelante ;

- Una asignación eficiente, basada en los diagnósticos locales de la situación de salud y de los recursos disponibles.

La APS se constituye entonces en una estrategia global (bio-psico-social) que se propone resolver el problema de salud de las poblaciones mediante la reorientación y reorganización de todos los recursos (los disponibles mas los necesarios) para satisfacer las aspiraciones de toda la sociedad, en función de los requisitos de la Salud Para Todos en el Año 2.000.

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II - OBJETIVOS.

1) OBJETIVOS GENERALES.

1.1. Desarrollar en forma integral el programa de Atención Primaria de Salud (APS) a nivel de todo el país, con énfasis en la extensión de cobertura y en la diversificación de los programas, integrando aquellos incluidos en el programa de Salud de la Concertación y que no han sido cubiertos hasta ahora.

1.2. Lograr un desarrollo armónico de la APS urbana y rural en el contexto de servicios y regiones, con el objeto de eliminar las distorsiones que se han observado hasta ahora.

2) OBJETIVOS ESPECÍFICOS

2.1. Implementar las medidas tendientes a mejorar la calidad de la atención en el nivel primario, haciendo que ésta sea más sectorizada, con mayor capacidad resolutiva.

2.2. Desarrollar un diagnóstico acabado a nivel comunal de las necesidades y de la estructura del sector salud, con énfasis en los grupos prioritarios: niños menor de 5 años, adolescente, mujer, trabajadores, recibirán este

2.3. Dar un fuerte impulso a la participación en salud a través de la creación, consolidación de instancias tales como los Comités Comunales de Salud en las 330 comunas del país u otras instancias de participación existentes o que se generen.

2.4. Dar un fuerte impulso a la Coordinación Intersectorial, con énfasis en el nivel comunal, poniendo en marcha proyectos integrados de desarrollo, particularmente en las 104 comunas que han sido postergadas.

2.5. Reforzar considerablemente la Educación para la Salud y Comunicación Social en términos de APS y de los programas prioritarios, con énfasis en el nivel local y utilizando una metodología adaptada a las necesidades locales.

2.6. Preparar e implementar el reemplazo legal del FAPEM por una medida de asignación de recursos financieros en APS per cápita que tienda a asegurar la satisfacción de las necesidades de la APS.

2.7. Implementar con el personal de APS las medidas que el Ministerio de Salud elabore en cuanto a nueva Carrera funcionaria de los profesionales médicos y paramédicos.

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48

2.8. Reforzar las actividades iniciadas en las áreas de validación en las comunas de La Florida y Conchalí en la perspectiva de concretizar la experiencia de Sistemas Locales de Salud

2.9. Continuar reforzando la Capacitación del Personal de Atención Primaria, con énfasis en el nivel local y utilizando la estrategia participativa.

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III) ESTRATEGIA :

1.) Definición de incremento de cobertura:

a) Consolidación en 1991 de la cobertura lograda en el 2o semestre de 1990 en las 24 comunas urbanas y las 104 comunas rurales (Ver Lista en Anexos No 1 y 1 A).

b) Aumento de la cobertura a 32 comunas intermedias en el sector urbano y peri-urbano (Ver Lista en Anexo No 2).

2.) Definición de los Programas y de las actividades que se van a implementar:

a) Extensión de la APS básica: Salud Materno-Infantil, Medicina General, Programa de crónicos, Enfermería, etc.

b) Implementación de Programas nuevos orientados a grupos prioritarios, tradicionalmente postergados

- Salud Mental
- Salud Laboral
- Medio Ambiente
- Mujer Trabajadora
- Adolescente embarazada
- Adulto mayor

3) Coordinación con el Departamento de Programación para la implementación de los diferentes programas, especialmente los de Educación para la Salud Comunicación Social y Salud Mental.

4) Coordinación con los diferentes Ministerios a nivel regional (Seremis) para la implementación de los proyectos de desarrollo a nivel local, especialmente en las 104 comunas prioritarias.

5) Realización de algunas Jornadas movilizadoras de APS en algunas áreas específicas. Se sugiere realizar en 1991 una Jornada Nacional por el Medio Ambiente que incluya la realización de tareas tales como plantación de árboles, enterrar basuras en barrios periféricos, desratizaciones, etc.

También se pudiera discutir con el Departamento de Programación la realización de Jornadas Regionales o Comunes de Vacunación contra el Sarampión en 1991 en aquellas comunas que presentan bajas coberturas de vacunación en 1989. (Planteamientos hechos por el Pdte Aylwin en su Mensaje del 21/05/1990).

6) Las actividades propuestas en este documento se enmarcan dentro de lo que ha sido el planteamiento nacional del Depto de Atención Primaria en cuanto a ampliar de manera urgente este nivel de atención para hacer frente a las necesidades más importantes y más sentidas por la población y dentro de las limitaciones

presupuestarias planteadas por el Ministerio de Hacienda para 1991; igualmente están hechas dentro del marco actual de elaboración del presupuesto del Ministerio, en la perspectiva de solo ampliar los techos del FAPEM y los convenios actuales con las Municipalidades, procedimientos que deseáramos ver modificados en el curso de 1991.

7) Implementación progresiva en 1991 en el personal de Atención Primaria de las proposiciones de Carrera Funcionaria elaboradas por el Departamento de Recursos Humanos, una vez que hayan sido legalmente aprobados por el Ministerio.

8) Implementación legal en 1991 de un texto que incentive la creación de Consejos Comunales de Salud u otros mecanismos que den cauce a la participación en salud, de acuerdo a los cánones legales vigentes.

9) El Plan de Acción de APS en 1991 continuará apoyándose en las Direcciones de Atención Primaria (DAP) de cada Servicio como elemento "fundamental" para la implementación del Programa y también para apoyando la creación y el reforzamiento de éstos en aquellos Servicios donde aún están débiles o no constituidos

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ANEXO No 1.

PROGRAMA DE REFORZAMIENTO DE ATENCION PRIMARIA EN
COMUNAS DE MAYOR RIESGO EN 1990.

SERVICIOS DE SALUD. ---

COMUNAS PRIORITARIAS.

1) Metrop. Oriente	Barnechea Peñalolén.
2) Metrop. Sur-Oriente	Florida Pintara Puente Alto San Ramón.
3) Metrop. Sur	Cisterna El Bosque La Espejo San Joaquín Pedro Aguirre Cerda San Bernardo
4) Metrop. Central	Estación Central Maipú
5) Metrop. Poniente	Cerro Navia Pudahuel Renca Lo Prado
6) Metrop. Norte	Conchalí Huechuraba
7) Valparaíso	Valparaíso
8) Viña del Mar	Viña del Mar
9) Concepción	Concepción
10) Temuco	Temuco

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57

LISTADO DE CONSULTORIOS POR SERVICIO, COMUNA

Y ACTIVIDADES.

<u>SERVICIO.</u>	<u>CONS C/IMPLEMENTAC DE PEPSONAL.</u>	<u>TERCER TURNO</u>	<u>SAPUL</u>
1) METROP. SUR.	La Feria Joao Goulart Cóndores de Chile San Bernardo Conbrat Carol Urzúa San Joaquín (7)	Dávila Sor Teresa Valledor 3 Cisterna Sur Santa Anselma Julio Acuña P (6)	Santa Anselma
2) METROP S P-CE	La Granja La Bardera Pablo de Riera San Rafael Stgo del N. Extremo Bellavista Villa O'Higgins Los Castaños Los Quillayes Mied. del R. San Gregorio (11)	La Granja La Bardera Los Castaños Villa O'Higgins San Rafael/Doble turno (5)	Los Quillayes
3) METROP ORIENTE	La Paera Punta Renard (2)	Sr Luis de Bernal. Sta Julia (2)	Lo Barnechea (*) Aristia (*)
4) METROP NORTE	Lucas Sierra Quinta Buin Pincoya Eneas Gonell A Scroggle J Symon Valdivieso (6)	Lucas Sierra Quinta Buin Pincoya Scroggle (4)	Lucas Sierra
5) METROP OCCID	Sta Anita R Yazigi C Avendafo A Steeger C. Albertz Pudahuel La Estrella Renca Huamachuco (9)	R. Yazigi C. Avendaño A. Steeger C. Albertz Pudah. Poniente Huamachuco (6)	Renca Pudahuel Cerro Navia

* = ya en funcionamiento.

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METROPOLITANA CENTRAL	Maipú Los Nogales Lo Valedor (3)	Maipú Los Nogales Cerrillos (3)	San José Chuchunco.
VALPARAISO	Mena Quebrada Verde Reina Isabel Los Placeres Plaza Justicia Podelillo Puertas Negras (7)	Reina Isabel Los Placeres (2)	Quebrada Verde
PUERTO MARIPOSA	Nueva Aurora Miraflores Cifras Carreras Luzitania 4	Nueva Aurora Canal Beagle Miraflores Fiestal 4	Concón(*)
VALDIVIA	Costanera Castel Costanera San Pedro Cruces de Arenas Chiguayante 5	San Pedro Fiestal (2)	Chiguayante
PUERTO MONTT	Puerto Nuevo Padre Las Casas Las Águilas Villa Alegre Santa Rosa Miraflores 6	Puerto Nuevo Padre Las Casas (2)	Miraflores

TOTALES

1 - CONSULTORIOS CON AUMENTO DE PERSONAL 61
 2 - CONSULTORIOS CON TERCER TURNO 36
 3 - CONSULTORIOS CON SAPU 13 (de los cuales 3 están ya en funcionamiento)

* = ya en funcionamiento

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ANEXO No 2

22 COMUNAS PROPUESTAS PAR BENEFICIAR DE APOYO APS EN 1991.

<u>COMUNAS</u>	<u>POBLACION (30/06/1990)</u>
1) APICA	191.803
2) IQUIQUE	149.482
3) ANTOFAGASTA	219.291
4) CALAMA	116.709
5) COPIAPO	80.241
6) OVALLE	84.552
7) COQUIMBO	115.158
8) LA SERENA	116.738
9) SAN FELIPE	50.570
10) LOS ANDES	50.668
11) VALPARAISO	54.400
12) QUILQUE	108.289
13) BANGUA	95.305
14) SAN FERNANDO	48.045
15) TERCER BRUNO	106.081
16) TALCA	117.981
17) SAN BERNABE	47.385
18) TARRAGONA	70.528
19) PICHINAN	109.565
20) TERCER BRUNO	147.011
21) TERCER BRUNO	44.817
22) CORONEL	75.108
23) LOS ANDES	104.522
24) LEB	15.553
25) TERCER BRUNO	44.070
26) TERCER BRUNO	111.011
27) TERCER BRUNO	130.155
28) TERCER BRUNO	100.410
29) TERCER BRUNO	33.414
30) TERCER BRUNO	39.888
31) TERCER BRUNO	49.818
32) TERCER BRUNO	102.272
TOTAL POBLACION	2.033.547

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Annex B.

Logical Framework

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><u>Program or Sector Goal</u> To improve the quality of life of the Chilean population.</p>	<p><u>Measures of Goal Achievement</u> Continued reduction/maintenance of infant and child morbidity and mortality rates.</p>	<p>GOC statistics and reports, other organizations reports (IBRD, BID), and independent evaluations; data collected through MOH management information system</p>	<p>GOC continues to promote strategies o improved health status through primary and preventive care.</p> <p>Economic, political and social conditions do not detrimentally affect target groups.</p>
<p><u>Program Purposes (Specific Objectives):</u></p>	<p><u>End of Project Status (EOPS).</u></p>		
<p>1. To improve access to primary health care of the Chilean population, especially the poorest sectors, located in dispersed rural areas and marginal urban concentrations.</p>	<p>Application of technology and information are reflected in increased access to PHC of the poorest sectors.</p>	<p>GOC reports, records, evaluations, and special studies</p>	<p>GOC commitment to institutional and policy reforms continues.</p> <p>GOC supports studies and operations research which would help to formulate health financing policies and improved delivery of PHC services</p>
<p>2. To improve the quality of and opportunity for health care services through an increase in the capacity for health care problem resolution at the primary care level.</p>	<p>Application of technology and information are reflected in improved quality of and opportunity for health services.</p>	<p>Review of GOC semi-annual reports; joint review meetings.</p>	<p>Host country institutions have adequate funding and absorptive capacity to fund and manage PHC programs.</p> <p>Adequate funding is available for programs and models which will utilize information provided by these activities.</p> <p>Local currency component from this program used to finance activities and purchase equipment/medical supplies which contribute to improved health status.</p>

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Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<u>Outputs:</u>	<u>Conditions Indicating Outputs Have Been Achieved:</u>		
<u>Institutional and Policy Reforms-</u>			
1. <u>Strengthening Primary Health Care in Rural and Urban Communities Accompanied by Improvement of Administrative and Supervisory Capacity of PHC.</u>	<p>Reestablishment and reinforcement of a functional system of technical supervision of the municipalized primary care system by the Directorates of Primary Health Care (DAPs) in each Health Service Area including:</p> <ul style="list-style-type: none"> - DAPs reconstituted and assigned personnel, vehicles, operating expenses and training resources; - New Agreements signed between the Health Service Areas and the local Mayors which include agreements on specific PHC activities and supervisory responsibilities, and - Personnel of DAPs and municipalized PHC system trained in implementation of supervisory system 	<p>Review of GOC semi-annual reports; joint review meetings</p> <p>Data collection from MOH management information system.</p>	<p>GOC commitment to institutional and policy reforms continues.</p> <p>GOC supports studies and operations research which will help to formulate health financing and management policies and improved delivery of PHC services.</p> <p>Required technical services are available.</p>

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
	<p>Establishment of a new system for resource allocation for the PHC system including.</p>		
	<ul style="list-style-type: none"> - Studies of actual costs of each type of primary care service completed in a representative sample of PHC centers in small urban and metropolitan populations. 		
	<p>A management information system (MIS) for the PHC level designed, tested and implemented in priority Health Service Areas in order to provide accurate and timely data to support planning and management, the new supervisory role of the DAPs, and resource allocation decisions.</p>		
	<p>Morale of municipalized PHC personnel improved through</p>		
	<ul style="list-style-type: none"> - Motivational training completed, 		
	<ul style="list-style-type: none"> - Feasibility studies completed on potential for establishing a career civil service for PHC workers in the municipalities; and 		

