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~~Payson~~
~~Anderson~~
~~Witter~~



TO
THE UNITED STATES
AGENCY FOR INTERNATIONAL DEVELOPMENT
IN RELATION TO
CONTRACT AID/ta-C-1320

AMERICAN PUBLIC HEALTH ASSOCIATION
Division of International Health Programs
1015 Eighteenth Street, N.W.
Washington, D.C. 20036

SEMI-ANNUAL REPORT
TO
THE UNITED STATES
AGENCY FOR INTERNATIONAL DEVELOPMENT
IN RELATION TO
CONTRACT AID/ta-C-1320

DECEMBER, 1976

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SEMI-ANNUAL REPORT FROM THE
AMERICAN PUBLIC HEALTH ASSOCIATION

TO

THE U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

IN RELATION TO

CONTRACT AID/ta-C-1320

December, 1976

INTRODUCTION

This report summarizes activities under Contract AID/ta-C-1320 which have taken place since June 1, 1976 when that Contract was signed as a follow-on to Contract AID/csd-3423. This Contract as the earlier one provides funds for operations over the next three years to assist in the design, development and evaluation of integrated health, population and nutrition delivery systems which can provide health services and information to a majority of citizenry of LDCs. The emphasis of such systems, according to the Contract, is to be on "women of childbearing age and pre-school children with services to be offered at a cost the host government can afford without prolonged external subsidy."

1. Intermediate Management of the Demonstration Project in Thailand

The Agreement between the Royal Thai Government and the APHA was renewed on October 1, 1976 to provide for continuing support of the Lampang Health Development Project through September 30, 1979. Shortly thereafter the Second Annual Project Review was held in Lampang and Chiangmai (November 22-26, 1976) and attended by representatives from APHA, AID, USOM and the RTG. The report prepared by the Project from that review as well as the APHA "evaluation" report on the Review are attached as Appendix A. The very detailed report prepared by Drs. Shutt and Britanik has been reviewed and appropriate followup actions taken.

Since the review, APHA has continued to provide support to the Project in the fiscal, logistic and evaluation areas. The latter will be discussed under Section 3 . APHA is currently corresponding with the Project about staffing changes, final dispensation of approximately \$8,000 remaining from the earlier Agreement and use of currency exchange differentials. A fiscal audit of project records was performed by the management accounting firm of SGV, a copy of which is also attached as Appendix B. A copy of the 9th Quarterly Progress Report (Oct. 1-Dec. 31, 1976) is also attached as Appendix B1.

2. The Provision of Consulting Assistance

Between June 1, 1976 and December 31, 1976, 775 man-days of consultant assistance have been provided under the Contract. The following overseas consultancies were performed during that period:

2.1 John A Massey, Health Educator served as a consultant in El Salvador and Honduras in the development of curricula for short-term training of auxiliary personnel.

2.2 Robert Dyar, M.D. and Donald Conwell, M.D. consulted with APHA and AID on evaluation of a regional public health training project in the Cameroon.

2.3 Technical assistance was provided to the Ministry of Health and the National Institute of Health of Colombia by Dieter K. Zschock, and Robert L. Robertson, Ph.D's. Under the consultancy, reviews were made of the health sector financing study carried out by the Planning Division of the MOH and of responses to the economic portion of the pilot round of the National Morbidity Survey.

2.4 The Ministry of Health of Bolivia was provided technical assistance by Ralph Frerichs, DVM and Robert Emery, Ph.D. in improvement of its epidemiologic reporting, on the identification of key health indicators, development of simplified low-cost reporting and analysis system, and on a methodology for dissemination of the information throughout the system.

2.5 Roy Scholtz, M.D. served as consultant to APHA and AID in exploring ways in which aspects of eye treatment might be undertaken by rural health auxiliaries, in training and supervision required, and the roles of such persons in the existing health delivery systems.

2.6 Assistance was provided by Stephen C. Joseph and Eugene Boostrom, M.D.'s to the Government of Mali and USAID in developing a Rural Health Services Development Project.

2.7 Henry van Zile Hyde, M.D. traveled to several Middle East and European countries as a consultant to the APHA and AID in exploring the feasibility and in investigating sources of funding for a program of regional seminars and a world conference on education and health care.

2.8 Assistance was provided to the Government of Jordan by Stephen C. Joseph, M.D. in the first phase of designing a national health plan.

2.9 Charles Myers, Ph.D. served as a consultant to the Government of Colombia in reviewing and completing an analysis plan for data to be collected in the national morbidity survey.

2.10 The Government of Indonesia as well as USAID/Indonesia were provided consultation by Emmanuel Voulgaropoulos, M.D. in development of a project to strengthen Indonesian health research capabilities.

2.11 Eugene Boostrom, M.D. consulted with the Government of Haiti and USAID Haiti in development of documentation for a FY 78 health delivery system grant/loan.

2.12 Robert William Lennox, Sc.D. provided technical assistance to the Government of Mali in development of health aspects of proposals for two agricultural projects.

2.13 Three APHA consultants; Robert LeBow, Eugene Boostrom, M.D.'s, and Alfred Davidson assisted USAID Brazil in a review of two integrated health projects being implemented under an AID loan.

In addition, domestic consultants served under the Contract during this period in the following areas:

2.14 N.R.E. Fendall of the Liverpool School of Medicine consulted with TA/H and APHA representatives on the subject of "Non-physician Health Manpower in Development Countries."

2.15 Anthony Meyer, Ph.D. of the Institute of Communication Research met with AID and APHA staff to discuss the subject of behavior modification in campaigns against infectious disease, malnutrition and overpopulation in lesser developed countries.

2.16 Assistance in review of a CARE/OPG proposal on a Siliana Water Improvement Project for Tunisia was provided by F. Eugene McJunkin.

2.17 Several consultants assisted in the data processing and analysis of the State of the Art Study.

2.18 Consultants have also participated in the development of the conference activity described in Section 6 of this report.

3. Development of Evaluation Guidelines

A. Major Accomplishments/Activities

An Evaluation Officer was appointed to the APHA staff in August 1976, and activities undertaken to result in development of evaluation guideline for integrated health delivery systems. These have included collection of resource materials on evaluation methodology and projects, investigation of evaluation efforts of other organizations such as PAHO/WHO, Population Council, the U.N. and various universities. On the basis of these activities, a tentative format and schedule for a set of evaluation manuals has been developed which will be presented to AID.

Technical assistance being provided in evaluation under the consultation aspect of the Contract is being coordinated with activities to develop the guidelines. APHA is continuing to provide staff and consultant assistance to the evaluation aspect of the Lampang Health Development Project in Thailand. To this end, Dr. William Reinke, Johns Hopkins University and the APHA Evaluation Officer met with the Project's evaluation staff in September to discuss data analysis and evaluation plans for the next two project areas, E2 and E3. In addition, the APHA Evaluation Officer attended the Second Annual Review at which the evaluation activity was a major focus.

APHA is also participating in the development of a Seminar on Evaluation to be sponsored by PAHO and AID in the summer of 1977.

B. Future Plans

1. Presentation to AID in February 1977 of the format and scheduling of the various parts of the Guidelines.

B. Future Plans (continued)

2. Continuing assistance to the Lampang Project especially in completion of the analysis plan, presentation of refined baseline data and revision of impact indicators.

3. Continuing coordination with other organizations engaged in evaluation of health delivery as well as other development projects, focusing on alternative techniques for evaluation.

C. Actions Required by AID

Following presentation of the format and schedule of the guidelines to AID, joint discussions will be held to identify projects and mechanisms for contract access to projects engaged in evaluation.

4. State of the Art

A. Major Accomplishments/Activities

The State of the Art Study is a continuation of a major activity under the earlier DEIDS Contract to survey health projects in LDS's in order to identify low cost delivery systems, innovative approaches and trends in health delivery in these areas.

Under the current contract, APHA is to disseminate results of the study and to develop means of making such information more available and useful to health field workers.

The preliminary report on the survey was submitted to AID for review and comment on June 1976. Based on the suggestions received from AID and other sources, a detailed summary was prepared and submitted to AID in September 1976. Additional suggestions were made about how the Report might be revised for maximum usefulness in the field. The final draft of the summary, consisting of over 100 pages plus extensive appendices, was submitted to AID in December 1976. Authorization for publication from AID was received early in January, and printing arrangements made which will permit distribution of the Report during the first week in February.