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
2. <u>Improvement of Technical Problem-Solving Capacity in PHC Centers</u>	<p>- Adequate equipment and supplies available so that personnel can perform their duties.</p> <p>Basic diagnostic equipment available and basic diagnostic laboratories established and equipped in priority PHC areas.</p> <p>Design, testing, and implementation of technical training programs for PHC personnel in priority areas in the use and maintenance of basic diagnostic equipment.</p>	<p>Review of GOC semi-annual reports; joint review meetings</p> <p>Data collection from MOH management information system</p>	<p>GOC commitment to institutional and policy reforms continues.</p> <p>Required technical services are available.</p> <p>GOC supports studies and operations research which will help to formulate health financing and management policies and improved delivery of PHC services.</p>
3. <u>Improved Access to PHC</u>	<p>A list of NGOs providing parallel PHC services compiled; development of an instrument to accredit, select, and contract NGOs to provide PHC services in cooperation with both HSAs and the municipalities.</p> <p>Pilot programs for PHC service delivery by selected NGOs established and tested in priority urban areas</p>	<p>Review of GOC semi-annual reports, joint review meetings.</p> <p>Data collection from the MOH management information system</p>	<p>GOC commitment to institutional and policy reforms continues.</p> <p>GOC supports studies and operations research which will help to formulate health financing and management policies and improved delivery of PHC services.</p> <p>Required technical services are available.</p>

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
4. <u>Innovative Programs in Primary Health Care</u>	<p>Thirteen planned 24-Hour Emergency Services (SAPUs) established and pilot tested for effectiveness and efficiency in low-income urban areas; completion of a model for expansion of SAPUs to additional consultorios.</p> <p>An additional (third) shift established in at least 38 priority PHC centers; evaluation of the model for expansion to additional consultorios.</p>	<p>Review of GOC semi-annual reports, joint review meetings</p> <p>Data collection from the MOH management information system.</p>	<p>GOC commitment to institutional and policy reforms continues.</p> <p>GOC supports studies and operations research which will help to formulate health financing and management policies and improved delivery of PHC services.</p> <p>Required technical services are available.</p>
	<p>An evaluation completed of the ongoing University affiliated pilot training program for Family Health Practitioners; extension of this training to actual PHC service delivery</p>		
	<p>A pilot service delivery model for caring for the elderly, including chronic disease monitoring, developed and tested, a refined model for elderly care approved for use and replication in the PHC system.</p>		

Logical Framework

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
	Community Health Councils and community support systems (SICOS) established and functioning in at least 80% of the priority municipalities.		

5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded with Development Assistance loans; and B(3) applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

A. GENERAL CRITERIA FOR PROJECT

1. FY 1990 Appropriations Act Sec. 523; 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?
2. 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?
3. 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?

A Congressional Notification was submitted on November 19, 1990.

Yes. A budget has been prepared with a reasonable estimate of the cost of the assistance.

This project does not require such action.

4. FAA Sec. 611(b); FY 1990 Appropriations Act Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in 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
5. FAA Sec. 611(e). If project is capital assistance (e.g., 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
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. No.
7. 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 project will support efforts of the GOC to incorporate non-governmental organizations into the primary health care system.
8. 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). Technical assistance under the project will be provided by private firms contracted by A.I.D.

9. 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. The GOC is contributing \$16.7 million of local currency to the program. Chile is not an excess foreign currency country.
10. 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? No.
11. FY 1990 Appropriations Act Sec. 521. 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
12. FY 1990 Appropriations Act Sec. 547. Will the assistance (except for programs in Caribbean Basin Initiative 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? No.
13. FAA Sec. 119(g)(4)-(6) & (10). 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 No.

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?

14. FAA Sec. 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)? N/A

15. FY 1990 Appropriations Act, Title II, under heading "Agency for International Development." 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? N/A

16. FY 1990 Appropriations Act Sec. 537. If assistance is being made available to a PVO, has that 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.? N/A

17. FY 1990 Appropriations Act Sec. 514. 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? N/A

65

18. 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). N/A
19. Trade Act Sec. 5164 (as 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? N/A
20. FY 1990 Appropriations Act, Title II, under heading "Women in Development." Will assistance be designed so that the percentage of women participants will be demonstrably increased? No. This project will necessarily focus on women since it can be assumed that at least 50% of primary health care personnel are women.

21. FY 1990 Appropriations Act Sec. 592(a).

If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies, 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 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? a)Yes. b)Yes. c)Yes.

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? Yes.

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? Yes.

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? Yes.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FY 1990 Appropriations Act Sec. 546 (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 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?

N/A

b. 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

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

The program supports delivery of health care at the local level with community involvement. The GOC will be responsible for carrying out the program.

d. 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, to the development of human resources through improved improved health.

e. FAA Secs. 102(b), 111, 113, 281(a). Describe extent to which activity will: (1) 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; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a 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.

This project supports a self-help effort of Chile.

f. FAA Secs. 103, 103A, 104, 105, 106, 120-21; FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA." Does the project fit the criteria for the source of funds (functional account) being used?

Yes.

g. FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA." Have local currencies generated by the sale of imports or foreign exchange by the government of a country in Sub-Saharan Africa from funds appropriated under Sub-Saharan Africa, DA been deposited in a special account established by that government, and are these local currencies available only for

N/A

use, in accordance with an agreement with the United States, for development activities which are consistent with the policy directions of Section 102 of the FAA and for necessary administrative requirements of the U. S. Government?

h. FAA Sec. 107. Is emphasis placed on use of appropriate technology (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

i. 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)?

Yes.

j. 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. The program uses poverty indicators to target its activities. The program targets the public health care system while wealthier Chileans rely on the private system.

k. FAA Sec. 281(b). Describe extent to which program 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 civil education and training in skills required for effective participation in governmental processes essential to self-government.

The project supports a GOC initiative. Training of municipal-level health care providers will provide important institutional development

l. FY 1990 Appropriations Act, under heading "Population, DA," and Sec. 535. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?

No.

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.

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.

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? Yes.

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? No.

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.

m. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes.

n. FY 1990 Appropriations Act Sec. 579. 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 This project will be implemented through already-existing A.I.D. contracts.

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)?

o. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? 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 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

Yes. A categorical exclusion has been made.

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; and (11) utilize the resources and abilities of all relevant U.S. government agencies?

p. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project: (1) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (2) take full account of the environmental impacts of the proposed activities on biological diversity?

N/A

q. FAA Sec. 118(c)(14). 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; or (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?

N/A

r. FAA Sec. 118(c)(15). Will assistance be used for: (1) activities which would result in the conversion of forest lands to the rearing of livestock; (2) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (3) the

N/A

colonization of forest lands; or (4) the construction of dams or other water control 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?

s. FY 1990 Appropriations Act Sec. 534(a). 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

t. FY 1990 Appropriations Act Sec. 534(b). If assistance relates to energy, will such assistance focus on improved energy efficiency, increased use of renewable energy resources, and national energy plans (such as least-cost energy plans) which include investment in end-use efficiency and renewable energy resources?

N/A

Describe and give conclusions as to how such assistance will: (1) increase the energy expertise of A.I.D. staff, (2) help to develop analyses of energy-sector actions to minimize emissions of greenhouse gases at least cost, (3) develop energy-sector plans that employ end-use analysis and other techniques to identify cost-effective actions to minimize reliance on fossil fuels, (4) help to analyze fully environmental impacts (including impact on global warming), (5) improve efficiency in production, transmission, distribution, and use of energy, (6) assist in exploiting nonconventional renewable energy resources, including wind, solar, small-hydro, geo-thermal, and advanced

biomass systems, (7) expand efforts to meet the energy needs of the rural poor, (8) encourage host countries to sponsor meetings with United States energy efficiency experts to discuss the use of least-cost planning techniques, (9) help to develop a cadre of United States experts capable of providing technical assistance to developing countries on energy issues, and (10) strengthen cooperation on energy issues with the Department of Energy, EPA, World Bank, and Development Assistance Committee of the OECD.

u. FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA"

N/A

(as interpreted by conference report upon original enactment). If assistance will come from the Sub-Saharan Africa DA account, is it: (1) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (2) being provided in accordance with the policies contained in section 102 of the FAA; (3) being provided, when consistent with the objectives of such assistance, through African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (4) being used to help overcome shorter-term constraints to long-term development, to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take

25

into account, in assisted policy reforms, the need to protect vulnerable groups; (5) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks, to maintain and restore the renewable natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

v. International Development Act Sec. 711, FAA Sec. 463. If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (1) the world's oceans and atmosphere, (2) animal and plant species, and (3) parks and reserves; or describe how the exchange will promote: (4) natural resource management, (5) local conservation programs, (6) conservation training programs, (7) public commitment to conservation, (8) land and ecosystem management, and (9) regenerative approaches in farming, forestry, fishing, and watershed management.

N/A

w. FY 1990 Appropriations Act Sec. 515. 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 Appropriations Committees been properly notified?

N/A

2. Development Assistance Project Criteria
(Loans Only)

N/A

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

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

c. 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?

3. Economic Support Fund Project Criteria

N/A

a. 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?

b. FAA Sec. 531(e). Will this assistance be used for military or paramilitary purposes?

c. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

3(A)2 - NONPROJECT ASSISTANCE CHECKLIST

The criteria listed in Part A are applicable generally to FAA funds, and should be used irrespective of the program's funding source. In Part B a distinction is made between the criteria applicable to Economic Support Fund assistance and the criteria applicable to Development Assistance. Selection of the criteria will depend on the funding source for the program.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED?

A. GENERAL CRITERIA FOR NONPROJECT ASSISTANCE

1. FY 1990 Appropriations Act Sec. 523; FAA Sec. 634A. Describe how authorization and appropriations committees of Senate and House have been or will be notified concerning the project. A Congressional Notification was submitted on Nov. 19, 1990.
2. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance? N/A
3. FAA Sec. 209. Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs. No.

4. 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.

The assistance will support efforts of the GOC to foster private initiative through incorporation of non-governmental organizations into the primary health care system.

5. 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).

The program will finance U.S. exports of health-care commodities to Chile.

6. FAA Sec. 121(d). If assistance is being furnished under the Sahel Development Program, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of A.I.D. funds?

ex N/A

B. FUNDING CRITERIA FOR NONPROJECT ASSISTANCE

1. Nonproject Criteria for Economic Support Fund

N/A

a. 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?

b. FAA Sec. 531(e). Will assistance under this chapter be used for military or paramilitary activities?

c. 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?

d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

e. FY 1990 Appropriations Act, Title II, under heading "Economic Support Fund," and Sec. 592. If assistance is in the form of a cash transfer: (a) Are all such cash payments to be maintained by the country in a separate account and not to be commingled with any other funds? (b) Will all local currencies that may be generated with funds provided as a cash transfer to such a country also be deposited in a special account, and has A.I.D. entered into an agreement with that government setting forth the amount of the local currencies to be generated, the terms and conditions under which they are to be used, and the responsibilities of A.I.D. and that government to monitor and account for deposits and disbursements? (c) Will all such local currencies also be used in accordance with FAA Section 609, which requires such local currencies to be made available to the U.S. government as the U.S. determines necessary for the requirements of the U.S. Government, and which requires the remainder to be used for programs agreed to by the U.S. Government to carry out the purposes for which new funds authorized by the FAA would themselves be available? (d) Has Congress received prior notification providing in detail how the funds will be used, including the U.S. interests that will be served by the assistance, and, as appropriate, the economic policy reforms that will be promoted by the cash transfer assistance?

2. Nonproject Criteria for Development Assistance

a. 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?

This program targets municipalities in rural areas and will assist them to provide primary health care. The program is a GOC initiative.

b. FAA Secs. 103, 103A, 104, 105, 106, 120-21. Is assistance being made available (include only applicable paragraph which corresponds to source of funds used; if more than one fund source is used for assistance, include relevant paragraph for each fund source):

No.

(1) [103] for agriculture, rural development or nutrition; if so (a) extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, account shall be taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made; (b) extent to which assistance is used in coordination with efforts carried out

under Sec. 104 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 of poor and vulnerable people; and (c) 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.

(2) [104] for population planning under Sec. 104(b) or health under Sec. 104(c); if so, 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 program emphasizes low-cost, integrated health care systems for the urban and rural poor, implemented through clinics and non-government organizations.

(3) [105] for education, public administration, or human resources development; if so, (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

N/A

and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

(4) [106] for energy, private voluntary organizations, and selected development problems; if so, extent activity is:

(i)(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
(b) facilitative of 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;

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

(iii) research into, and evaluation of, economic development processes and techniques;

(iv) reconstruction after natural or manmade disaster and programs of disaster preparedness;

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

(vi) for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.

(5) [120-21] for the Sahelian region; if so, (a) extent to which there is international coordination in planning and implementation; participation and support by African countries and organizations in determining development priorities; and a long-term, multidonor development plan which calls for equitable burden-sharing with other donors; (b) has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of projects funds (dollars or local currency generated therefrom)?

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84

Chile

- 1 -

5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to: (A) FAA funds generally; (B)(1) Development Assistance funds only; or (B)(2) the Economic Support Fund only.

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FY 1990 Appropriations Act Sec. 569(b). Has the President certified to the Congress that the government of the recipient country is failing to take adequate measures to prevent narcotic drugs or other controlled substances which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully?

2. FAA Sec. 481(h); FY 1990 Appropriations Act Sec. 569(b). (These provisions apply to assistance of any kind provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance from the Child Survival Fund or relating to international narcotics control, disaster and refugee relief, narcotics education and awareness, or the provision of food or medicine.) If 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

No, the President has NOT so certified.

The recipient is not a major illicit drug producing or drug-trans country.

95

are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government): (a) Does the country have in place a bilateral narcotics agreement with the United States, or a multilateral narcotics agreement? and (b) Has the President in the March 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without Congressional enactment, within 45 days of continuous session, of a resolution disapproving such a certification), or has the President determined and certified to the Congress on any other date (with enactment by Congress of a resolution approving such certification), that (1) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to satisfy the goals agreed to in a bilateral narcotics agreement with the United States or in a multilateral agreement, to prevent illicit drugs produced or processed in or transported through such country from being transported into the United States, to prevent and punish drug profit laundering in the country, and to prevent and punish bribery and other forms of public corruption which facilitate production or shipment of illicit drugs or discourage prosecution of such acts, or that (2) the vital national interests of the United States require the provision of such assistance?

3. 1986 Drug Act Sec. 2013. (This section applies to the same categories of assistance subject to the restrictions in FAA Sec. 481(h), above.) If recipient country is a "major illicit drug producing country" or "major drug-transit country" (as defined for the purpose of FAA Sec 481(h)), has the President submitted a report to

The recipient is not a major illicit drug producing or drug-transit country.

Congress listing such country as one:
(a) which, as a matter of government policy, encourages or facilitates the production or distribution of illicit drugs; (b) in which any senior official of the government engages in, encourages, or facilitates the production or distribution of illegal drugs; (c) in which any member of a U.S. Government agency has suffered or been threatened with violence inflicted by or with the complicity of any government officer; or (d) which fails to provide reasonable cooperation to lawful activities of U.S. drug enforcement agents, unless the President has provided the required certification to Congress pertaining to U.S. national interests and the drug control and criminal prosecution efforts of that country?

4. 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?

The government is not so indebted.

5. FAA Sec. 620(e)(1). If assistance is to a 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?

The government has not taken such action.

6. FAA Secs. 620(a), 620(f), 620D; FY 1990 Appropriations Act Secs. 512, 548. 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, Cambodia, Cuba, Iraq, Libya, Vietnam, South Yemen, 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?

The recipient is not a Communist country.

7. 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?

The country has taken adequate measures to prevent such actions.

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8. FAA Sec. 620(l). Has the country failed to enter into an investment guaranty agreement with OPIC?

The country does not currently have an OPIC agreement.

9. 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? (b) If so, has any deduction required by the Fishermen's Protective Act been made?

The country has not taken such action.

88

10. FAA Sec. 620(g); FY 1990 Appropriations Act Sec. 518 (Brooke Amendment). (a) Has the government of the 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? The country is not in default
11. 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? (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.) N/A
12. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption? The country has not severed diplomatic relations with the United States.
13. 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 country is not in arrears.

14. FAA Sec. 620A. Has the President determined that the recipient country grants sanctuary from prosecution to any individual or group which has committed an act of international terrorism or otherwise supports international terrorism? The President has not so determined.
15. FY 1990 Appropriations Act Sec. 564. 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? The President has not so determined.
16. ISDCA of 1985 Sec. 552(b). Has the Secretary of State determined that the country is a high 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? The Secretary of State has not so determined.
17. 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? The country does not so object.
18. 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 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? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.) The country has not so delivered or transferred such equipment or devices.

19. FAA Sec. 670. 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?
- The country has not so attempted.
20. 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.)
- The President has so taken it into account in the "Taking Into Consideration" memo.
21. FY 1990 Appropriations Act Sec. 513. Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been terminated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance?
- A democratically elected government is in office.
22. FY 1990 Appropriations Act Sec. 539. Does the recipient country fully cooperate with the international refugee assistance organizations, the United States, and other governments in facilitating lasting solutions to refugee situations, including resettlement without respect to race, sex, religion, or national origin?
- The recipient fully cooperates.

LAC-IEE-91-06

ENVIRONMENTAL THRESHOLD DECISION

Project Location : Chile
Project Title : Program for the Immediate
Improvement of Primary Health Care
Project Number : 513-0350
Funding : \$10 Million (G)
Life of Project : 2 years
IEE Prepared by : Jeffrey, J. Brockaw
LAC/DF E
Recommended Environmental Decision : Categorical Exclusion
Bureau Environmental Decision : Concur with Recommendation
Comments : None
Copies to : Paul Fritz, Director
USAID/Santiago
Copies to : Howard Clark, USAID/Quito
Copies to : Peter Lapera, LAC/DF
Copies to : Thomas Park, LAC/HPN
Copies to : IEE File

John O Wilson Date OCT 22 1991

John O. Wilson
Deputy Chief Environmental Officer
Bureau for Latin America
and the Caribbean

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ANNEX E

Initial Environmental Examination

Project Location : Chile
Project Title : Program for the Immediate Improvement of Primary Health Care
Project Number : 513-0350
Funding : \$10 million (G)
Life of Project : 2 years
IEE Prepared by : Jeffrey J. Brokaw
LAC/DR/E
Recommended Threshold Decision : Categorical Exclusion

Project Description: The purpose of the Government of Chile's Program for the Immediate Improvement of Primary Health Care is to improve the quality and access of primary health care for the Chilean population, especially the population's poorest sectors. The Program's six components are:

1. Strengthening Primary Health Care in Rural Areas -- The supervisory system of the Directorate of Primary Health Care for each Health Service Area will be strengthened. This will be done through training and motivational workshops, management appraisals in each Service Area, adjustments in the resource allocation system, development of educational materials, revised Agreements between the Ministry of Health and the municipal health system, and establishment of community councils and community support systems.

2. Studies for Improvement of Planning, Administration and Supervision - Operations research, special studies, and development of an information system at the primary level will be done for design, implementation, monitoring and evaluation of Primary Health Care system interventions.

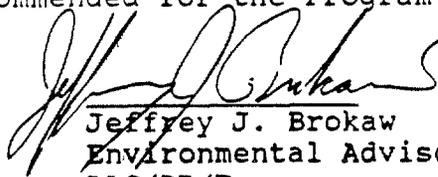
3. Basic Reequipping at the Primary-Health Level -- The capacity of the primary-level health facilities to diagnose and treat disease will be improved. Standardized, basic, and technologically appropriate equipment will be provided. Staff will be increased and trained in the equipment's use.

4. Incorporation of Non-governmental Organizations (NGOs) into the Primary Care System -- A public-private partnership will be forged to provide basic health care as well as specific services, such as mental health or health education, to populations where no public system is currently operating.

5. Development of Innovative Models of Care -- Innovative preventative and curative health care services will be developed and implemented that are oriented toward current epidemiological profiles, especially those diseases affecting adolescents and the elderly. Improvement in targeting and access of basic primary health services will also be made.

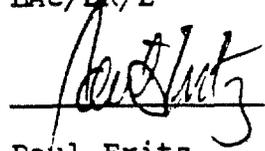
6. External Technical Assistance -- The Ministry of Health will be supported and advised in the development of suitable program interventions and other monitoring/evaluation and system management activities.

Environmental Impacts and Recommendation: Under 22 CFR Part 216.2(c)(2)(viii), programs involving nutrition, health care or population and family planning services qualify for a Categorical Exclusion except to the extent that such activities include those directly affecting the environment (such as construction of facilities, water supplies systems, waste water treatment, etc.). The Immediate Improvement of Primary Health Care Program involves institution building, technical assistance, studies, training, and the provision of some medical equipment. It does not include activities that will directly affect the environment. Therefore, a Categorical Exclusion is Recommended for the Program.


Jeffrey J. Brokaw
Environmental Advisor
LAC/DR/E

Date October 3, 1990

Concurrence:


Paul Fritz
Representative
USAID/Santiago

Date Oct 10, 1990

República de Chile
Ministerio de Salud

SANTIAGO, 10 de Octubre de 1990

Señor
Paul Fritze,
Representante S.A.I.D.,
Consulado de los Estados Unidos de América
P R E S E N T E

Señor Fritze :

El Gobierno de Chile está efectuando un Programa de Corto Plazo para el Mejoramiento de la Atención Primaria de Salud, con el objeto de superar una de las principales deficiencias que existe actualmente en el Sector Salud. Este Programa es importante, porque la Atención Primaria, desde el punto de vista de la Población, representa la puerta de entrada al Sistema de Salud, que ve en ella una urgen global del sistema estatal destinado a este tema.

El Programa contempla acciones para cumplir los siguientes objetivos :

- 1.- Mejorar la oportunidad y calidad del acceso al sistema estatal de Atención Primaria de la Salud por parte de los pobres de las zonas rurales y aquellos ubicados en las áreas urbanas.
- 2.- Desarrollar modelos apropiados de Atención Primaria para enfrentar el nuevo perfil epidemiológico, incluyendo acciones de prevención y educación con énfasis en la atención de adultos y adolescentes.
- 3.- Diseño e implementación de sistemas eficientes de administración de la Atención Primaria de la Salud, mejorando los sistemas de información y gestión.

Para realizar todo este programa, se ha estimado un presupuesto de US\$ 27 millones en el período 1990 - 1992.

Para estos efectos, me permito solicitar sus gestiones en orden a obtener la participación del Gobierno de Estados Unidos de América a través de A.I.D., colaborando con el financiamiento del Programa citado en un monto de US\$ 10 millones. De esta cantidad, US\$ 0.3 millones serán destinados a programas locales y el resto, US\$ 0.7 millón para asistencia técnica y la administración y seguimiento del programa de A.I.D.

Saluda atentamente a Ud.

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Jorge Jimenez de la Jara

DR. JORGE JIMENEZ DE LA JARA
MINISTRO DE SALUD

TECHNICAL ASSISTANCE PROJECT

Additional support to the Government of Chile's Program for the Immediate Improvement of Primary Health Care (PII/PHC) includes a 2 year US\$500,000 Technical Assistance Project. It is designed to support and advise the Ministry of Health regarding development of suitable program interventions, and other monitoring/evaluation and system management activities.

This Technical Assistance Project contains the following components: 1) Technical Assistance for the Program for the Immediate Improvement of Primary Health Care, 2) Program Support (Program Coordinator), and 3) Audit and Financial Reviews.

I. Technical Assistance for PII/PHC

A. Identify Technical Assistance Needs

The Technical Assistance Project of the Chile Program for the Immediate Improvement of Primary Health Care will provide selected appropriate technical assistance to the Ministry of Health. A major part of this is assistance in addressing informational or technical needs on a short term basis in the areas of health care management, health care financing, and studies/research.

The services required may include operations research, systems analyses, special studies, and development of an information system at the primary level to assist with design, implementation, monitoring, and evaluation of Primary Health Care interventions in order to improve the efficiency and effectiveness of primary health service delivery. Examples of these studies may include the following:

- Design and implementation of a system to obtain cost information at the primary care level.

- Diagnosis and monitoring of the efficiency of the health delivery system at the regional Health Service Area.

- Jim: Please expand this section

PHASE I:

In order to support and advise the Ministry of Health regarding development of suitable program interventions and other monitoring/evaluation and system management activities, the A.I.D. Latin America and Caribbean Bureau will provide the technical services of a senior U.S. technical consultant (at no cost to the MOH or USAID). This consultant will be funded through the new LAC Regional Health and Nutrition Technical Services Support Project (598-9657).

Scope of Work:

The consultant will work with the MOH to carry out the following tasks:

1. Review and gain familiarity with the Government of Chile's Program for Immediate Improvement of Primary Health Care (PII/PHC);
2. Review both administrative/managerial and technical constraints of the PII/PHC especially those which impede the institutional and policy reform efforts of the MOH;
3. Assist the MOH with the systematic identification and preliminary development of operations research, special studies, information systems, and other appropriate research efforts to define and address these constraints;
4. Identify the types of technical assistance required to support and advise the MOH in design, implementation, and analyses of health financing and health management operations research, special studies, information systems, and other appropriate research efforts as defined in #2 and #3 above;
5. Prepare a 2 year Plan of Action for Technical Assistance to the MOH for the PII/PHC Program which includes identification of specific A.I.D. central S&T/Health and/or LAC Regional contracts that are able to provide the required short term technical assistance; and
6. Provide additional technical assistance to the MOH as appropriate.

Qualifications of technical consultant:

1. PhD in social science/DrPh in Public Health;
2. Strong working knowledge and technical skills in health research (particularly operations research, data bases, information systems, evaluation);
3. Fluency in Spanish required (S-3/R-3);
4. Familiarity with A.I.D. procedures and programs, especially with potential "buy-ins" to S&T/Health and LAC Regional Technical Assistance Projects; and
5. Overseas experience in project design and implementation in the LAC Region.

Time: two (2) weeks beginning o/a December 3, 1990.

Responsibilities: The technical advisor will report to Paul Fritz, AID/Representative, and work with Dr. Carlos Andriquez and James Sitrick, Office of International Cooperation, Ministry of Health and other Ministry of Health officials identified by the OIC.

Reporting: The technical advisor will debrief the MOH and USAID, and submit a draft report to them for review prior to departure from country. A final report (which will include identification of operations research and other special studies/research to be implemented by the MOH, the plans for design and implementation of research/studies, and scopes of work for the necessary A.I.D. supported technical assistance) will be sent to USAID/Chile not later than January 14, 1991 for presentation to the MOH.

PHASE II:

Based on USAID/Chile and MOH review and concurrence with this proposed 2 year Plan of Action for Technical Assistance, USAID will prepare the required PIO/Ts for "buy-ins" to the centrally funded AID/W projects.

Due to the need for timeliness and a quick response for the provision of technical assistance, additional support from LAC/DR/HPN will be required in order to complete document preparation and contracting for the "buy-ins" as well as to facilitate timely provision of appropriate short term technical assistance throughout the two year period of this Program.

197

B. Management

This component will be managed by USAID/Chile. The technical services required will be procured, in most cases, by using Program funds (approximately US\$500,000 will be reserved for foreign exchange costs of technical assistance) to "buy-in" to centrally-funded A.I.D. projects (including S&T and LAC Regional Projects) as required for the specific technical advisory tasks.

USAID/Chile will coordinate the requests for technical assistance through these contracts with the Ministry of Health. The Ministry of Health, through the Program Coordinator (refer to Section II. of this Annex) will submit written requests to USAID (at least 1 month prior to the requested arrival date of the technical consultant) for all short term technical assistance and include specific scopes of work, dates, duration of assignment, identification of responsible MOH officials, and the technical advisor's qualifications and name(s), if known.