Drawing upon the finding that there is great interest in the field in the type of information under study, as well as willingness among field workers to share their experiences, a series of technical monographs and a quarterly newsletter were planned and approved by AID. These activities are a part of APHA's efforts to stimulate an effective communications network involving primarily the people responsible for the design and implementation of low cost health systems in LDCs.

B. Future Plans

1. Case Studies: A screening and selection procedure is in process which will result in identification of up to 30 field projects worthy of in-depth study through the analysis of existing and newly acquired data.

2. From the above cases, six to ten will be selected for site visits by teams of health experts for more intensive assessment. Mailed questionnaires will be employed as screening instruments when appropriate prior to field visits, with the results of these studies being incorporated into special publications.

3. The computerized State of the Art data bank will be systematically enlarged with data stored to insure rapid retrieval according to major characteristics of each project. This data bank will be used to respond to requests from field workers and health planners as well as to provide data to health researchers and communication specialists, including those working on APHA and other publications.

C. Actions Required by AID

Plans for publications, case studies and site visits have already been reviewed with TA/H. A proposal for a steadily expanding data bank and its utilization in support of field programs will be sought shortly.

5. Information Dissemination

5.1 Newsletter

A. Major Accomplishments/Activities

The first issue of a quarterly newsletter entitled "Salubritas," a Latin word meaning health or well-being, is to be published the last week in January. The issue includes

a summary of the State of the Art study to allow readers to identify areas in which additional information is needed. To meet the needs of information of field level workers a tear-out sheet was included requesting suggestions for subjects and recipients for future issues.

Information meetings were held with representatives of the World Federation of Public Health Associations (WFPHA) to discuss the need to form a Policy/Advisory Board and to continue the support of the publication on a long term basis.

Channels of communication were established with the following institutions for the exchange of information regarding potential authors, articles of interest, names of suitable recipients, announcements of training events and bibliographic and photographic materials: IDRC, PAHO, WHO, UN, LIFE, AID-TA/NUB.

Forty-eight institutions (34 universities and 14 agencies) in the U.S., Canada, Puerto Rico and the West Indies were requested to send us information on training opportunities.

As of this date, the newsletter audience and magnitude of distribution for the first issue is as specified on the attached description sheet. (Appendix D)

B. Problems Encountered

Development of the newsletter took longer than expected. The editor was recruited in September 1976 and recruitment of support staff was completed by the middle of October 1976. The manuscript of the first issue was submitted to AID TA/H on December 7, 1976, and approval was received on December 22, 1976. Typesetting and printing work were started after the holidays. A work schedule has been adopted which result in publication of issues on a quarterly basis from here on.

C. Future Plans

Preparation of SALUBRITAS II

Continue development of mailing list according to contract specifications.

D. Actions Believed Required of AID

Approval of new activity implementation targets determined by date of publication of first issue (January 1977).

5.2 Monographs

A. Major Accomplishments/Plans

After staff consultation it was determined that the first monograph would be based on the instrument used in the State of the Art survey of low cost health delivery systems. This monograph has been completed in draft and has been submitted to TA/H. A tentative topic for the second monograph has been selected: "Health Manpower for Developing Countries" and author proposed. Subjects of the remaining four monographs are still under discussion.

6. Conference Management

A. Major Accomplishments/Activities

Under the new contract, APHA is to undertake conference management activities designed to stimulate interest and promote information exchange on low cost health delivery.

To this end, in August, APHA submitted a "Proposed Conference Plan" to AID. Following that APHA staff met in Geneva with WHO staff to discuss the proposed WHO-sponsored International Conferences on Primary Health Care to be held in Russia in September 1978. It was agreed with AID that APHA/DEIDS conference activities would be used to support the WHO/PHC activities. As a result APHA, in October, met with WHO/PHC Conference Director (Dr. Tejada) in Miami to work out a strategy for APHA involvement, and in November, initiated a series of meetings with the PAHO Director and staff to discuss design of PAHO pre-conference plans and to identify APHA consultant assistances in implementation. Since then APHA staff members have met with several potential Latin American participants (Panama, Costa Rica, Guatemala and Mexico) to discuss PAHO conference plans and obtain their recommendations.

B. Problems Encountered

1. Dual Objectives: AID/APHA-DEIDS Conference Management Activities have now been integrated into the AID support of WHO-PHC Conference activities. This means that two sets of objectives/goals must be met at one time. To date this has not been a problem due to close cooperation and regular dialogue between APHA and AID staff.

2. DEIDS Conference Funds Not Clearly Defined: The amount of financial support for conference management in the DEIDS contract is not well defined at present and appears to be rather limited considering the increased size of APHA role (i.e., support WHO-PHC conference activities). As a result, during current APHA negotiations with WHO, support has been defined only as "technical consultants" to assist in the implementation of the Regional Pre-Conference activities.

Related to this is the increased volume of work associated with supporting conference activities in five (5) WHO regions of the world. Current APHA staff support is limited to one professional and one assistant.

3. WHO Recognition of APHA Role: WHO-Geneva still seems uncertain as to the exact role and relationship of APHA to AID and the U.S. Government input into the PHC Conference activities. This could easily be clarified with a letter from AID to WHO.

C. Future Plans

In the next few months, discussions with PAHO are to be completed resulting in a formalized written agreement.

Meetings are to be held in February in Geneva to review current WHO/PHC conference plans and Regional Pre-Conference plans and to plan APHA inputs to SEARO, WPRO, EMRO and AFRO.

In February and March, at the request of WHO regional directors, APHA staff will travel to the regional offices to develop pre-conference plans and identify possible APHA inputs. APHA staff will then coordinate such inputs and provide support to the WHO/PHC Conference activities where appropriate. (Staff Trip Report on WHO/PHC Conference Activities is attached as Appendix C)

D. Actions Required by AID

1. AID should send an official letter to WHO-Geneva, identifying the role and responsibility of APHA in supporting the WHO-PHC Conference activities indicating that this is being done under a contractual arrangement.

2. AID should review and re-assess the current level of financial and manpower commitments made to APHA Conference Management activities and determine whether in view of the expanded role of APHA, if there should be additional AID support.

7. Private Voluntary Sector

A. Major Accomplishments/Activities

As another aspect of APHA efforts to support low cost health delivery systems, the Association is providing secretariat-type assistance for U.S. initiatives in promoting increased private voluntary sector support of such systems.

In October, the Secretariat completed a survey of 1400 U. S. multinational corporations and 450 U.S. voluntary non-governmental associations (e.g. labor unions, professional associations, etc.) which have concerns in Latin America, to determine their interest in participating in a cooperative program. Eighty corporations and 70 voluntary associations responded positively. A full meeting of the International Planning Group was assembled in November at which time the International Health Research Consortium (IHRC) was organized to promote voluntarism in community health services.

An Interim Executive Committee of the IHRC was formed with task forces on membership, finance and program. The APHA Secretariat representative met in Costa Rica with counterpart groups and government to determine interest in developing a cooperative demonstration program.

B. Problems Encountered

1. Although the IHRC is a "private sector" effort, there is great difficulty in obtaining initial "seed money" to organize the demonstration model and related travel funds.

2. APHA provides the Secretariat for the IHRC and utilizes volunteers. There is no mechanism, however, in the contract to authorize an honorarium for these volunteers.

C. Future Plans

January 1977 - Inform WHO-Geneva of the IHRC development and request the establishment of official WHO advisory liaison committee.

February 1977 - Assist IHRC Executive Committee in establishing fund raising from the U.S. private sector and assist U.S. development team to go to Costa Rica to discuss possible demonstration project.



AMERICAN PUBLIC HEALTH ASSOCIATION
1015 Eighteenth Street, N.W., Washington, D.C. 20036 • (202) 467-5000

PROTECTING HEALTH

MEMORANDUM

TO: The Record

DATE: December 13, 1976

FROM: P. Marnane

SUBJECT: Administrative Review of Lampang Project - November 26, 1976

A meeting was held in Lampang on the afternoon of November 25 at which the agenda for the Administrative Review was set.

The Administrative Review meeting was held in Chiang Mai on November 26 at the Railway Hotel.

I. Contracts and Financing

Item IA. Unexpended Funds and Exchange Differentials.

Because the project received in excess of 20 baht/one U.S. dollar, there was a surplus of some \$8000 at the end of the year.

Hood recommended that the money be turned back to AID and that the books be closed.

Ron Wilson suggested using the money in a "representation fund" and this was discussed generally.

Dr. Somboon mentioned that the program's production unit was developing fast and the money could be used to buy equipment for that unit.

Shutt suggested that it should and would be possible, he thought. It would be necessary to submit a proposal with specifics which would then be studied by the legal group at AID.