C. Relationship to Other A.I.D. Projects

1. The Science and Technology Bureau (S&T) works with the Latin America and Caribbean Bureau to ensure that the most appropriate applications of science and technology are used to complement and support development programs. The S&T offices carry out their responsibilities through technical assistance to LAC field programs and implementation of assistance projects which respond to needs that extend beyond bi-lateral or regional interests or capabilities. To this end there exist specific S&T projects which are relevant to the components identified in this Program. An illustration of an appropriate S&T Project which could provide appropriate technical assistance support to the GOC PII/PHC Program is as follows:

Project Title: APPLIED RESEARCH IN CHILD SURVIVAL SERVICES
(ARCSS)

Project #: 639-5992 Coop Agreement #: DPE-5992-A-00-0050-00

Purpose/Description: Methodologies developed under PRICOR-II revealed widespread shortcomings in the way primary health care (child survival) services are actually delivered in large scale programs. The ARCSS project will continue and refine the innovative strategies developed under PRICOR-II as well as address new technical areas. Major issues and new areas for the ARCSS project include the following activities:

1. Refinement of data collection methodologies;
2. Generation of systems analyses/operations research data base;
3. Further simplification of operations research studies;
4. Adaptation of systems analysis for routine use as a management information system;
5. Application of research to policy and management issues;
6. Correlation of process and effectiveness measures;
7. Examination of cost issues; and
8. Training.

Services: Limited short term technical assistance and training in addressing quality-of-care and related topics identified above. Selected technical services can be carried out through mission "buy-ins".

Implementing Agency: University Research Corporation (URC)
Center for Human Services
7200 Wisconsin Ave.
Bethesda, Maryland 20814-4204
Contact: David Nicholas, M.D.
Phone: 301/654-8338

Subcontractors: Johns Hopkins Institute for International Programs
Academy for Educational Development (AED)

2. In addition, the Latin America and Caribbean Bureau has authorized an LAC Regional project to assist missions in developing regional and bilateral programs and activities in the health and nutrition sectors of LAC. The project is as follows:

Project Title: HEALTH AND NUTRITION TECHNICAL SERVICES
SUPPORT PROJECT (HNTSS)

Project #: 598-9657

Purpose/Description: The purpose of this project is to improve the effectiveness of strategies, programs, and projects in the areas of health management, health financing, and nutrition in the LAC Region by facilitating the exchange and application of technology and information among LAC Missions and LAC host country institutions with respect to activities in these areas.

Services: To achieve these purposes, the project will fund the following services, utilizing regional LAC funds and also, Mission funds through the "buy-in" mechanism.

a. A "Core Contract" with the University Research Corporation (URC) will provide advisors in the areas of health management and health finance (of relevance for the PII/PHC Program). The advisors will assist the LAC Missions, as requested, in such activities as the preparation of strategies, analyses, and assessments; the performance of evaluations; the preparation of analyses required for PIDs and PPs; development of tracking and monitoring systems; carrying out operations research, special studies, and cross cutting evaluations; and information exchange.

The Core Contract will also provide a roster of LAC-experienced short term consultants who will provide selected services in these areas in response to LAC Missions and host country requests.

URC Coop Agreement #: LAC-0657-C-00-0051-00

b. A Cooperative Agreement has been awarded to the Association of University Programs in Health Administration (AUPHA) for services in the field of health management education and training. This component currently aims at strengthening the network of health management and training programs in the LAC Region and the ties between the LAC country trainers and training institutions in North America. Under the Cooperative Agreement AUPHA is to:

- carry out assessments of host country needs and resources;
- hold workshops and conferences concerning key problem areas; and
- provide technical assistance to host country training programs.

AUPHA Coop Agreement #: LAC-0657-0-A-00-9031-00

Implementing Agencies: a. University Research Corporation (URC)
7200 Wisconsin Ave.
Bethesda, Maryland 20814-4204
Contact: Lani Marquez
Phone: 301/654-8338

Subcontractors: Community Systems Foundation (CSF)
International Science and Technology
Institute (ISTI)
Development Group (DG)

b. Association of University Programs in
Health Administration (AUPHA)
1911 No. Fort Myer Drive
Suite 503
Arlington, Virginia 22209
Contact: Bernardo Ramirez, M.D.
Phone: 703/524-5525

II. Program Support

In order to assist the Ministry of Health of the Government of Chile with coordinating and monitoring the 2 year USAID health sector assistance program for PII/PHC, the services of a Program Coordinator are required.

A. Proposed Scope of Work:

The Program Coordinator will work with the Ministry of Health and USAID to carry out the following tasks:

1. Review and maintain familiarity with the GOC Program for the Immediate Improvement of Primary Health Care;
2. Ensure the implementation of the necessary studies, assessments, pilot activities, seminars, workshops, and training activities as well as advise regarding the purchase of supplies and commodities aimed at achieving the intended institutional and policy reforms;
3. Monitor the policy and institutional reform program and prepare all technical reports for the Ministry of Health as required by USAID/Chile;
4. Coordinate all joint reviews and evaluations of the institutional and policy reform program;
5. Coordinate and manage requests for external technical assistance to be supplied through "buy-ins" to central AID/W and LAC Regional contracts;

6. Prepare and review with the Ministry of Health and USAID/Chile any changes or revisions in the Grant Agreement;
7. Coordinate and carry out the necessary reviews and evaluations to ensure that the agreed upon institutional and policy reforms have been properly implemented; and
8. Provide additional program coordination and program support to the Ministry of Health and USAID/Chile as appropriate.

Qualifications of Program Coordinator:

1. MPH in Health Administration (or other related public health degree);
2. Written and spoken fluency in Spanish and English required (S-3/R-3);
3. Overseas experience with health programs, especially in the LAC Region;
4. Strong written and oral communication skills required;
5. Familiarity with Government of Chile Ministry of Health program and procedures required; and
6. Familiarity with USAID programs and procedures desired.

Duration: Available immediately for 24 month period beginning o/a December 1990.

B. Management Responsibilities:

The program support services of the Program Coordinator will be contracted by the Ministry of Health using Program funds (approximately US\$100,000 will be reserved for local costs). The Program coordinator will work at the Ministry of Health under the supervision of the Office of International Cooperation (OIC) and will liaise with the USAID/Chile Representative and his/her designee.

III. Audit and Financial Reviews

Audits and financial reviews will be performed by an independent CPA firm(s) and will be phased to provide assurance that procedures and controls are effective in their application during implementation as well as annual compliance verifications. Financial assessments will be undertaken at the inception of the program to provide financial analyses of the entity managing the dollar separate and local currency special accounts and of the Ministry of Health. A covenant in the grant agreement will assure that any recommendations resulting from the financial analysis will be implemented.

The first Non-Federal Audit will be performed at the end of the first year of operations, which will encompass the dollar transfers. The audit will examine implementation of recommendations of the First Financial Review. A follow-on financial review will be scheduled shortly thereafter to assure the effective application of any necessary remedial actions. Finally, a program close-out, Non-Federal Audit will be performed to coincide with the final program evaluation.

All of the financial reviews and Non-Federal Audits will be contracted by A.I.D. and will be in accordance with established criteria, including General Accounting Office and Generally Accepted Auditing Standards. Funding will be provided by the Grant (refer to Annex G. Section III.); the scopes of work for the financial reviews and Non-Federal Audits will be developed and competed according to standard Regional Inspector General (RIG) procedures.

ANNEX G:10/08/90

ACTION: AID-2 INFO: AMB DCM ECON USIS AGR COML\B

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TO RUEHSG/AMEMBASSY SANTIAGO IMMEDIATE 9174
INFO RUEHPE\AMEMBASSY LIMA IMMEDIATE 5422
BT
UNCLAS SECTION 01 OF 02 STATE 321528

LOC: 410 497
23 SEP 90 0125
CN: 07256
CHRG: AID
DIST: AID

AIDAC AID/REP., PAUL FRITZ, CONTROLLER USAID/LIMA

E.O. 12356: N\A

TAGS:

SUBJECT: PROGRAM FOR IMMEDIATE IMPROVEMENT OF PRIMARY HEALTH CARE (513-0350) PID REVIEW

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1. INTRODUCTION. THE ISSUES MEETING FOR SUBJECT PROGRAM WAS HELD ON THURSDAY, SEPT. 13. THE ISSUES MEETING WAS CHAIRED BY LAC/DR DIRECTOR PETER BLOOM AND INCLUDED REPRESENTATIVES FROM LAC/GC, LAC/DR, LAC/SAM, LAC/DP AND PPC/PB. DUE TO THE UNIQUE NATURE OF THE PROPOSED PROGRAM, IT WAS DECIDED THAT, IN LIEU OF A FULL DAEC, A SMALLER MEETING WOULD BE HELD WITH DAA FREDERICK SCHIECK. THE MEETING WAS HELD ON MONDAY, SEPTEMBER 17, AND WAS BASED ON A SUMMARY OF THE PROPOSED PROGRAM, QUOTED IN PARA. 2.

2. SUMMARY OF PROPOSED PROGRAM. QUOTE. ACTION REQUESTED: THAT YOU APPROVE THE DEVELOPMENT OF A DOLS 10.0 MILLION SECTOR PROGRAM (NON-PROJECT ASSISTANCE) FOR PROVISION OF U.S. ASSISTANCE TO THE CHILE HEALTH PROGRAM. THIS APPROACH WAS DISCUSSED AND RECOMMENDED BASED ON THE RESULTS OF THE SEPTEMBER 13TH ISSUES MEETING FOR THE CHILE PROGRAM FOR THE IMMEDIATE IMPROVEMENT OF PRIMARY HEALTH CARE (513-0350).

BACKGROUND: PUBLIC INTEREST POLLS TAKEN SHORTLY BEFORE THE NEW DEMOCRATICALLY ELECTED ADMINISTRATION OF PRESIDENT AYLWIN TOOK OFFICE IN MARCH OF 1990 SHOWED THAT PROVISION OF ADEQUATE HEALTH SERVICES WAS THE SINGLE MOST URGENT ISSUE FACING THE GOVERNMENT AND THE CHILEAN POPULATION. IN RESPONSE, THE GOC BOTH FORMULATED A STRATEGY AND ACTION PLAN, AND MOBILIZED DONOR ASSISTANCE IN ORDER TO ADDRESS THIS PROBLEM. IN RESPONSE, THE U.S. CONGRESS EARMARKED DOLS 10 MILLION FOR HELP IN QUOTE JUMP STARTING UNQUOTE THE PRIMARY HEALTH CARE SYSTEM.

MULTILATERAL AND BILATERAL ASSISTANCE (APPROXIMATELY DOLS 450 MILLION FOR THE PERIOD 1990-1995) IS TO BE USED TO ASSIST IN COMPLETING THE REFORM OF THE HEALTH SECTOR AND TO AUGMENT THE INVESTMENT BUDGET WHICH HAS BEEN VIRTUALLY NON-EXISTENT OVER THE PAST DECADE. THE U.S.

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ASSISTANCE IS DESIGNED TO LAY THE EARLY GROUNDWORK FOR POLICY AND INSTITUTIONAL REFORMS WHICH WILL BE CONTINUED AND EXPANDED WITH THE SUBSTANTIAL DONOR ASSISTANCE.

DISCUSSION: THE NPA SECTOR PROGRAM APPROACH WOULD GIVE THE GOC THE FLEXIBILITY IT NEEDS TO EFFECTIVELY COORDINATE THE A.I.D. RESOURCES WITH NATIONAL RESOURCES AND WITH THOSE OF OTHER EXTERNAL DONORS. FURTHERMORE, THE TYPES OF INSTITUTIONAL REFORMS CONTEMPLATED WOULD BE STRONGLY FACILITATED BY A SECTOR PROGRAM VERSUS A PROJECT APPROACH. THE SPECIAL PROCEDURES AND DETAILED END USE MONITORING AND CONTROL REQUIRED IN A PROJECT DEFEAT THE INTENT OF THE U.S. CONGRESS ASSISTANCE TO BE FLEXIBLE, QUICK DISBURSING, AND SIMPLE. GENERALIZED SUBSECTOR SUPPORT FOR THE PRIMARY HEALTH CARE PROGRAM WOULD ASSURE THAT THE RESTRUCTURED SERVICE DELIVERY MECHANISMS AND PROGRAMS DEVELOPED BY THE MOH ARE CONSISTENT WITH AND CAN FUNCTION EFFECTIVELY AND EFFICIENTLY UNDER THE NORMAL OPERATIONS OF THE PUBLIC HEALTH SERVICES. A PROGRAM APPROACH IN A COUNTRY LIKE CHILE WHERE IMPLEMENTATION CAPACITY AND SKILLS ARE HIGH ALSO WOULD ALLOW THE U.S. GOVERNMENT TO SUPPORT THE KIND OF THOUGHTFUL INSTITUTIONAL REFORM PROCESS THE CHILEANS WANT TO AND NEED TO CARRY OUT WITH A.I.D.'S LIMITED PERSONNEL RESOURCES IN CHILE.

PROGRAM CHARACTERISTICS: THE ASSISTANCE WILL CONSIST OF THREE PROCESSES: 1) CONDITIONAL DOLLAR DISBURSEMENT, 2) LOCAL CURRENCY EQUIVALENT TO THE DOLLAR TRANSFER, AND 3) TECHNICAL ASSISTANCE AND EVALUATION/AUDIT IN SUPPORT OF PROGRAM OBJECTIVES.

THE DOLLAR DISBURSEMENTS WILL BE MADE IN TRANCHEES (ONE OR TWO), ON SATISFACTION OF CONDITIONS PRECEDENT (BENCHMARKS WHICH WILL ESTABLISH THE BASIS FOR THE INSTITUTIONAL AND POLICY REFORMS OF THE IMMEDIATE IMPROVEMENT OF PRIMARY HEALTH CARE PROGRAM). U.S. FOREIGN EXCHANGE WILL BE USED TO FINANCE U.S. IMPORTS DESTINED FOR THE HEALTH SECTOR (USING THE REIMBURSEMENT METHOD.)

EITHER PRIOR TO OR AT THE TIME OF EACH DOLLAR DISBURSEMENT, THE GOC WILL DEPOSIT THE LOCAL CURRENCY EQUIVALENT INTO A SPECIAL LOCAL CURRENCY ACCOUNT. FUNDS WILL THEN BE TRANSFERRED TO THE PRIMARY HEALTH CARE SUB-SECTOR OF MOH'S BUDGET AND WILL BE USED TO FINANCE APPROXIMATELY ONE-HALF OF THE GOC'S IMMEDIATE IMPROVEMENT OF PRIMARY HEALTH CARE PROGRAM (TOTAL SUB-BUDGET IS DOLS 23 MILLION). THE LOCAL CURRENCY WILL BE A CONTRIBUTION TOWARDS IMPLEMENTATION OF THE POLICY AND INSTITUTIONAL REFORM OBJECTIVES OF THE PROGRAM.

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MONITORING ARRANGEMENTS: LAC/DR AND LAC/CONT. HAVE REVIEWED THE FINANCIAL AND TECHNICAL MONITORING REQUIREMENTS ACCORDING TO BOTH CURRENT AND NEW, DRAFT GUIDANCE ON LOCAL CURRENCY. LOCAL CURRENCY WILL BE JOINTLY PROGRAMMED FOR GENERAL SECTOR SUPPORT, BY CONTRIBUTING TOWARDS THE GOC'S IMMEDIATE IMPROVEMENT OF THE PHC PROGRAM. AID WILL BE REQUIRED TO VERIFY THAT LOCAL CURRENCY HAS REACHED THE PRIMARY HEALTH CARE SUB-SECTOR. AID WILL NOT BE REQUIRED TO TRACE LOCAL CURRENCY TO SPECIFIC LINE ITEMS UNDER ACTIVITIES COMPRISING THE PROGRAM. ON THE TECHNICAL SIDE, CONSISTENT WITH LOCAL CURRENCY GUIDANCE AND OUR RATIONALE FOR PROVIDING THE ASSISTANCE, THE AID\REP. WILL RECEIVE PERIODIC TECHNICAL REPORTS ON THE PROGRAM IN GENERAL FOR APPROXIMATELY TWO YEARS.

TECHNICAL ASSISTANCE AND EVALUATION/AUDIT REQUIREMENTS WILL BE FUNDED THROUGH A SEPARATE A.I.D. MANAGED DOLLAR ACCOUNT. DETAILS OF THE EXACT TECHNICAL ASSISTANCE AND EVALUATION/AUDIT REQUIREMENTS WILL BE DEFINED DURING PAAD PREPARATION. END QUOTE.

3. DECISIONS. DURING THE MEETING THE DAA AGREED WITH THE APPROACH SUMMARIZED ABOVE AND PROVIDED THE FOLLOWING GUIDANCE:

A. THE BUREAU, WORKING THROUGH LEG, SHOULD DISCUSS THE PROPOSED NPA WITH APPROPRIATE CONGRESSIONAL STAFF. THIS

SHOULD OCCUR AS SOON AS POSSIBLE-EITHER BEFORE OR WHILE THE DESIGN TEAM IS IN SANTIAGO WORKING ON THE PAAD.

B. GIVEN CONCERNS WITH QUOTE BUY AMERICA UNQUOTE AND CONGRESSIONAL INTEREST IN THIS PROGRAM, IT IS IMPORTANT TO FINANCE HEALTH-RELATED IMPORTS FROM THE U.S. WITH THE FOREIGN EXCHANGE.

C. THE PAAD DESIGN TEAM AND THE AID\REP. SHOULD ASCERTAIN THAT THE GOC DEDICATE SUFFICIENT STAFF (AT LEAST ONE FULL TIME PERSON) TO ENSURE TIMELY PROCESSING OF AND ACCOUNTING FOR THE DOLLAR ASSISTANCE.

D. THERE SHOULD BE TWO DOLLAR DISBURSEMENTS: THE FIRST SHOULD BE BASED ON SATISFYING CERTAIN CONDITIONS/BENCHMARKS AND THE SECOND ON A FORMAL PROGRESS REVIEW AND THE AID\REP'S ASSESSMENT THAT THE GOC HAS MADE REASONABLE, SUBSTANTIAL PROGRESS IN IMPLEMENTING THE PROGRAM DURING THE FIRST SIX TO NINE MONTHS OF THE PROGRAM. THE INFLATION RATE IN CHILE MAKES IT INADVISABLE TO DISBURSE DOLLARS SUBSTANTIALLY FASTER THAN THE LOCAL CURRENCY IS REQUIRED FOR THE PROGRAM.

E. THE PAAD SHOULD BE CONSISTENT WITH NEW, DRAFT LOCAL CURRENCY GUIDANCE, SOON TO BE ISSUED.

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4. FUTURE STEPS. THE AID REP. IS REQUESTED TO DISCUSS THE PROPOSAL CONTAINED IN PARA. 2 WITH GOC OFFICIALS, PRIOR TO THE ARRIVAL OF THE PAAD DESIGN TEAM. THE PAAD DESIGN TEAM WILL INCLUDE TWO LAC\DR OFFICERS (JULIE KLEMENT AND PETER LAPERA), WHO WILL COMPLETE THE PAAD DURING A TWO TO THREE WEEK PERIOD BEGINNING SEPTEMBER 27. THE TEAM WILL FOCUS ON DEFINING APPROPRIATE CONDITIONS/BENCHMARKS, MONITORING AND EVALUATION PROCEDURES FOR THE PROGRAM, AS WELL AS THE PROGRAMMING AND USE OF DOLLARS AND LOCAL CURRENCY. IN THE LATTER AREA, THE TEAM WILL BE ASSISTED BY JERRY MARTIN OF THE CONTROLLER'S OFFICE, USAID/LIMA AND WILL BE ABLE TO CONSULT WITH JAMES WESBERRY, WHO WILL BE WORKING ON THE REGIONAL FINANCIAL MANAGEMENT PROJECT. BOTH WILL BE IN SANTIAGO DURING THE FIRST WEEK OF OCTOBER.

5. THE BUREAU WILL ADVISE AID/REP. OF REVIEW DATES FOR THE PAAD (TENTATIVELY THE THIRD OR FOURTH WK. IN OCTOBER). BAKER

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ANNEX I

A. Socio-political Analysis

1. Socio-political Context

Chile has had a long tradition of health care delivery to its general population. Numerous independent systems of delivery evolved early in this century in such areas as mining and the civil service, which were subsequently combined into a National Health System (SNS). There is also a tradition of independent private health care providers. The development of these systems of care reflects a widespread attitude among Chileans that health care is a social responsibility within their nation.

Although the SNS became a highly centralized, essentially monopolistic system operating under the direct control of the Minister of Health, with little competition from the small private system, most Chileans were reasonably satisfied with the SNS and proud of the general progress in health status which it had helped to accomplish. Even with the very long geography which characterizes Chile, the SNS did improve and unify health status throughout the country.

Given the importance of health care within Chilean society, it is not surprising that the Ministry of Health became a politically powerful organization. Many politicians served as Ministers of Health (MOH), and many have been physicians, including former President Allende. The extension of their concern from health care to other more general living conditions and social issues was a political phenomenon with a long-standing tradition in Chile.

The evolution of the SNS also held economic implications for Chile as well. The Chilean economy prior to 1973 was generally based on import substitution and extensive governmental control. Chile's inability to compete in international markets at this time can, in part, be attributed to high unit labor costs. One, among many factors contributing to high labor costs, were social programs on behalf of workers, which included the SNS. Since health care was not being provided by the SNS in an efficient manner (i.e., without long waiting lines, suboptimal utilization, top-heavy administration, etc.), health care services were contributing to rising labor costs.

With the advent of the military government in 1973 and its free market approach to economic development, an all-out effort was made to reduce unit labor costs in order to meet international price competition. In line with this goal, the

Military Government sought to privatize many of the previously existing social programs, including health care. The popularity of health care, and the concept that it was a social responsibility, made privatization of the SNS a politically difficult task for the Military and the last to be accomplished. In short, the Military sought to weaken the political influence of the MOH and its system for delivery of health care services through the gradual privatization of health care in Chile, through a total restructuring of the SNS, and through the process of decentralization.

The new public system introduced to replace the SNS is known as the National Health Services System (SNSS). It is based on a decentralized system which corresponds to the regionalization process also undertaken by the Military Government. There are 27 Servicios de Salud (SS), which might loosely be viewed as comparable to Health Service Areas (HSA) in the U.S. Instead of the highly centralized approach of the previous SNS, the new SNSS has endeavored to establish more autonomy for the individual SS. Decisionmaking at the level of the SS is also shared with municipal government officials. The MOH under the new system retained only the responsibility for general policy formation and for the establishment of standards. The delivery of health care service and the financing thereof became the responsibility of the local SS. A new method of collecting funds to finance health care expenditures was established and a new institution called the National Health Fund, or FONASA, and autonomous of the MOH was created to carry out this task. The new health care system also paved the way for development of private health insurance companies known as ISAPRES which operate under a variety of financing mechanisms.

As the decade of the 1980s unfolded, it became clear that the theory of how the SNSS and private sectors were to operate was quite different from the reality. The decentralization of the MOH and SNS frequently resulted in confusion. The expectation that the private sector could expand rapidly, and at a pace sufficient to absorb the population previously covered by the public sector, was not met. For those people whose only recourse was the public system, another problem arose. As the Military Government enacted laws to foster expansion of the private health care sector, it simultaneously commenced to reduce funding for the public sector. In short, the public health care system was allowed to languish while the private sector, specifically the ISAPRES, were encouraged. Presently, approximately 80 percent of the total population of Chile receive their care from the public sector. The ISAPRES account for between 15 to 20 percent.

The list of problems associated with the current health care system in Chile have been elaborated upon earlier in this

document. It should be readily apparent that confronted with the health care expectations of the general Chilean population, combined with the inadequacy of the current health care system, the newly elected democratic government of Patricio Aylwin faces an enormous challenge. In order to satisfy political pressures, the new government will need financial and technical assistance from international sources. In order to maintain a low rate of inflation and to remain competitive in international markets, the new government must establish a modern and efficient health care sector. Change in the health care sector will require several years for completion. It is to be hoped that the general population will manifest sufficient patience to allow creation of an efficient new system of health care delivery.

2. Beneficiaries

The beneficiaries of the Program will include the following groups:

- the sectors of extreme poverty in the rural and marginal urban areas and intermediate size cities.
- the high priority health program target groups of the Aylwin Administration: women, workers, youth, and the elderly.
- the civil servants at the municipal primary health care level who will be better trained and motivated, and able to participate in the creation of a professional civil service as well as the process of restructuring the national health system.
- the municipal health system which will be truly decentralized, promote self-management and be better financed to provide adequate salaries and other resources.
- the secondary and tertiary care levels of the health system which will coordinate better with the primary level in order to avoid the heavily used and expensive emergency services for minor disease treatment.
- the technicians at the primary care level who will be better trained to implement the results of efficiency improvement studies, development of new information systems, epidemiological surveillance, and mental health programs.
- the development of new health fields such as family health, preventive health care, information systems, and participative evaluation.

111

- the social sciences which will apply scientific discipline to the development and management of the SICOS and Community Councils.

3. Impact

The significant socio-political feasibility issue to be addressed is whether any specific group or groups in Chile will be adversely affected by the policy changes contemplated under this Primary Health Care Program.

The most prominent group which may be adversely affected (or perceive to be adversely affected) by this Program are the Mayors who control and are responsible for provision of basic Primary Health Care at their municipal level. The data are not sufficient enough to make this kind of analysis. However, it is worth noting that these organizations, while interdependent, function at different levels of capacity as semi-autonomous units from the MOH system. The mayors may not positively respond to the increased demands of the MOH supervision system.

B. Economic Analysis

1. Introduction

It is not possible to complete a rigorous economic analysis for the Program for the Immediate Improvement of Primary Health Care. Aside from the fact that the assistance being provided is for a human resources project, one of the purposes of the program and AID assistance is to provide a bridge to much larger efforts being financed by the IDB and IBRD. Therefore, many of the constraints discussed in Part II. Description of the Problem will be addressed under the IDB and IBRD efforts, and the Program will "set the stage", at least in the area of primary health care.

Furthermore, the GOC, with IBRD assistance, proposes to address macro financial and economic issues affecting the health sector, including, among other issues: 1) reform of health care financing, in general; 2) incentive systems for health care personnel; 3) strengthening of health management at the national level; 4) establishment of joint ventures between public and private institutions in health care delivery; and 5) development of integrated health care systems and physical investments in the low-income areas. The IDB will concentrate on the improvement of health care delivery, management capacity, and information and maintenance systems at the local level, starting with a pilot project in selected Health Service Areas.

Thus, the Program which A.I.D. is supporting will feed

directly into the major improvements contemplated under the IDB and IBRD-backed efforts which total \$450 million. The GOC's Program has a total cost of \$27 million, of which AID is contributing \$10 million or 37%.

Another reason why it is not possible to complete a rigorous economic analysis is because no data on primary health care delivery costs is available. The GOC will begin to collect cost data on delivering primary health care under the Program, and the issue of all health care delivery costs will be thoroughly examined under the IBRD financed project. In this sense, there will be an ongoing economic analysis built into the Program, and into the effort to improve the entire health system, beginning in one year.

2. General Cost Effectiveness of Intervention

Other sections of the PAAD (Introduction, Description of the Problem, and the Technical Analysis) discuss the appropriateness of the type of intervention contained in the Program for the Immediate Improvement of Primary Health Care. Essentially, the Program will improve the public sector's current primary health care system. The current system, described in detail in I. Introduction and II. Description of the Problem is a decentralized system in which the municipalities have the major responsibility for providing primary health care and the Government of Chile, through the Ministry of Health has responsibility of overseeing the financing of the system and quality control. Decentralization of health care system is a world wide phenomenon which makes technical sense and is supported by AID in a number of health projects and programs.

The GOC's Program is an initial attempt to improve the current primary health delivery system, through specifically addressing the constraints and bottlenecks of the system (see D. Specific Constraints and Bottlenecks of the Primary Health Care System and E. GOC Strategies for Overcoming Identified Constraints and Bottlenecks.) In addition to technical arguments for improving the current system, it is logical that improving that system is more cost effective than installing either a purely municipality-based system or centralized health delivery system. As discussed in the Background, the current system has produced impressive results when compared to other developing and advanced developing countries. This was accomplished at a relatively minor cost. The health sector budget averaged approximately 9% of total central government expenditures from 1980 though 1987.