Hood believed that there would be difficulty in trying to apply the funds to the new budget.

Both Hood and Shutt concluded that an attempt should be made to get the new budget amended to add on the \$8000.

Shutt asked if it might be possible to calculate the unreimbursed expenses to project personnel over the most recent completed budget year. He said that he would like to see it used on those unreimbursed expenses if possible and concluded that an attempt be made to try to do so.

It was finally concluded that the funds could be used to pay for items ordered during the most recent completed budget year. Further, a request would be submitted asking for a determination on possible reimbursement for out of pocket expenses of program personnel during the most recent completed budget year. Such expenses would have to be justified [via receipts and affidavits].

Item IB. Budget Details by Category and Line.

A copy of the proposed budget (requested budget) was circulated.

Wilson asked for clarification on budget categories.

Hood said that he will write a letter clarifying budget categories.

Dr. Somboon asked how long it would take to get a new position approved if certain tasks were to be moved away from NIDA and given to a direct hire person within the Project.

Shutt and Hood concluded that if no new funds are needed it would be a simple problem.

Item IC. Budget Adjustments and Phasing.

Wilson observed that the three-year budget was divided almost equally for each of the three years. He noted that this is not realistic since start-up costs may be greater. He thought that \$175,000 more was needed in the first year but \$170,000 less in the second year.

Shutt said that this problem would be easily accommodated because Congress has promised to make 1977 monies available early in the year.

Hood asked how soon a request should be made.

Shutt said that it should come as soon as possible. The Project should write a letter to Washington quickly.

It was understood that the Project will submit a request for reallocation of funds by year as soon as it can.

Rogosh asked if the total funding could be increased for subsequent years.

Shutt concluded that increasing the total would involve a large problem with documentation and justification. It is still, however, too early to talk formally about a budget for 1979. Revised budgets for 1979 should be submitted later in the second year of the present contract period.

Item ID. Annual Budgets and Transition.

Shutt pointed out that transition between budget years should be smoother because of earlier allocation of funds in future years.

Dr. Somboon expressed a desire to have administrative review meetings held semi-annually rather than annually.

The next meeting would thus be in March or April of 1977. It was agreed that semi-annual meetings would be desirable. Hood asked that it be determined if project funds could be used for travel from Lampang if the meeting were held in Hawaii.

The decision about where the next meeting would be held was not made. Voulgaropoulos offered the University of Hawaii as host for the meeting.

Item IE. Project Disbursement Policies.

There was a problem in paying salary supplements to Project personnel because DTEC would not allow them. The Project has identified the funds as "research allowances" and this has been approved by MOH and DTEC. Shutt asked for written notification of that approval.

Item IF. Project Staff Travel Outside of Thailand.

Wilson noted that there are no funds for project personnel to attend meetings but that some persons had expressed interest in attending relevant meetings in the region. He asked if there were any way to get additional money for this or to use APHA funds.

Hood observed that there is money for conference participation but not observation. Requests must be submitted on a case by case basis. In response to a question from Wilson he indicated that probably 4-6 weeks lead time would be needed to obtain approval.

II. International Conference and Next Annual Review

Hood said that he had spoken with Gunaratne re a regional conference on primary health care to be held in 1977. Hood said he believed WHO's and APHA's plans and needs for regional conferences could be made congruent and mutually supportive.

Shutt noted that WHO recommends regional and international conferences prior to the Alma-Ata Conference.

It was pointed out that Gunaratne has plans for an October meeting and this would fit well with APHA scheduling.

Somboon noted that UNICEF also is interested in primary health care projects. He further said that Thailand would be an appropriate host for the regional conference.

Hood said that there should be no cost to the Project but some in-kind contribution would be needed.

Shutt mentioned that SERO would be expected to use its own funds and the AID mission should support it to some extent. Local arrangements would be handled among the host country, APHA and others.

Hood indicated that 6-8 months lead time would be necessary. Russ Morgan (of APHA) will be in touch with Gunaratne soon.

Dr. Somboon said he is going to Delhi in January and will talk with Gunaratne. That would be the first week in January, probably the 3rd or 4th. (Later changed by a cable to Feb. 4). He can coordinate with Morgan.

It was agreed that the conference and its planning should be put on the agenda of the next administrative review meeting.

Hood pointed out that we are now discussing this only on a preliminary basis but that we are prepared to follow up. At present, we can do no more than start communication with WHO and other agencies.

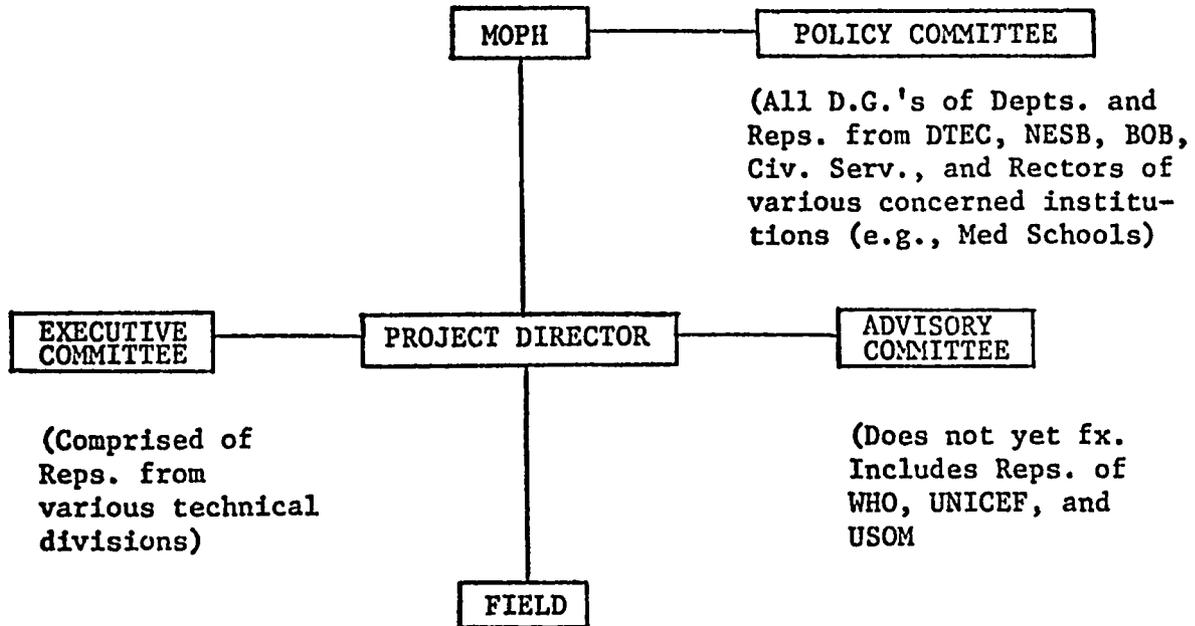
III. Relationships with Other Agencies, USOM, DTEC, Others

Shutt noted that there had been concern expressed by many about DTEC and USOM Project relationships. Some topics need open discussion and statement of intent on the part of this group. Shutt had talked with Jim Williams and determined that it was not USOM's desire to interfere with project activities. A problem emerges because there is an agreement between the Government of the U.S. and the TRG that all U.S. funded projects will be coordinated via DTEC.

The meeting was informed that all DTEC requires is an annual program review in which DTEC participates.

It is not part of the APHA contract to bring in or to coordinate with DTEC. USOM wants to participate ONLY TO THE EXTENT that agreement exists between USOM and DTEC.

Dr. Somboon said that the Lampang Project is a MOPH project. He presented the following T.O.:



Somboon said that quarterly reports are sent to the Executive Committee, the Policy Committee, and the Advisory Committee.

Somboon questioned whether USOM and DTEC might not be more explicit as they might be about their interests in the program.

Hood mentioned that Somboon has presented this chart to USOM.

Shutt offered to assist in resolving any misunderstandings with USOM

IV. Technical Aspects

Item IV.A Evaluation and NIDA Contacts.

Marnane spoke to the point of putting the task and cost analysis directly under the director rather than under evaluation. He said he was concerned with the evaluation group being responsible for too many things, their charge is too broad. As a beginning task and cost analysis might be placed within program management where it can be more closely monitored by those who are most directly concerned with applying the results. The program's management information system might be another aspect which might be placed in the Administrative Division.

LAMPANG PROJECT
SECOND ANNUAL ADMINISTRATIVE REVIEW
CHIENGMAI
26 November, 1976

AGENDA

I. Contracts & Financing

- A. Unexpended funds and exchange differential remaining from the 1974-1976 contract
- B. Budget details by category and line - 1976-1977
- C. Budget adjustments and phasing
- D. Annual budgets and transition - 1976-1977 and 1977-1978
- E. Project disbursement policies
- F. Project staff travel outside of Thailand

II. International Conference & Next Annual Review

III. Relationships with other agencies

IV. Technical Aspects

- A. Evaluation and NIDA contacts
- B. Family planning information
- C. Nutrition information
- D. Communicator Ratios
- E. Replication Timetable

At any rate, the responsibility for producing the task and cost analysis seems misplaced in NIDA since they have not been able to produce anything yet and they are not responsive to requests from the Project.

Dr. Paen noted his concern for the computer capacity at NIDA. He also suggested that the task and cost analyses be conducted by a directly hired person rather than subcontracted.

Item IV.B&C Nutrition and Family Planning Information.

Shutt noted that AID is interested in obtaining operational information in these areas.

Marnane reported that (based upon his discussions with Harold Rice) AID's Nutrition Office in Washington was prepared to provide assistance in determining nutrition levels in the Project area. Project personnel should follow up on this offer.

Item IV.D Ratios of Communicators.

Shutt suggested that it might be desirable to evaluate the effectiveness of different ratios of communicators/population.

There was a general discussion of plans to use health post volunteers in other areas.

Item IV.E Replication Timetable.

There was a brief discussion of plans for replication and Dr. Somboon pointed out that there was a timetable for replicating some aspects of the project in other areas.



Patrick J. H. Marnane

Appendix B



THE SGV GROUP
PHILIPPINES
TAIWAN
THAILAND
INDONESIA
MALAYSIA
SINGAPORE
KOREA
HONGKONG

SGV-NA THALANG & CO., LTD.

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U. S. A.

We have examined the statement of cash receipts and disbursements of the Thailand Project for Development and Evaluation of An Integrated Health Delivery System (DEIDS) for the two-year period from September 23, 1974 to September 30, 1976. Our examination was limited to funds granted by the American Public Health Association. Our examination was made in accordance with generally accepted auditing standards, and accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the statement referred to above presents fairly the cash receipts and disbursements of the DEIDS Thailand Project for the two-year period from September 23, 1974 to September 30, 1976.

The accompanying supplementary information are not necessary for a fair presentation of the statement of cash receipts and disbursements but are presented as additional financial data. These information have been subjected to the tests and other auditing procedures applied in the examination of the above-mentioned statement and, in our opinion, are fairly stated in all material respects in relation to the financial statement taken as a whole.

SGV-NA Thalung & Co. Ltd

November 15, 1976

DEVELOPMENT AND EVALUATION OF AN INTEGRATED
HEALTH DELIVERY SYSTEM
(DEIDS) THAILAND PROJECT
STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS
FOR THE PERIOD SEPTEMBER 23, 1974 TO SEPTEMBER 30, 1976

	FY 1974-75		FY 1975-76		Total	
	Baht	Translation into U. S. Dollars (Note 2)	Baht	Translation into U. S. Dollars (Note 2)	Baht	Translation into U. S. Dollars (Note 2)
CASH RECEIVED FROM AMERICAN PUBLIC HEALTH ASSOCIATION						
Funds received in accordance with the agreement budget between Royal Thai Government and American Public Health Association	5,670,147	279,411	7,623,951	374,712	13,294,098	654,123
Grants to DEIDS Thailand Project for vehicular support not included in the agreement budget between Royal Thai Government and American Public Health Association	69,016	3,400	203,470	10,000	272,486	13,400
Total Cash Receipts	5,739,163	282,811	7,827,421	384,712	13,566,584	667,523
CASH DISBURSEMENTS						
Budgeted Expenditures						
01 Salaries/allowances	2,701,762	133,136	3,172,133	155,948	5,873,895	289,084
02 Consultant (Honorarium)	84,500	4,164	343,000	16,863	427,500	21,027
03 Travel and transportation	103,210	5,086	179,183	8,809	282,393	13,895
04 Per diem/allowances	372,090	18,336	731,604	35,967	1,103,694	54,303
05 Honoraria for teachings, meetings and conferences	186,200	9,175	357,000	17,551	543,200	26,726
06 Other direct costs	183,731	9,054	1,022,036	50,245	1,205,767	59,299
07 Equipment	126,252	6,221	343,613	16,893	469,865	23,114
08 Materials and supplies	440,470	22,149	616,651	30,316	1,066,121	52,465
10 Training stipends	333,500	16,434	750,300	36,886	1,083,800	53,320
11 Repair and maintenance	242,648	11,957	634,252	31,181	876,900	43,138
12 Freight	14,746	727	13,158	647	27,904	1,374
Sub-Total	4,798,109	236,439	8,162,930	401,306	12,961,039	637,745
Vehicular Support Costs						
Ten Motorcycles	69,016	3,400	-	-	69,016	3,400
Two Pick-up Trucks	-	-	203,470	10,000	203,470	10,000
Sub-Total	69,016	3,400	203,470	10,000	272,486	13,400
Total Cash Disbursements	4,867,125	239,839	8,366,400	411,306	13,233,525	651,145
EXCESS OF CASH RECEIPTS OVER CASH DISBURSEMENTS	872,038	42,972	(538,979)	(26,594)	333,059	16,378

DEVELOPMENT AND EVALUATION OF AN
INTEGRATED HEALTH DELIVERY SYSTEM
NOTES TO STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS
FOR THE PERIOD FROM SEPTEMBER 23, 1974 TO SEPTEMBER 30, 1976

1. NATURE OF PROJECT AND OBJECTIVES

The Development and Evaluation of an Integrated Health Delivery System (DEIDS) - Thailand Project is an operations research undertaking conducted by the Thai Ministry of Public Health in collaboration with University of Hawaii.

DEIDS Thailand Project was established primarily to study the feasibility of a low-cost "integrated" health delivery system which could be replicated in other parts of Thailand. The northern part of Lampang was selected as the study area.

2. BASIS OF FINANCIAL STATEMENT

The statement of cash receipts and disbursements covers only the grant of American Public Health Association (APHA) to DEIDS Thailand Project.

The books of accounts are maintained on a cash basis at the project site. Cash receipts are recorded at the time these are actually received and disbursements are recognized upon actual payment in baht, the currency of Thailand where the project is located.

For financial statement purposes, local currency figures were translated into U.S. dollars on the following bases:

1. Baht receipts at the actual U.S. dollar equivalents released by APHA to the DEIDS Thailand Project.
2. Baht expenditures and fund balances at the weighted average rate of exchanges, calculated by dividing all U.S. dollar receipts during the period by the total equivalent baht receipts, which are as follows:

For the year ended September 30, 1975	- Baht 20.2933
For the year ended September 30, 1976	- Baht 20.3409

The translation into U.S. dollars should not be construed as representations that the Thai baht have been, could have been, or could in the future be, converted into United States dollars at the same exchange rates.

3. EQUIPMENT

Certain equipment with a total cost of US\$ 16,526 are not included in the Statement of Cash Receipts and Disbursements. As these were purchased directly by APHA out of budgeted funds not released to the DEIDS Project. For purposes of comparing actual expenditures against budget, however, the costs of these equipment have been included in the Schedule of Expenditures in the accompanying Supplementary Information.

4. RECLASSIFICATION OF ACCOUNTS

Certain accounts in last year's statement of cash receipts and disbursements were reclassified to conform with this year's presentation.

DEVELOPMENT AND EVALUATION OF AN
INTEGRATED HEALTH DELIVERY SYSTEM
(DEIDS) THAILAND PROJECT
SUPPLEMENTARY INFORMATION

A. Fund Balance - Bht. 333,059 (US\$ 16,378)

The fund balance as of September 30, 1976 represented the Project's current account balance with the Siam Commercial Bank - Lampang Branch. This unexpended funds represent about 2% of the total budget of the Project and about 3% of the total budgeted funds released by APHA to the Project.