However, improving the primary health care system entails additional costs: current funding for primary care is at \$11.5 million and the GOC has budgeted another \$5.2 million, aside from AID's \$10 million assistance for the program. Therefore, total cost (to the Central Government) is approximately \$17 million. The Program will encompass two activities which could minimize costs and begin to resolve the problem of chronic under-funding of primary health care. One of the activities is to improve the health fund resource distribution system in order to make more funds available to the municipalities, as described under E. Strategies for Overcoming Identified Constraints and Bottlenecks. The other activity will be that NGOs will be incorporated into the primary health care system through joint delivery of primary services with the municipal sector.

3. Examples of Potential Benefits

Under present system of primary health care delivery, public health care beneficiaries spend inordinate amounts of time waiting for care. Estimates range from 3 to 4.2 hours on average per visit. Most of the burden of lost time falls on the lowest income groups, for whom lost time is very critical. One consequence of improved primary health care delivery should be the reduction in waiting time for the beneficiaries. Using the only data available-1983 cost data-a health economist contracted to complete the economic analysis made calculations on the benefits of reducing waiting time. (His full analysis is available in LAC/DR files.) The calculations were conservative, i.e. biased toward underestimating the value of lost labor time. Basically, the methodology used was to calculate values of time lost assuming 4 1/2 hours and comparing that to value of time lost assuming 3 hrs, thereby arriving at the value of saving 1 1/2 hours in waiting time.

The 1983 data indicated that the average number of visits per patient per year was 6.4. At 4 1/2 hours waiting time per visit, this translates to 26.9 hours of lost time per year for each patient. It was found that hourly wage rates varied according to whether work days were 8, 10 or 12 hours long (high, medium, low, respectively). . Multiplying the three different hourly wage rates by 26.9 hours of average time lost and the resultant figure by the number of public health

beneficiaries, 9.2 million yielded values of total time lost of \$119 million (high), \$95 million (medium) and \$79 million (low).

Doing the same calculation on 3 hours of waiting time yielded values of total time lost of \$85 million (high), \$68 million (medium) and \$57 million (low). Subtracting the second set of figures from the first yields the annual value of reducing waiting time by 1 1/2 hours: \$34 million (high), \$27 million (medium) and \$22 million (low). A weighted average arc elasticity was calculated and a value of $E = 1.33$ was obtained. This suggested what may seem the obvious: that reductions in the value of lost labor time are more than proportional to reductions in waiting time.

It is likely that another significant economic benefit resulting from improved primary health care delivery will be the reduction of emergency room services. In Chile, there has been a trend to substitute emergency room services for clinical services to obtain primary health care. While use of non-emergency clinics has decreased, use of emergency rooms have increased. Between 1963 and 1987, emergency room visits as a percentage of total consultations more than doubled from 13% to 29%. Likewise, the ratio of emergency care to non-emergency care almost tripled from 30% in 1963 to 80% in 1987. While comparative cost data are not available, reversing the trend would yield substantial benefits as non-emergency care (including primary care) is considerably cheaper than emergency care, as indicated by U.S. data.

Finally, another general area where savings will accrue will be the shifting from curative care to preventive care. The extent and benefit of this shift cannot be quantified at this time, but with the collection of cost data under the IBRD project, the MOH will be able to measure the benefit of the shift.

C. Financial Analysis Considerations

Handbook 3 suggests that financial analysis of Project Papers determine financial viability of proposed activities and "that the stream of projected expenses can actually be financed as envisioned in the implementation plan." The financial analysis should also contain discussion on Methods of Implementation and Financing as required by payment verification policies.

As discussed under E. GOC Strategies for Overcoming Identified Constraints and Bottlenecks, funding for the Program for the Immediate Improvement of Health Care is assured. The cost of the program totals \$27 million and the GOC has budgeted \$17 million in normal and supplemental resources, in addition to the \$10 million contribution by AID. Therefore, the stream of expected expenses will actually be financed as envisioned in the implementation plan.

In terms of the discussion on Methods of Implementation and Financing, except for the technical assistance and auditing which A.I.D. will contract for directly, financial and contracting capabilities of the GOC will be relied upon. This is consistent with program assistance (i.e. non-project assistance). Other financial management procedures of program assistance are discussed in detail under VI B. Dollar Transfer and Local Currency Procedures and Management. Provisions for assessing the financial management and contracting capabilities of the GOC are discussed in VIII. Compliance with Non-Project Assistance Cash Transfer and Local Currency Guidance.

D. Institutional Analysis

1. Structural Organization of the Health Sector

Chile has a long tradition of health care delivery to its general population and of viewing health care as a social responsibility of the state.

Recognizing this tradition, the Political Constitution of 1980 guarantees that all persons living in Chile have the right to protection of health (Section 9 of Article 19). Consequently, the function of the state is to create the necessary conditions which provide adequate access to health services for the population.

Actually, all working persons pay a universal health care tax of 7% of their salary. The employee decided if this tax should go to the public or private system.

Since 1952 the National Health system (SNS) has been the principal provider of all curative and preventive health care in the country. In 1979, the Military Government began to change this system with the introduction of decentralization and privatization.

The government undertook major institutional and financial reforms of the health care system. They included, among others: 1) decentralizing the National Health Service (SNS) into 27 autonomous Health Service Areas (HSAs) of the National Health Service System (SNSS) capable of providing preventive and curative services in 26 specified geographical areas ; 2) transferring responsibility for primary health care services and infrastructure to the municipalities; 3) allowing workers to chose whether to apply their payroll deductions to public or private health providers; 3) continuing the role of the Ministry of Health as the policy-making, normative, supervisory, and evaluating agent; and 4) creating a public sector financial institution to collect health sector revenues and to distribute these funds.

The following descriptions highlight the primary responsibilities of the public sector:

- The Ministry of Health (MINSAL) has the responsibilities for establishing norms and controls in addition to formulating and evaluating plans and programs, and for coordinating the activities and the organization of the system.

- The National Health Service System (SNSS) is a decentralized system of 27 autonomous Health Service Areas (HSAs) providing curative and preventive services in 26 specified geographical areas in addition to an environmental unit based in Santiago.

- The Regional Secretariates of the Ministry of Health (SEREMIs), which represent the Ministry in the 13 Regions, form the link with the Ministry in terms of supervision and control of the Health Services. Moreover, they formulate the budget together with the Directors of the Health services.

- The Institute of Public Health (ISP) is responsible for the national reference laboratory, standardization and supervision of the laboratories of public health of the country. They carry out the quality control of pharmaceuticals activities and are the official institution for the

manufacturing of biologics as well as a center for investigation and training.

- The National Health Fund (FONASA) is responsible for the administration of the financial revenue collected from the national budget and the payroll deuctions for health care, and for distributing these funds, including paying the providers of services.

- The Central Supply (CA) of the SNSS provides the medicines and other necessary medical supplies for the development and functioning of the system.

Private health insurance companies (ISAPRES) were established in 1981 and currently provide mainly curative health services to approximately 15% of the population. These institutions receive the 7% universal health tax directly.

2. Ministry of Health Administration and Management of the Program

The A.I.D. Chile Sector Assistance Program constitutes assistance to the larger global Ministry of Health Program for the Immediate Improvement of Primary Health Care (PII/PHC) which will be carried out by the Department of Primary Health Care. The Office of International cooperation (OIC) is responsible for the management of all bilateral assistance in the health sector which includes the A.I.D. assistance. Within this Office is a coordinator specifically dedicated to maintaining the liaison between A.I.D. and the MOH. This coordinator also acts as the primary link with the Department of Primary Health care, and other entities of the MOH, and the Office of International Cooperation (refer to the Organizational Chart of the Ministry of Health).

The Department of Primary Health Care administers the technical and developmental aspects of the global PII/PHC Program and its sub-components. The OIC, as coordinator of the A.I.D. assistance, is responsible for all aspects of the A.I.D. Program and for keeping A.I.D. informed regarding Program status.

The Program Coordinator will provide semi-annual written reports describing the status and achievements of the Program. Specifically required are details regarding implementation efforts, achievement of the benchmarks, problems and bottlenecks encountered, and what changes have been made in the plan or the model. The report will include expenditures.

3. Problem Analysis

Ministry of Health officials are aware of their management shortcomings. The development of the Organizational Chart of the Ministry of Health was a key effort by newly appointed officials (the new government was installed in March 1990) to define and establish agreed upon responsibilities and relationships within this politically diverse institution. The mutual development of the A.I.D. Program served as a catalyst for the Ministry to begin the difficult process of reorganization. Some of the constraints facing the Ministry are as follows:

a) Lack of information for decision-making is a critical obstacle to effective and efficient use of resources. Current information gathering by the ministry includes massive compilation of data on multiple reporting forms. Unfortunately, the data are often not appropriate to current needs or are never analyzed. The Program will assist with review of the data needs with regards to decision making. A refined management information system will be developed.

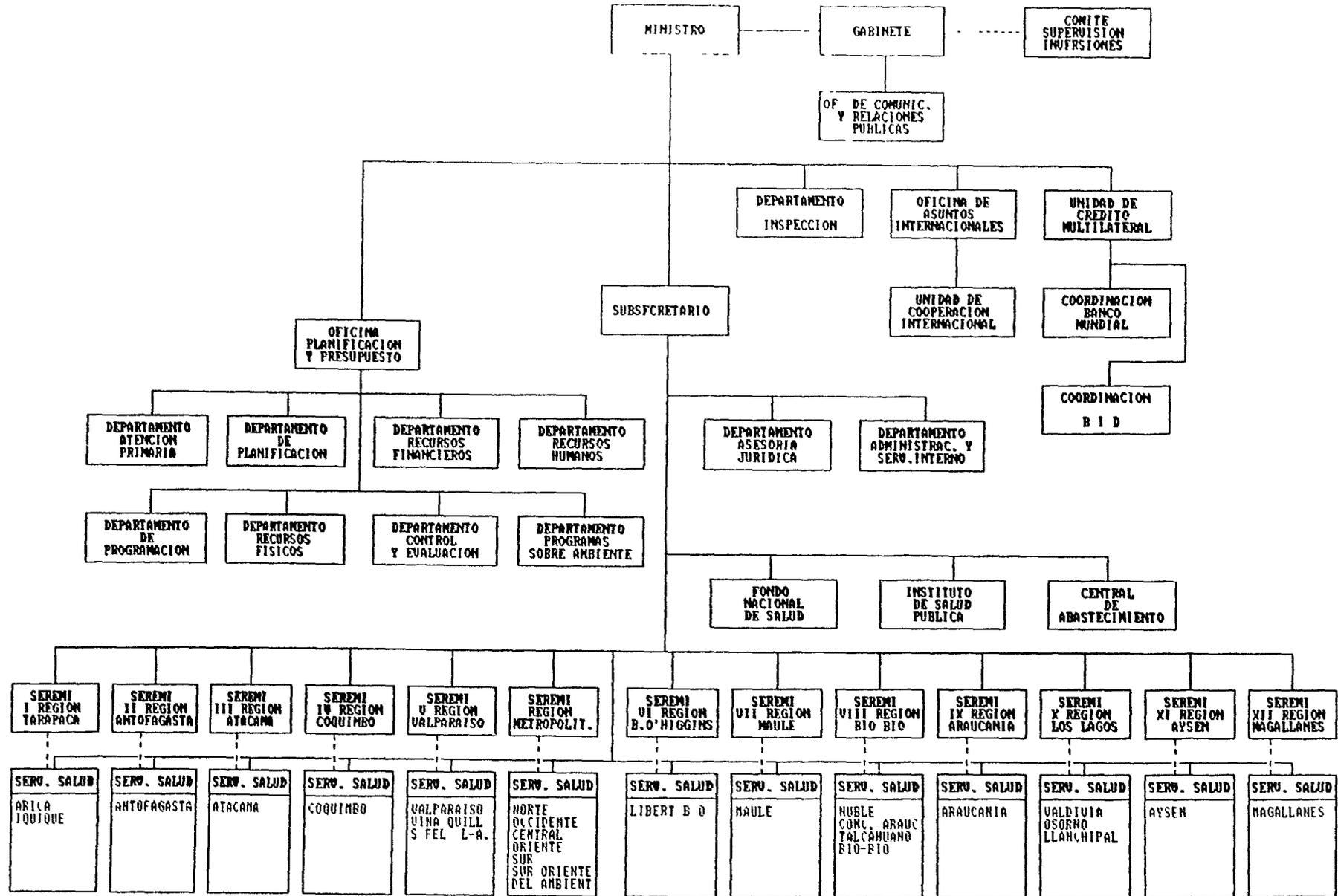
b) Lack of material resources at the local level seriously limits the timely and appropriate provision of quality primary health care services. Laboratory equipment, including service and maintenance, supplies, pharmaceuticals and other medical commodities are severely limited and are simply inadequate for maintaining operations of the existing primary care delivery system at an optimal level.

c) There has not been adequate administration and financial management training to accommodate decentralized administration and provision of primary care services. This has had a direct impact on personnel morale and performance.

4. MOH Capability

Clearly the Ministry of Health has successfully planned and implemented a wide variety of health service program activities throughout Chile. However, current administration and management of services (and donor assistance) may be hampered by lack of internal coordination. The sheer quantity of funds being programmed for the MOH as well as the responsibility to monitor pose a major challenge to the absorptive capacity of the MOH. Therefore, the role of the Program Coordinator becomes the key to successful management and monitoring of the A.I.D. assistance.

ORGANIGRAMA
 MINISTERIO DE SALUD
 REPUBLICA DE CHILE



Embassy of the United States of America
UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
Santiago - Chile

October 10, 1990

Doctor
Jorge Jimenez
Minister of Health
Mac-Iver 541, 3 floor
Santiago

Dear Mr. Minister:

The purpose of this letter is to convey basic financial procedure requirements of the US \$10.0 million in assistance which the U.S. Government, through the Agency for International Development (A.I.D.), is providing to the Government of Chile for Program for the Immediate Improvement of Primary Health Care. Such procedures have been discussed by Ministry of Health, other Chilean government officials and the A.I.D. design team during the past several weeks. I anticipate that your government will apply the basic procedures and requirements described below to formulate specific financial procedures suitable to the Chilean financial system and institutions. The specific procedures should be presented to A.I.D. . either before the signing of the Program agreement or before the disbursement of the first dollar tranche (anticipated on or about November 30, 1990).