B. Cash Receipts from APHA - Bht. 13,566,584 (US\$ 667,523)

The DEIDS Project's main source of funding are grants from APHA of the United States. The details of funds received by the Project from APHA are as follows:

<u>Date</u>	<u>In U.S. Dollars</u>	<u>In Thailand Baht</u>
<u>For Budgeted Expenditures</u>		
November 11, 1974	\$ 21,885	Bht. 444,235
November 13, 1974	32,000	648,000
January 28, 1975	41,799	848,490
March 25, 1975	15,261	309,768
April 2, 1975	18,136	368,131
May 6, 1975	27,445	557,108
May 26, 1975	23,571	478,461
June 25, 1975	24,609	499,533
July 28, 1975	27,855	565,426
August 28, 1975	25,537	518,371
September 25, 1975	21,313	432,624
October 17, 1975	20,957	425,397
December 3, 1975	22,225	452,249
December 18, 1975	26,651	542,318
January 28, 1976	23,562	479,457
February 20, 1976	31,774	646,571
March 23, 1976	34,410	700,213
April 23, 1976	36,082	734,239
May 19, 1976	29,859	607,601
June 22, 1976	27,775	565,191
August 10, 1976	33,518	682,061
August 26, 1976	36,166	735,948
September 20, 1976	25,000	508,720
September 24, 1976	26,733	543,986
Sub-Total	\$ <u>654,123</u>	Bht. <u>13,294,098</u>

<u>Date</u>	<u>In U.S. Dollars</u>	<u>In Thailand Baht</u>
<u>For Vehicular Support</u>		
May 6, 1975	\$ 3,400	Bht. 69,016
May 17, 1976	<u>10,000</u>	<u>203,470</u>
Sub-Total	<u>13,400</u>	<u>272,486</u>
Grand Total	\$ <u>567,523</u>	Bht. <u>13,566,584</u>

Out of the agreed budget of US\$ 733,198, the Project received from APHA a total of 654,123 during the two-year period, or about 89% of the total budget.

C. Cash Disbursements - Bht. 12,961,039 (US\$ 637,745)

These represent cash expenditures incurred by the project. Presented in Schedule 1 are the details of the actual expenditures for the two-year period up to September 30, 1976, (including budgeted expenditures disbursed directly by APHA) as compared with the total budget for the same period.

D. Equipment and Vehicles - Bht. 469,865 (US\$ 23,114)

This represents only the cost of fixed assets acquired by DEIDS during the period and includes the costs of telephone installation, xerox rental and miscellaneous supplies. A reconciliation of the baht expenditures under the budget component "Equipment and Vehicles" with the actual property and equipment procured by the DEIDS project and through APHA is presented in Schedule 2.

E. Unpaid Liabilities - Bht. 30,528 (US\$ 1,501)

As of September 30, 1976 the DEIDS project had unpaid liabilities estimated at Bht. 30,528 (US\$ 1,501). Details of these liabilities are shown in Schedule 3.

DEVELOPMENT AND EVALUATION OF
AN INTEGRATED HEALTH DELIVERY SYSTEM
(DEIDS) THAILAND PROJECT
SCHEDULE OF BUDGETED AND ACTUAL EXPENDITURES
FOR THE PERIOD SEPTEMBER 23, 1974 TO SEPTEMBER 30, 1976
(In U S Dollars)

Budget Code	Budget Item	ACTUAL EXPENDITURES			Budget	Variance	
		Paid up to September 30, 1975	Paid up to September 30, 1976	Total		Over (Under) Budget	%
01	Salaries/allowances	\$ 133,136	\$ 155,948	\$ 289,084	\$ 307,594	\$ (18,510)	(6.0)
02	Consultant (Honorarium)	4,164	16,863	21,027	20,550	477	2.3
03	Travel and transportation	5,086	8,809	13,895	36,860	(22,965)	(62.3)
04	Perdiem/allowances	18,336	35,967	54,303	54,750	(447)	0.8)
05	Honoraria for teachings, meetings and conferences	9,175	17,551	26,726	40,000	(13,274)	(33.2)
06	Other direct costs	9,054	50,245	59,299	64,300	(5,001)	(7.8)
07	Equipment *	8,364	31,276	39,640	40,919	(1,279)	(3.1)
08	Vehicles	-	-	-	900	(900)	(100.0)
09	Materials and supplies	22,149	30,316	52,465	54,950	(2,485)	(4.5)
10	Training stipends	16,434	36,886	53,320	67,375	(14,055)	(20.9)
11	Repair and maintenance	11,957	31,181	43,138	40,000	3,138	7.8
12	Freight	727	647	1,374	5,000	(3,626)	(72.5)
	Total	\$ 238,582	\$ 415,689	\$ 654,271	\$ 733,198	\$ (78,927)	(10.8)

* The amount in US dollars includes equipment procured directly by APHA for DEIDS Thailand Project per agreement budget as follow

FY 1974-75	US\$ 2,143
FY 1975-76	US\$ <u>14,383</u>
Total	US\$ <u>16,526</u>

SCHEDULE 2

DEVELOPMENT AND EVALUATION OF
AN INTEGRATED HEALTH DELIVERY SYSTEM
(DEIDS) THAILAND PROJECT
SCHEDULE OF EQUIPMENT
SEPTEMBER 30, 1976

Division	Per Agreement Budget		Vehicular Support		Total
	Locally Purchased	Purchased by APHA	Shipped by University of Hawaii	Reimbursed by APHA	
Administrative Services	\$ 4,060	\$ 793	\$ -	\$ -	\$ 4,853
Personnel Development	743	2,837	-	-	3,580
U.S. Counterpart Office	732	567	4,900	-	6,199
Medical and Health Services	5,615	4,085	4,900	5,000	19,600
Information, Research and Evaluation	919	1,013	-	1,020	2,952
Midwifery School	644	6,500	-	-	7,144
Field Director Office	66	731	3,318	5,000	9,115
Health Centers at Hangchat	-	-	-	2,380	2,380
Total	\$ <u>12,779</u>	\$ <u>16,526</u>	\$ <u>13,118</u>	\$ <u>13,400</u>	\$ <u>55,823</u>

RECONCILIATION WITH STATEMENT OF CASH RECEIPTS
AND DISBURSEMENTS :

Total equipment as per above		\$ 55,823
Deduct equipment expenditures not paid out of Baht funds:		
Equipment purchased directly by APHA	\$ 16,526	
Vehicular support from University of Hawaii	13,118	
Cost of vehicles reimbursed by APHA	<u>13,400</u>	(43,044)
Add Baht expenditures for supplies and services:		
Xerox rental	\$ 5,845	
Cost of telephone installation	188	
Miscellaneous	<u>4,302</u>	<u>10,335</u>
Total Baht Expenditures for Equipment		\$ <u>23,114</u>

SCHEDULE 3

DEVELOPMENT AND EVALUATION OF AN INTEGRATED
HEALTH DELIVERY SYSTEM
(DEIDS) THAILAND PROJECT
SCHEDULE OF UNPAID LIABILITIES
SEPTEMBER 30, 1976

<u>Budget Code</u>	<u>Budget Item/Particulars</u>	<u>Baht</u>	<u>Translation into US Dollars</u>
03	Travel and transportation	Bht. 686	\$ 34
04	Perdiem/allowances	1,600	79
05	Honoraria for teachings, meetings and conferences	6,200	305
06	Other direct costs	7,539	371
09	Materials and supplies	14,473	711
11	Repair and maintenance	<u>30</u>	<u>1</u>
	Total	<u><u>30,528</u></u>	<u><u>1,501</u></u>

SUMMARY OF PRINCIPAL AUDITING PROCEDURES

As set forth in the first paragraph of our report, our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances. Such tests and auditing procedures were applied with due consideration to our evaluation of the existing system of internal check and control of DEIDS Thailand Project.

Presented below are our brief comments on the application of these tests and procedures.

1. The cash in bank was confirmed directly to us by the Siam Commercial Bank - Lampang Branch.
2. Equipment of the Project was physically inspected on a test-basis. The acquisition costs of these equipment were vouched against the pertinent supporting documents.
3. Unpaid liabilities as at September 30, 1976 were vouched against suppliers' invoices and related supporting documents.
4. Documents supporting the receipts and expenditures of grants were examined on a test-basis as deemed necessary, having regard to the existing system of internal check and control.

LAMPANG HEALTH DEVELOPMENT PROJECT
NINTH QUARTERLY PROGRESS REPORT

(October 1 to December 31, 1976)

Introduction

At the beginning of October, there was a brief lull in project activity while awaiting the new project budget, and as project staff prepared for the second Annual Review. But as the quarter progressed, all components returned to full-scale operation aimed at making rapid progress in the additional six districts to be covered by expanded implementation.

Project Inputs

A. Volunteer Training and Deployment

1. During the ninth quarter, the Personnel Development Division began an intensive schedule of training of community volunteers, beginning with Muang District. During these three months, 45 health post volunteers and 888 health communicators were trained and returned to the villages in the Muang District (traditional midwives had been trained prior to the end of the eighth quarter).

2. During the quarter, Dr. Pricha Desavasi, the Project Field Director, and Dr. Choomnoom Promkutkao, the Head of the Division of Personnel Development, travelled to a training center outside of Bangkok to take part in a Ministry of Public Health Seminar for planning the training and placement of village health volunteers in other areas of the country. The Ministry plans to train Health Post Volunteers and Health Communicators in a large number of provinces during the Ministry's next development plan covering period of 1977-1981; the seminar was therefore arranged to consider training methodologies and job roles for these volunteers. The Training Division of the Ministry had already planned certain training packages, which are basically programmed learning packets which will be handed out to the prospective Health Post Volunteers to study on their own. Lampang Project staff raised the question of how provincial health staff in any province can assure that the Health Post Volunteers will indeed study the packages handed out, as well as how much of the content will be absorbed if they do study them. At the same time, there were questions raised about the support and management for these volunteers. At the seminar's final session, chaired at the participants' request by Dr. Somboon Vachrotai, the Lampang Project Director, it was agreed that in some areas (about 80 districts) where HPVs will be trained, the Lampang Project model will be followed.

3. As a result of discussions during the Annual Review, the Planning and Programming Division has decided to test different mixes of volunteer placement in several areas in the E₂ implementation areas. The ratio of Health Communicators to Health Post²Volunteers will be varied, and some areas no Health Communicators will be trained at all.

B. Wechakorn

Selection of the candidates for wechakorn training, and opening sessions for the second class took place during the ninth quarter. Rather than select wechakorn candidates specifically from one district as has been done for Hang Chat, all potential candidates in the province were screened and interviewed by the selection committee at one time. The selection committee then reviewed all applicants and decided which people would be trained in the subsequent training groups. In this way, selection will not need to be done repeatedly in the future, and a full complement of candidates can be planned in advance for the next two groups.

The second wechakorn group comprises 26 trainees - 4 nurses (two from the Provincial Hospital, one from the Provincial Chief Medical Office, and one from the Jae Hom District Health Center), 12 sanitarians, and 10 midwives. This group of 26 is somewhat larger than the first group (15), but because of the planned schedule of implementation, it is necessary to expand the size of classes to complete all training by the end of the project.

The wechakorn curriculum has been presented to the Civil Service Commission, and a team from the Commission will be visiting the Project early in the tenth quarter to look at training and work activities first-hand, and to make the final decision concerning salary increases that will be provided for those who complete training.

Also in group of 26 volunteers is one trainee from Samerng District of Chiangmai Province. This trainee will receive a year of wechakorn training, and will return to Samerng District to take part in the integrated health project that has been established in Chiangmai Province.

C. As implementation in the E₂ area was expanded, village health committees were set up in 8 tambols and 28 villages of Muang District, and health volunteers were selected for training. At the same time, a supply and supervision network was developed for volunteers as they finished their training program, and orientation programs for health center staff in each district were completed.

D. In order to better integrate the province's special communicable disease activities into project operations, a meeting of program supervisors from leprosy control, TB control, malaria eradication units was arranged to clarify roles and plan for improved cooperation and communication.

E. Private Sector Involvement

Project staff have continued discussions of possible avenues for private sector involvement, and a meeting of a variety of representatives from drug stores, private clinics and hospitals is being planned for mid-January, 1977. Preliminary discussions with private sector providers have been held, and the meeting should identify specific cooperative activities of mutual benefit.

F. Annual Review

As important event in the middle of the quarter was the Second Annual Review, held in Lampang and attended by a large number of Thais from many institutions and agencies, and as well as by a number of outside participants from international agencies and the collaborating institutions. As in 1975, the Annual Review was broken into two parts; the first three days were a technical review for all participants, and the final two days were an administrative review for representatives of the collaborating agencies directly involved in project operations. Unlike 1975, however, during the technical review the main group did not split into separate units to consider each area of project operations. Instead, all participants remained in a large plenary body and considered each area of project operations sequentially: field operations, training, and evaluation. During the Annual Review, the Representative of UNICEF to Thailand turned over seven Suzuki jeep-like vehicles to the Project. Dr. V.T. Gunaratne, the WHO Regional Director for SEARO, made a presentation concerning primary health care as part of a more general discussion of that subject.

One outcome of the review was a decision to hold a small administrative review session for members of the collaborating agencies twice each year so that planning and problem solving can be facilitated conveniently. The next meeting is planned for March or April 1977.

G. Project Evaluation

After completion of the Annual Review, the Project Evaluation Board met to consider a number of issues that has been raised before and during the Review. As result of these discussions, a number of decisions were made concerning further project evaluation. Among these were:

1. Sampling for the Community Health Survey in the E₂ Area

After reviewing the recommendations of recent evaluation consultants, Dr. Prachoom Suwattce of NIDA presented an alternative sampling design for consideration. In the alternative design, sampling will be done in two stages. In the first stage, approximately sixty villages (from a total of 422) will be drawn from the experimental districts by stratified random sampling. These villages will be divided into two strata, one with health facilities and other without health facilities. The sample will contain 20 villages from the first stratum and 40 villages from the second stratum, which is approximately proportional to the general distribution of villages with and without health facilities, respectively. The number of villages drawn from each district will be selected in proportion to the total number of households in the district. In the second stage, instead of the original plan to stratify the sample according to household size, a simple random sample of households in each village will be drawn in proportion to the total number of households in the district. The total number of sample households from each district is shown in the following table:

District	No. of households in the 2nd stage sample
Ko Kha	488
Mae Prik	127
Muang	1,225
Serm Ngam	226
Sob Prab	185
Thern	414
TOTAL	2,665

The Evaluation Board agreed that the alternative sampling design is the one that should be used, since it will simplify both household selection and data analysis.

2. Nutrition Survey

After reviewing the results and timing of the first round Dental and Nutrition Survey (done by the Nutrition Division, Ministry of Public Health), Evaluation staff have come to several conclusions:

- a. The dental portion of the survey is not crucial to project evaluation needs, and will be eliminated.
- b. In order to facilitate the timely output and analysis of data, the nutrition survey methodology must be simplified. The data most important to project evaluation needs in assessing pre-school child nutritional status are age, height, and weight. These three data items will therefore be collected to assess (cross-sectionally) pre-school child nutritional status.
- c. This data will be collected as part of the Community Health Survey by interviewers during the course of their household visits. Therefore, a brief additional nutrition form will be added to the Community Health Survey instrument. In each household included in the sample, whenever a pre-school child is encountered, the height/weight measurements will be made and entered on the nutrition form as a part of the complete Community Health Survey questionnaire.
- d. The sampling method to use most conveniently would be to simply include all children encountered in the general community health survey sample. Estimating the potential sample size based on pre-school child proportion of the population in Hang Chat (approximately 12% of the total population), a sample size of approximately 1,500 children under six years of age might be expected in the six districts comprising E₂.

3. A household listing (and mapping) has been carried out in the six E₂ districts in preparation for baseline surveys which should begin during the middle of the next quarter.

4. Peter Kunstadter of the East-West Center, consulted with the Evaluation staff in November concerning analysis of survey data, primarily from the Community Health Survey (see enclosed report).

H. Organization Development

As a part of the follow up to the earlier Project Management Seminars, Professor Nit Sarnaphan from NIDA's School of Business Administration made several consultation visits to the Project as part of his organization development inputs. After interviewing most provincial health officials and Project staff to gather information about project operations and management, Professor Nit organized feedback sessions. He will also extend his activities to include team-building training sessions during the next quarter, which will aim at improving cooperation and teamwork among the provincial health and Project staffs.

I. During October, Dr. Somboon Vachrotai, the Project Director, and Dr. Ronald Wilson, University of Hawaii School of Public Health, Chief-of-Party, travelled to the Miami to jointly present a paper at the APHA Annual Meeting, and to take part in administrative discussions with other members of the collaborating agencies.

J. Dan and Lalit Kraushaar, CARE staff from the Health Development Project in Solo, Indonesia, visited the Project in early December to review experiences in Lampung as part of the final planning process for their own project.

Problems Encountered

A. A number of lingering problems related to performance by NIDA evaluation staff have been resolved by senior NIDA faculty. After a series of internal meetings aimed at constructive criticism, several personnel shifts have been made which should smooth future NIDA contributions.