A distinction should be made between two modes which A.I.D uses to provide assistance. One mode is project assistance, by which A.I.D. and the host country government jointly implement a project. Under this mode A.I.D. must very carefully monitor the implementation of the project and must track project funds to their end use. The other mode is program assistance. Under this mode, A.I.D contributes to a

program of the host country government. With program assistance, A.I.D. monitors implementation in a general way and wishes to assure itself only that program funds have reached the program. Unlike project assistance, tracking funds to specific end use is not required.

Program assistance is appropriate for Advanced Developing Countries such as Chile, where A.I.D. can rely on sophisticated implementation and financial management capabilities. This was the primary reason for selecting the program assistance mode for A.I.D. assistance.

A.I.D. has basic financial procedures under program assistance. They are as follows:

1. Under program assistance, the host government is provided with a dollar grant. Dollars are disbursed into an interest bearing, separate dollar account after certain agreed-upon conditions or benchmarks are met.
2. The dollars are to be used to finance U.S. made equipment and supplies imported after the signing of the agreement. In the case of this program, imports must be for the health sector (public or private).
3. Once acceptable import documentation is presented to A.I.D. dollars can be released from the separate dollar account to the Government of Chile.
4. Preferably at the time the dollars are disbursed to the separate dollar account, the host government will deposit the local currency equivalent of the dollar disbursement into a special local currency account. The special account will also be a separate, non-commingled account. If justification is adequate, the deposit of local currency can be made when dollars are released from the separate dollar account.
5. As the host government needs local currency for implementation of the program, it may draw down on the special local currency account.
6. A.I.D. wishes to be able to track local currency from the special account to program or sector being supported, not to specific line items or activities.

In the system described above, there are minimum requirements which have been authorized by the U.S. Congress and cannot be waived. These minimum requirements are as follows:

-There must be a separate dollar account to receive dollar disbursements. The account can contain only dollars disbursed under the agreement and must be interest bearing.

-There must be a special local currency (peso) account which contains only that local currency equivalent to the dollar disbursements or withdrawals from the separate account. This account must also be interest bearing, unless prohibited by the laws of the host country government.

-Interest earned in either the separate dollar account or the special local currency (peso) account accrues to the program and must be used for program purposes.

In addition to the financial procedure requirements, there are also minimum, standard auditing requirements. Basically, both the dollar procedures and the local currency transactions, as described above must be audited annually by an independent C.P.A. firm. In addition, a financial assessment of institutions managing the dollar separate account and the special local currency account must be performed at the beginning of the Program.

Sincerely,



Paul Fritz,
Representative

UNCLASSIFIED
AGENCY FOR INT'L DEV.
TELECOMMUNICATIONS CENTER

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OUTGOING
TELEGRAM

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SUBJECT PROGRAM FOR IMMEDIATE IMPROVEMENT OF PRIMARY
HEALTH CARE (S13-0350) PID REVIEW

1 INTRODUCTION THE ISSUE MEETING FOR SUBJECT
PROGRAM WAS HELD ON THURSDAY, SEPT 13. THE ISSUE
MEETING WAS CHAIRMED BY LAC/DP DIRECTOR PETER BLOOM AND
INCLUDED REPRESENTATIVES FROM LAC/GC, LAC DR, LAC SAM,
LAC DP AND PPC/PB. DUE TO THE UNIQUE NATURE OF THE
PROPOSED PROGRAM IT WAS DECIDED THAT, IN LIEU OF A FULL
DAILY A SMALLER MEETING WOULD BE HELD WITH DAA FREDERICK
SCHIECK. THE MEETING WAS HELD ON MONDAY, SEPTEMBER 17,
AND WAS BASED ON A SUMMARY OF THE PROPOSED PROGRAM,
QUOTED IN PARA 2.

2 SUMMARY OF PROPOSED PROGRAM QUOTE ACTION
REQUESTED THAT YOU APPROVE THE DEVELOPMENT OF A DOLS
10.0 MILLION SECTOR PROGRAM (NON-PROJECT ASSISTANCE) FOR
PROVISION OF U.S. ASSISTANCE TO THE CHILE HEALTH
PROGRAM. THIS APPROACH WAS DISCUSSED AND RECOMMENDED
BASED ON THE RESULTS OF THE SEPTEMBER 13TH ISSUES
MEETING FOR THE CHILE PROGRAM FOR THE IMMEDIATE
IMPROVEMENT OF PRIMARY HEALTH CARE (S13-0350).

BACKGROUND PUBLIC INTEREST POLLS TAKEN SHORTLY BEFORE
THE NEW DEMOCRATICALLY ELECTED ADMINISTRATION OF
PRESIDENT AYLWIN TOOK OFFICE IN MARCH OF 1990 SHOWED
THAT PROVISION OF ADEQUATE HEALTH SERVICES WAS THE
SINGLE MOST URGENT ISSUE FACING THE GOVERNMENT AND THE
CHILEAN POPULATION. IN RESPONSE, THE GOC BOTH
FORMULATED A STRATEGY AND ACTION PLAN, AND MOBILIZED
DONOR ASSISTANCE IN ORDER TO ADDRESS THIS PROBLEM. IN
RESPONSE, THE U.S. CONGRESS EARMARKED DOLS 10 MILLION
FOR HELP IN QUOTE JUMP STARTING UNQUOTE THE PRIMARY
HEALTH CARE SYSTEM.

MULTILATERAL AND BILATERAL ASSISTANCE (APPROXIMATELY
DOLS 450 MILLION FOR THE PERIOD 1990-1995) IS TO BE USED
TO ASSIST IN COMPLETING THE REFORM OF THE HEALTH SECTOR
AND TO AUGMENT THE INVESTMENT BUDGET WHICH HAS BEEN
VIRTUALLY NON-EXISTENT OVER THE PAST DECADE. THE U.S.
ASSISTANCE IS DESIGNED TO LAY THE EARLY GROUNDWORK FOR
POLICY AND INSTITUTIONAL REFORMS WHICH WILL BE CONTINUED

DISCUSSION THE NPA SECTOR PROGRAM APPROACH WOULD GIVE
THE GOC THE FLEXIBILITY IT NEEDS TO EFFECTIVELY
COORDINATE THE AID RESOURCES WITH NATIONAL RESOURCES
AND WITH THOSE OF OTHER EXTERNAL DONORS. FURTHERMORE,
THE TYPES OF INSTITUTIONAL REFORMS CONTEMPLATED WOULD BE
STRONGLY FACILITATED BY A SECTOR PROGRAM VERSUS A
PROJECT APPROACH. THE SPECIAL PROCEDURES AND DETAILED
END USE MONITORING AND CONTROL REQUIRED IN A PROJECT
DEFEAT THE INTENT OF THE U.S. CONGRESS ASSISTANCE TO BE
FLEXIBLE, QUICK DISBURSING, AND SIMPLE. GENERALIZED
SUBSECTOR SUPPORT FOR THE PRIMARY HEALTH CARE PROGRAM
WOULD ASSURE THAT THE RESTRUCTURED SERVICE DELIVERY
MECHANISMS AND PROGRAMS DEVELOPED BY THE MOH ARE
CONSISTENT WITH AND CAN FUNCTION EFFECTIVELY AND
EFFICIENTLY UNDER THE NORMAL OPERATIONS OF THE PUBLIC
HEALTH SERVICES. A PROGRAM APPROACH IN A COUNTRY LIKE
CHILE WHERE IMPLEMENTATION CAPACITY AND SKILLS ARE HIGH
ALSO WOULD ALLOW THE U.S. GOVERNMENT TO SUPPORT THE KIND
OF THOUGHTFUL INSTITUTIONAL REFORM PROCESS THE CHILEANS
WANT TO AND NEED TO CARRY OUT WITH AID'S LIMITED
PERSONNEL RESOURCES IN CHILE.

PROGRAM CHARACTERISTICS THE ASSISTANCE WILL CONSIST OF
THREE PROCESSES: 1) CONDITIONAL DOLLAR DISBURSEMENT, 2)
LOCAL CURRENCY EQUIVALENT TO THE DOLLAR TRANSFER AND 3)
TECHNICAL ASSISTANCE AND EVALUATION/AUDIT IN SUPPORT OF
PROGRAM OBJECTIVES.

THE DOLLAR DISBURSEMENTS WILL BE MADE IN TRANCHE (ONE
OF TWO), ON SATISFACTION OF CONDITIONAL PRECEDENT
(BENCHMARKS WHICH WILL ESTABLISH THE BASIS FOR THE
INSTITUTIONAL AND POLICY REFORMS OF THE IMMEDIATE
IMPROVEMENT OF PRIMARY HEALTH CARE PROGRAM). U.S.
FOREIGN EXCHANGE WILL BE USED TO FINANCE U.S. IMPROVEMENTS
DESTINED FOR THE HEALTH SECTOR (USING THE REIMBURSEMENT
METHOD).

EITHER PRIOR TO OR AT THE TIME OF EACH DOLLAR
DISBURSEMENT, THE GOC WILL DEPOSIT THE LOCAL CURRENCY
EQUIVALENT INTO A SPECIAL LOCAL CURRENCY ACCOUNT. FUNDS
WILL THEN BE TRANSFERRED TO THE PRIMARY HEALTH CARE
SUB-SECTOR OF MOH'S BUDGET AND WILL BE USED TO FINANCE
APPROXIMATELY ONE-HALF OF THE GOC'S IMMEDIATE
IMPROVEMENT OF PRIMARY HEALTH CARE PROGRAM (TOTAL
SUB-BUDGET IS DOLS 23 MILLION). THE LOCAL CURRENCY WILL
BE A CONTRIBUTION TOWARDS IMPLEMENTATION OF THE POLICY
AND INSTITUTIONAL REFORM OBJECTIVES OF THE PROGRAM.

MONITORING ARRANGEMENTS LAC/DR AND LAC/CONT HAVE
REVIEWED THE FINANCIAL AND TECHNICAL MONITORING
REQUIREMENTS ACCORDING TO BOTH CURRENT AND NEW, DRAFT
GUIDANCE ON LOCAL CURRENCY. LOCAL CURRENCY WILL BE
JOINTLY PROGRAMMED FOR GENERAL SECTOR SUPPORT, BY
CONTRIBUTING TOWARDS THE GOC'S IMMEDIATE IMPROVEMENT OF
THE PHC PROGRAM. AID WILL BE REQUIRED TO VERIFY THAT
LOCAL CURRENCY HAS REACHED THE PRIMARY HEALTH CARE
SUB-SECTOR. AID WILL NOT BE REQUIRED TO TRACE LOCAL
CURRENCY TO SPECIFIC LINE ITEMS UNDER ACTIVITIES
COMPRISING THE PROGRAM. ON THE TECHNICAL SIDE,
CONSISTENT WITH LOCAL CURRENCY GUIDANCE AND OUR
RATIONALE FOR PROVIDING THE ASSISTANCE, THE AID/REP
WILL RECEIVE PERIODIC TECHNICAL REPORTS ON THE PROGRAM
IN GENERAL FOR APPROXIMATELY TWO YEARS.

TECHNICAL ASSISTANCE AND EVALUATION/AUDIT REQUIREMENTS
WILL BE FUNDED THROUGH A SEPARATE AID MANAGED DOLLAR
ACCOUNT. DETAILS OF THE EXACT TECHNICAL ASSISTANCE AND
EVALUATION/AUDIT REQUIREMENTS WILL BE DEFINED DURING

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OUTGOING
TELEGRAM

PAGE 02 OF 02 STATE 321528
PAAD PREPARATION END QUOTE

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3 DECISIONS DURING THE MEETING THE DAA AGREED WITH THE APPROACH SUMMARIZED ABOVE AND PROVIDED THE FOLLOWING GUIDANCE

A THE BUREAU, WORKING THROUGH LEG, SHOULD DISCUSS THE PROPOSED NPA WITH APPROPRIATE CONGRESSIONAL STAFF THIS

SHOULD OCCUR AS SOON AS POSSIBLE-EITHER BEFORE OR WHILE THE DESIGN TEAM IS IN SANTIAGO WORKING ON THE PAAD

E GIVEN CONCERN WITH QUOTE BUY AMERICA UNQUOTE AND CONGRESSIONAL INTEREST IN THIS PROGRAM, IT IS IMPORTANT TO BALANCE HEALTH-RELATED IMPORTS FROM THE U.S. WITH THE FOREIGN EXCHANGE

C THE PAAD DESIGN TEAM AND THE AID/REP SHOULD ASCERTAIN THAT THE GOC DEDICATE SUFFICIENT STAFF (AT LEAST ONE FULL TIME PERSON) TO ENSURE TIMELY PROCESSING OF AID ACCOUNTING FOR THE DOLLAR ASSISTANCE

D THERE SHOULD BE TWO DOLLAR DISBURSEMENTS THE FIRST SHOULD BE BASED ON SATISFYING CERTAIN CONDITIONS BENCHMARKS AND THE SECOND ON A FORMAL PROGRESS REVIEW AND THE AID/REP'S ASSESSMENT THAT THE GOC HAS MADE REASONABLE SUBSTANTIAL PROGRESS IN IMPLEMENTING THE PROGRAM DURING THE FIRST SIX TO NINE MONTHS OF THE PROGRAM THE INFLATION RATE IN CHILE MUST BE MANAGEABLE TO DISBURSE DOLLARS SUBSTANTIALLY FASTER THAN THE LOCAL CURRENCY IS REQUIRED FOR THE PROGRAM