B. Two areas of field operations which are receiving renewed emphasis are village committee participation and coordination between the village volunteers and health center staff. Village coordinating committees have participated in selecting volunteers, but have been less active in support activities. Project staff are seeking to stimulate increased initiative by the committees.

Realizing that the key to volunteer performance is regular support and encouragement from the local government health workers, Project staff are considering a variety of practical measures designed to foster improved support for volunteers, yet not overburden health center staff.

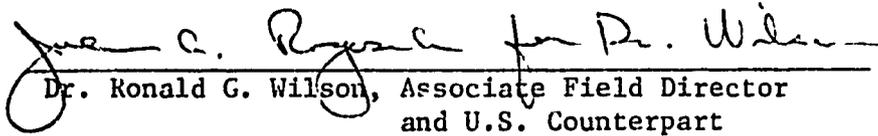
Conclusion

After several months' review of project operational problems and constraints, a number of corrective measures have been taken and are being planned. The experiences gained in the Project's first two years should help to reduce constraints in the six expansion districts.

Signed:



Dr. Pricha Desawadi, Field Director



Dr. Ronald G. Wilson, Associate Field Director
and U.S. Counterpart



Dr. Somboon Vachrotai, Project Director

Encl: Dr. Kunstadter's Report

EAST-WEST POPULATION INSTITUTE
East-West Center
1777 East-West Road
Honolulu, Hawaii 96822

MEMORANDUM

November 5, 1976

TO : Lampang Health Development Project (DEIDS/Thailand)

FROM : Peter Kunstadter, Ph.D., Research Associate,
East-West Population Institute

SUBJECT: Consultant Report on Activities of the Evaluation Division
with Respect to Community Surveys (including nutrition,
physical examination and food habits surveys),
2-5 November 1976

General Comments and Recommendations on Acquiring, Processing, Analysing, Interpreting and Using Data from the Community Surveys

1. Sample is often too small for drawing a quantitative baseline on a number of important topics, for example infant and child growth as a general index of target population nutritional status.

Recommendations - Sampling system should be revised prior to investigations in E₂ area to ensure adequate sample size for the intended purposes. Despite the small size, all available data should be used for program planning where possible, and at least for planning the next round of surveys.

2. Sample design of two stages (random sample of villages within the administrative unit, random sample of households within various size groups) has introduced as yet unanalysed biases into the frequencies derived from the initial surveys, and was based on the assumption that it would result in a higher number of "target" individuals in the sample. It has yet to be demonstrated that this assumption is correct, and the second stage sampling procedure has apparently introduced numerous problems resulting in lengthy delays in data processing, requiring special programs at every stage of data analysis and making the tabulations difficult to interpret directly.

Recommendation - The rationale for using the two stage sampling design should be reconsidered. Comparability with the original pilot study areas may not be a sufficient justification for continuing this procedure which has proven cumbersome, costly, and extremely time-consuming. The alternatives of random sampling of households, or random sampling of households with target individuals (identified on the basis of preliminary household listing) should be considered.

3. Reliability and validity of observations. The pilot studies in the first area (Hang Chat) did not include a routine check for reliability by follow-up interviews, therefore there is no measure of reliability attached to the various responses and measurements; no attempt has yet been made to compare observations on the same subject from independent sources, no attempt has yet been made to follow-up on apparently anomalous observations.

Recommendation - A resurvey of an appropriate number of households/individuals should be conducted to demonstrate an acceptable level of reliability in these surveys and to estimate measurement errors to the extent possible in E_1 and routinely in E_2 .

Examples: Reinterview to determine reliability of response to questions on recent illness, examine sample of relevant clinic records to compare reported date and nature of illness, compare Kamnan household registry records, survey results, and (eventually) village health volunteer records (see reports on "Survey of Population Change, "National Statistical Office, for comments on methodology and interpretation), re-examine blood specimens or draw new ones with reported hemoglobin over 18 grams; recheck maternal age and child birth date for children recorded as if they were born to mothers age 8-14 (in Table Hc.103, women age 15-44 in 1975 were reported to have given birth in to 47 children between 1939 and 1944 when they would have been only 8-13 years old), etc.

4. Data presentation. Presentation of the data at present is complicated by the format of the tables and in some cases by their content. Tables will be difficult to interpret for those who are not familiar in detail with the operations of the project's data processing.

Recommendation - A brief statement summarizing the nature of the data and the methods by which they were gathered and processed should be prepared to accompany any tabulations of these data which are made public. The statement should include a description of the study population and location, a description of the sampling method, interviewing techniques, coding instructions, data processing and data weighting. Readers should be informed of the total numbers of respondents in each tabulation (as well as the estimated values for the whole population, which are now the only figures given in the community survey tabulations). To the extent possible in the future the actual numbers of responses should be given, as well as percentages or rates.

The percentages given in the present tables are often inappropriate for the uses to which the tabulations may be put. Often a more appropriate statistic would refer to rates per person at risk, rather than percentage of respondents in row or column. Given the sampling and weighting procedures of the initial stage surveys this may be difficult to do, and is one reason for preferring a random sample, unstratified, within the sample villages.

Statistics which are presented sometimes do not conform to standard usage for example with respect to demographic rates. The present tabulation of age specific fertility apparently refers only to marital fertility (Table Hc.104), which will create a major distortion in estimating general or total fertility. Unmarried women should be added to the denominator where appropriate to determine the rate.

5. Evaluation of the evaluation system. The initial surveys were designed as a means of constructing an information system appropriate to this project. The first surveys were thus "pilot studies" and can be used to redesign subsequent surveys. They contain a considerable amount of redundancy which should be eliminated in the next round of surveys, but this cannot be done without a careful

examination and evaluation of each question in relation to the general purpose of the project, with the intention of eliminating those items which are unnecessary. Reduction of the bulk of the data, as well as greatly reducing the time between data collection and the publication of results is essential if this portion of the project is to have any impact on the project design, management and replication.

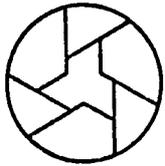
Recommendations - Review each item of the surveys with the intention of eliminating those which are unnecessary; select the minimum number of indices for the purposes required (specific examples are given below).

6. Administration of data processing and analysis. Time lag between data collection and presentation in useable form is much too long. Original data in the form of marginal totals are not available in Lampang. Original data in a form which could be manipulated with simple equipment (e.g., punch cards which could be used with a counter-sorter) are not available in Lampang.

Recommendations - The data analysis system should be re-examined in its entirety with a view toward simplification and return of direct control over the original data to the Lampang office and Lampang administration. Original data should be present in Lampang in the following forms: data listing for each interview in coded form; marginal totals for all tabulations in the form of actual numbers of responses (not weighted projections to the total population); punched cards in appropriate series (a series developed for each of the major areas of concern) which can be manipulated with simple, locally available equipment (card punch, sorter counter or tabulator).

A direct link should be established between the project and the data analysis. Professional data analysts, at the doctoral level, should be made directly responsible to the project administration, and should be physically present in Lampang for extended periods, so as to become intimately familiar with the details of the project operation and with the needs of project management. As much data processing as possible should be done in Lampang, by hand tabulation if necessary. Prompt and effective data analysis will require the assignment of several professionals for an extended period, starting as soon as possible (a) to complete the analysis and interpretation of the already completed surveys; (b) to modify the design of future surveys in light of experience gained to date; (c) to interpret research results in terms of project planning and management implications; (d) to analyse and interpret results of future surveys; (e) to follow-up with special investigations questions of particular scientific or program interest (e.g., epidemiology of anemia; historical circumstances of fertility decline). Several distinct areas of expertise are required in terms of methodological and technical skills, and knowledge of substance: biostatistics and epidemiology, computer data processing, medical sociology/anthropology (with special reference to Thailand), demography/family planning, maternal/child health and nutrition, infectious disease epidemiology. In order to get the necessary jobs done, it will probably be necessary to acquire three or more persons who together combine the necessary skills. Various alternatives should be explored for obtaining the services of such people (direct hire, contract for a specific period, contract for a specific series of jobs, etc.), and the persons acquired as soon as possible, to work under the direction and with the coordination of a responsible member of the project administration.

The ultimate aim of the acquisition and analysis of the data must be kept in mind, as stated in the Evaluation Plan -- to design a data acquisition system which will contribute directly to the management of the project and the achievement of project objectives (improving access to health services, improving health in specific areas of concern, improving cost-effectiveness, using data to modify project operations as appropriate).