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A FUTURE STEPS THE AID/REP IS REQUESTED TO DISCUSS THE PROPOSAL CONTAINED IN PARA 2 WITH GOC OFFICIALS, PRIOR TO THE ARRIVAL OF THE PAAD DESIGN TEAM THE PAAD DESIGN TEAM WILL INCLUDE TWO LAC/DR OFFICERS (JULIE KLEMENT AND PETER LAPEPA), WHO WILL COMPLETE THE PAAD DURING A TWO TO THREE WEEK PERIOD BEGINNING SEPTEMBER 27 THE TEAM WILL FOCUS ON DEFINING APPROPRIATE CONDITIONS/BENCHMARKS, MONITORING AND EVALUATION PROCEDURES FOR THE PROGRAM, AS WELL AS THE PROGRAMMING AND USE OF DOLLARS AND LOCAL CURRENCY IN THE LATTER AREA, THE TEAM WILL BE ASSISTED BY JERRY MARTIN OF THE CONTROLLER'S OFFICE, USAID/LIMA AND WILL BE ABLE TO CONSULT WITH JAMES WESBERRY, WHO WILL BE WORKING ON THE REGIONAL FINANCIAL MANAGEMENT PROJECT BOTH WILL BE IN SANTIAGO DURING THE FIRST WEEK OF OCTOBER

S THE BUREAU WILL ADVISE AID/REP OF REVIEW DATES FOR THE PAAD (TENTATIVELY THE THIRD OR FOURTH WK IN OCTOBER) BAKER

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AID/LAC/DR:PBL00M
AID/LAC/DR:EBRINEMAN {DRAFT}
AID/LAC/GC:PSULLIVAN{DRAFT}
AID/LAC/CONT:CADAMS{DRAFT}

AID/LAC/DP:BSCHOUTEN{DRAFT}
AID/LAC/SAM:RNELSON {DRAFT}
AID/PPC/PB:TBARKER {DRAFT}
AID/LAC/DR/HPN:ADANART {DRAFT}

IMMEDIATE SANTIAGO

IMMEDIATE LIMA

AIDAC AID/REP., PAUL FRITZ, CONTROLLER USAID/LIMA

E.O. 12356: N/A

TAGS:

SUBJECT: PROGRAM FOR IMMEDIATE IMPROVEMENT OF PRIMARY HEALTH CARE {513-0350} PID REVIEW

1. INTRODUCTION. THE ISSUES MEETING FOR SUBJECT PROGRAM WAS HELD ON THURSDAY, SEPT. 13. THE ISSUES MEETING WAS CHAIRED BY LAC/DR DIRECTOR PETER BLOOM AND INCLUDED REPRESENTATIVES FROM LAC/GC, LAC/DR, LAC/SAM, LAC/DP AND PPC/PB. DUE TO THE UNIQUE NATURE OF THE PROPOSED PROGRAM, IT WAS DECIDED THAT, IN LIEU OF A FULL DAEC, A SMALLER MEETING WOULD BE HELD WITH DAA FREDERICK SCHIECK. THE MEETING WAS HELD ON MONDAY, SEPTEMBER 17, AND WAS BASED ON A SUMMARY OF THE PROPOSED PROGRAM, QUOTED IN PARA. 2.

2. SUMMARY OF PROPOSED PROGRAM. QUOTE. ACTION REQUESTED: THAT YOU APPROVE THE DEVELOPMENT OF A DOLS 10.0 MILLION SECTOR PROGRAM (NON-PROJECT ASSISTANCE) FOR PROVISION OF U.S. ASSISTANCE TO THE CHILE HEALTH PROGRAM. THIS APPROACH WAS DISCUSSED AND RECOMMENDED BASED ON THE RESULTS OF THE SEPTEMBER 13TH ISSUES MEETING FOR THE CHILE PROGRAM FOR THE IMMEDIATE IMPROVEMENT OF PRIMARY HEALTH CARE {513-0350}.

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BACKGROUND: PUBLIC INTEREST POLLS TAKEN SHORTLY BEFORE THE NEW DEMOCRATICALLY ELECTED ADMINISTRATION OF PRESIDENT AYLWIN TOOK OFFICE IN MARCH OF 1990 SHOWED THAT PROVISION OF ADEQUATE HEALTH SERVICES WAS THE SINGLE MOST URGENT ISSUE FACING THE GOVERNMENT AND THE CHILEAN POPULATION. IN RESPONSE, THE GOC BOTH FORMULATED A STRATEGY AND ACTION PLAN, AND MOBILIZED DONOR ASSISTANCE IN ORDER TO ADDRESS THIS PROBLEM. IN RESPONSE, THE U.S. CONGRESS EARMARKED DOLS 10 MILLION FOR HELP IN QUOTE JUMP STARTING UNQUOTE THE PRIMARY HEALTH CARE SYSTEM.

MULTILATERAL AND BILATERAL ASSISTANCE (APPROXIMATELY DOLS 450 MILLION FOR THE PERIOD 1990-1995) IS TO BE USED TO ASSIST IN COMPLETING THE REFORM OF THE HEALTH SECTOR AND TO AUGMENT THE INVESTMENT BUDGET WHICH HAS BEEN VIRTUALLY NON-EXISTENT OVER THE PAST DECADE. THE U.S. ASSISTANCE IS DESIGNED TO LAY THE EARLY GROUNDWORK FOR POLICY AND INSTITUTIONAL REFORMS WHICH WILL BE CONTINUED AND EXPANDED WITH THE SUBSTANTIAL DONOR ASSISTANCE.

DISCUSSION: THE NPA SECTOR PROGRAM APPROACH WOULD GIVE THE GOC THE FLEXIBILITY IT NEEDS TO EFFECTIVELY COORDINATE THE A.I.D. RESOURCES WITH NATIONAL RESOURCES AND WITH THOSE OF OTHER EXTERNAL DONORS. FURTHERMORE, THE TYPES OF INSTITUTIONAL REFORMS CONTEMPLATED WOULD BE STRONGLY FACILITATED BY A SECTOR PROGRAM VERSUS A PROJECT APPROACH. THE SPECIAL PROCEDURES AND DETAILED END USE MONITORING AND CONTROL REQUIRED IN A PROJECT DEFEAT THE INTENT OF THE U.S. CONGRESS ASSISTANCE TO BE FLEXIBLE, QUICK DISBURSING, AND SIMPLE. GENERALIZED SUBSECTOR SUPPORT FOR THE PRIMARY HEALTH CARE PROGRAM WOULD ASSURE THAT THE RESTRUCTURED SERVICE DELIVERY MECHANISMS AND PROGRAMS DEVELOPED BY THE MOH ARE CONSISTENT WITH AND CAN FUNCTION EFFECTIVELY AND EFFICIENTLY UNDER THE NORMAL OPERATIONS OF THE PUBLIC HEALTH SERVICES. A PROGRAM APPROACH IN A COUNTRY LIKE CHILE WHERE IMPLEMENTATION CAPACITY AND SKILLS ARE HIGH ALSO WOULD ALLOW THE U.S. GOVERNMENT TO SUPPORT THE KIND OF THOUGHTFUL INSTITUTIONAL REFORM PROCESS THE CHILEANS WANT TO AND NEED TO CARRY OUT WITH A.I.D.'S LIMITED PERSONNEL RESOURCES IN CHILE.

PROGRAM CHARACTERISTICS: THE ASSISTANCE WILL CONSIST OF THREE PROCESSES: 1) CONDITIONAL DOLLAR DISBURSEMENT, 2) LOCAL CURRENCY EQUIVALENT TO THE DOLLAR TRANSFER, AND 3) TECHNICAL ASSISTANCE AND EVALUATION/AUDIT IN SUPPORT OF PROGRAM OBJECTIVES.

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THE DOLLAR DISBURSEMENTS WILL BE MADE IN TRANCHES (ONE OR TWO), ON SATISFACTION OF CONDITIONS PRECEDENT (BENCHMARKS WHICH WILL ESTABLISH THE BASIS FOR THE INSTITUTIONAL AND POLICY REFORMS OF THE IMMEDIATE IMPROVEMENT OF PRIMARY HEALTH CARE PROGRAM). U.S. FOREIGN EXCHANGE WILL BE USED TO FINANCE U.S. IMPORTS DESTINED FOR THE HEALTH SECTOR (USING THE REIMBURSEMENT METHOD.)

EITHER PRIOR TO OR AT THE TIME OF EACH DOLLAR DISBURSEMENT, THE GOC WILL DEPOSIT THE LOCAL CURRENCY EQUIVALENT INTO A SPECIAL LOCAL CURRENCY ACCOUNT. FUNDS WILL THEN BE TRANSFERRED TO THE PRIMARY HEALTH CARE SUB-SECTOR OF MOH'S BUDGET AND WILL BE USED TO FINANCE APPROXIMATELY ONE-HALF OF THE GOC'S IMMEDIATE IMPROVEMENT OF PRIMARY HEALTH CARE PROGRAM (TOTAL SUB-BUDGET IS DOLS 23 MILLION). THE LOCAL CURRENCY WILL BE A CONTRIBUTION TOWARDS IMPLEMENTATION OF THE POLICY AND INSTITUTIONAL REFORM OBJECTIVES OF THE PROGRAM.

MONITORING ARRANGEMENTS: LAC/DR AND LAC/CONT. HAVE REVIEWED THE FINANCIAL AND TECHNICAL MONITORING REQUIREMENTS ACCORDING TO BOTH CURRENT AND NEW, DRAFT GUIDANCE ON LOCAL CURRENCY. LOCAL CURRENCY WILL BE JOINTLY PROGRAMMED FOR GENERAL SECTOR SUPPORT, BY CONTRIBUTING TOWARDS THE GOC'S IMMEDIATE IMPROVEMENT OF THE PHC PROGRAM. AID WILL BE REQUIRED TO VERIFY THAT LOCAL CURRENCY HAS REACHED THE PRIMARY HEALTH CARE SUB-SECTOR. AID WILL NOT BE REQUIRED TO TRACE LOCAL CURRENCY TO SPECIFIC LINE ITEMS UNDER ACTIVITIES COMPRISING THE PROGRAM. ON THE TECHNICAL SIDE, CONSISTENT WITH LOCAL CURRENCY GUIDANCE AND OUR RATIONALE FOR PROVIDING THE ASSISTANCE, THE AID/REP. WILL RECEIVE PERIODIC TECHNICAL REPORTS ON THE PROGRAM IN GENERAL FOR APPROXIMATELY TWO YEARS.

TECHNICAL ASSISTANCE AND EVALUATION/AUDIT REQUIREMENTS WILL BE FUNDED THROUGH A SEPARATE A.I.D. MANAGED DOLLAR ACCOUNT. DETAILS OF THE EXACT TECHNICAL ASSISTANCE AND EVALUATION/AUDIT REQUIREMENTS WILL BE DEFINED DURING PAAD PREPARATION. END QUOTE.

3. DECISIONS. DURING THE MEETING THE DAA AGREED WITH THE APPROACH SUMMARIZED ABOVE AND PROVIDED THE FOLLOWING GUIDANCE:

A. THE BUREAU, WORKING THROUGH LEG, SHOULD DISCUSS THE PROPOSED NPA WITH APPROPRIATE CONGRESSIONAL STAFF: THIS

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128

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SHOULD OCCUR AS SOON AS POSSIBLE-EITHER BEFORE OR WHILE THE DESIGN TEAM IS IN SANTIAGO WORKING ON THE PAAD.

B. GIVEN CONCERNS WITH QUOTE BUY AMERICA UNQUOTE AND CONGRESSIONAL INTEREST IN THIS PROGRAM, IT IS IMPORTANT TO FINANCE HEALTH-RELATED IMPORTS FROM THE U.S. WITH THE FOREIGN EXCHANGE.

C. THE PAAD DESIGN TEAM AND THE AID/REP. SHOULD ASCERTAIN THAT THE GOC DEDICATE SUFFICIENT STAFF (AT LEAST ONE FULL TIME PERSON) TO ENSURE TIMELY PROCESSING OF AND ACCOUNTING FOR THE DOLLAR ASSISTANCE.

D. THERE SHOULD BE TWO DOLLAR DISBURSEMENTS: THE FIRST SHOULD BE BASED ON SATISFYING CERTAIN CONDITIONS/BENCHMARKS AND THE SECOND ON A FORMAL PROGRESS REVIEW AND THE AID/REP'S ASSESSMENT THAT THE GOC HAS MADE REASONABLE, SUBSTANTIAL PROGRESS IN IMPLEMENTING THE PROGRAM DURING THE FIRST SIX TO NINE MONTHS OF THE PROGRAM. THE INFLATION RATE IN CHILE MAKES IT INADVISABLE TO DISBURSE DOLLARS SUBSTANTIALLY FASTER THAN THE LOCAL CURRENCY IS REQUIRED FOR THE PROGRAM.

E. THE PAAD SHOULD BE CONSISTENT WITH NEW, DRAFT LOCAL CURRENCY GUIDANCE, SOON TO BE ISSUED.

4. FUTURE STEPS. THE AID REP. IS REQUESTED TO DISCUSS THE PROPOSAL CONTAINED IN PARA. 2 WITH GOC OFFICIALS, PRIOR TO THE ARRIVAL OF THE PAAD DESIGN TEAM. THE PAAD DESIGN TEAM WILL INCLUDE TWO LAC/DR OFFICERS (JULIE KLEMENT AND PETER LAPERA), WHO WILL COMPLETE THE PAAD DURING A TWO TO THREE WEEK PERIOD BEGINNING SEPTEMBER 27. THE TEAM WILL FOCUS ON DEFINING APPROPRIATE CONDITIONS/BENCHMARKS, MONITORING AND EVALUATION PROCEDURES FOR THE PROGRAM, AS WELL AS THE PROGRAMMING AND USE OF DOLLARS AND LOCAL CURRENCY. IN THE LATTER AREA, THE TEAM WILL BE ASSISTED BY JERRY MARTIN OF THE CONTROLLER'S OFFICE, USAID/LIMA AND WILL BE ABLE TO CONSULT WITH JAMES WESBERRY, WHO WILL BE WORKING ON THE REGIONAL FINANCIAL MANAGEMENT PROJECT. BOTH WILL BE IN SANTIAGO DURING THE FIRST WEEK OF OCTOBER.

5. THE BUREAU WILL ADVISE AID/REP. OF REVIEW DATES FOR THE PAAD (TENTATIVELY THE THIRD OR FOURTH WK. IN OCTOBER). 44

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129