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WORLD HEALTH ORGANIZATION
INTERNATIONAL CONFERENCE
ON THE
PROMOTION OF NATIONAL HEALTH SERVICES
AND
PRIMARY HEALTH CARE

Geneva Trip Report
(January 17-21, 1977)
by
Russell E. Morgan, Jr.
Senior Health Specialist
APHA/International Health Programs

Purpose of Trip:

The purpose of Mr. Morgan's trip was to "ascertain WHO's current plans for conference activities in preparation for the 1978 Alma Ata Conference".

Summary:

WHO has now committed itself by Executive Board action (Jan. 18, 1977) to budget \$2.2 m. for the International Primary Health Conference in Alma Ata, Russia. This does not include an estimated \$2.3 to \$2.5 m. of anticipated additional expenses which will be required to carry out the important pre-conference activities in each of the six regions.

APIHA with its current conference resources (manpower and finances) is working directly with WHO-Geneva, the Regional offices, member governments and several non-governmental groups in identifying where their technical

assistance (i.e. consultants supported by APHA) would be most beneficial in assuring the successful implementation of the pre-conference plans. APHA has developed a written agreement with PAHO, and staff activities are currently underway to develop similar arrangements with other regions.

AID should review this expanded conference role which they have asked APHA to assume, and determine whether the current level of APHA resources is sufficient to meet the increased demands.

Background:

In May 1976 when the DEIDS contract was signed between AID and APHA, in Article I-B-6 it states that APHA will undertake Conference Management Activities designed to stimulate and promote information exchange regarding the development of low-cost health delivery systems in developing countries.

By August 1976 APHA submitted to AID a proposal for carrying out these conference activities. In the meantime, however, the WHO Assembly in their May 1976 meeting decided to request WHO to sponsor an International Conference on Primary Health Care (PHC) in Russia in 1978.

In September 1976 APHA attended the AID-WHO coordination meeting in Geneva, where AID suggested that U.S. assistance to WHO for the implementation of the PHC conference activities would come, at least in part, from its contract with APHA. (refer. minutes AID-WHO Coordination Meeting - 1976). As such, APHA initiated discussions with WHO staff.

These discussions were followed up with more detailed talks in Miami in October 1977 - with Dr. David Tejada, ADG - who has overall responsibility for the WHO conference in Russia. At that time a strategy was agreed upon whereby APHA would work directly with the WHO regional offices while keeping in regular contact with WHO-Geneva.

It was at this point that the DEIDS Contract Objectives and those supporting the WHO pre-conference activities, became merged.

During the month of November and December 1977, APHA staff, together with the World Federation of Public Health Associations (which is a non-governmental organization in official relations with WHO) agreed to collaborate in supporting the WHO regional conference plans. As such, the first initiative was made with the PAN AMERICAN HEALTH ORGANIZATION (PAHO) - WHO regional office for the Americas. A series of five (5) meetings were held between the PAHO and APHA/WFPHA representatives. This resulted in some reorganization of the PAHO-PHC pre-conference activities including format, timetable and types of participants. A specific written agreement was also reached between the two groups identifying the assistance role of APHA/WFPHA.

[Note: Because of the general uncertainty of the amount of financial resources which could actually be made by AID to APHA for conference support - APHA decided to negotiate strictly on the basis that "conference assistance" was defined as technical consultants who directly assisted the regional WHO office or the national government in the implementation of their regional PHC pre-conference plan.]

It was decided, because of the successful negotiations with PAHO that APHA/WFPHA should meet with the other WHO Regional Directors (RD) to see if APHA "conference assistance" might also be helpful to them. Therefore, since all the RD's were in Geneva in January 1977 at the WHO Executive Board meeting - this was considered an ideal time to initiate such discussions.

Activities in Geneva:

Prior to going to Geneva, the President of the WFPHA sent personal letters to each of the following WHO Regional Directors (WPRO, SEARO, EMRO and AFRO) explaining the interest of APHA/WFPHA and requesting interviews with Mr. Morgan when he was in Geneva. Similarly notices were sent from the WHO coordination office in New York.

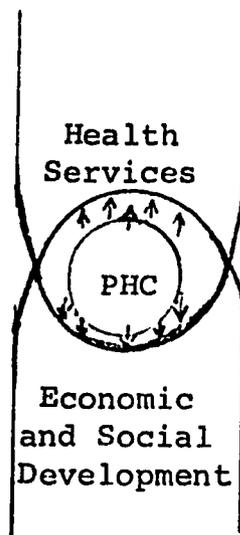
The Geneva Secretariat of the WFPHA organized the initial appointments. A list of all persons interviewed (Attachment A) and of the timetable for the week (Attachment B) are located at the end of the report.

WHO Executive Board Action:

The timing of the trip was ideal since the PHC conference agenda item (#13) was discussed by the Executive Board on Tuesday, January 18th.

In preparation for the discussions, the WHO staff organized, the evening before, a Progress Report on the PHC Conference activities (EB 59/INF. DOC. NO.4) which is found in Attachment C.

During Mr. Morgan's Monday meeting with Dr. Tejada it was explained that PHC should be viewed in 2 ways - in one way PHC is the basic-entry point for health services, in another it is an entry point for integrating health and the community into the development process.



Dr. Tejada emphasized that the "PHC worker" is a general development worker; this may even be a housewife. He was concerned that PAHO looked only at PHC as a base line for health services - and he asked that APHA input try to stimulate the acceptance of the 2 part approach to PHC.

The Executive Board (EB) discussions on the PHC Conference issue were very heated. Dr. D. D. Venediktov, Russian delegate, suggested that WHO had modified the conference plan since its original conception. He personally attacked Dr. Newell who he asked to define PHC and the WHO-PHC program.

Many of the EB members were concerned that WHO was proposing to spend \$2.2 million on a conference in Russia and perhaps as much as \$2.5 million on pre-conference activities at the regional level - at a time when the EB was cutting the overall operating budget of WHO by approximately 20%. To some members the cost/benefit of spending nearly \$5 million to "educate" and "politicize" 500 world leaders had questionable merit.

Dr. Mahler explained that of the 1000+ participants, nearly 450 were WHO staff responsible for translation and simultaneous interpretation into 5 official languages.

Several EB members proposed cutting down the size of WHO sponsored government delegates from 3 to 1. This was not approved.

The question of where the financial resources would come from to support the conference was continually kept muddled by the WHO staff, and Dr. Mahler said only UNICEF had made a firm financial commitment in writing. Therefore the entire conference burden was being placed in the WHO budget as a special item under comprehensive health service development.

In the end the Chairman made the following resolutions which were passed by the EB:

1. that \$2.1 million be budgeted for the PHC Conference in Russia; (the \$100,000 UNICEF contribution was deducted);
2. that the Director General make a general appeal to all member states for "voluntary contributions" to assist with the support of the Conference, particularly regarding travel funds;
3. that the date of September 6, 1978 be accepted. (Note: afterwards the DG together with the RD's and Dr. Venediktov were to meet on Feb. 1-2, to finalize the date.)

In general the Russian delegate was not pleased with the way WHO had been handling the Conference activities and at times it seemed as though Russia was questioning whether the Conference should still be held there.

Sources of Finance:

From responses made by the WHO staff in the EB meeting, and from further discussions with Mr. Furth and Dr. Tejada, it became clear that although WHO had budgeted the \$2.2 million (note breakdown on the back of the Status Report), only part of it was presently committed. The following table summarized the current status of financial support:

TABLE 1

Financial Status (January 1977) for
WHO-PHC Conference in September 1978

Item	I		II	III	Total
	Pre-Conference		International Conference	Post Conference (Geneva)	
	Regional	Geneva (7 mos.)	Russia		
Est. Costs	\$2.3-2.5m.	\$311,000	\$1.8m.	\$93,000	\$4.5-4.7m.
Est. Sources					
1. UNICEF	\$250,000		\$100,000		\$350,000
2. WORLD BANK (rep'd by Tejada)	\$500,000-750,000 (for rural PHC)				\$500,000-750,000
3. WHO Sp. Fund & Regional Offices	?		?		
4. UNDP	?		?		
5. Other Bi-lateral or Multi-lateral	?		?		
6. Others	?		?		

The UNICEF donation of \$350,000 is a firm agreement. UNICEF is also hiring a full-time person to be their coordinator, and in each country the UNICEF office has been asked to assign a liaison person to work with the WHO-Country Representative.

The World Bank offer of \$500-750,000 to support pre-conference activities is, according to Dr. Tejada, being negotiated and will be earmarked to assist pre-conference activities related to PHC and rural development.

The actual budgetary resources which WHO has set aside using its own funds is not available. Apparently, however, several full-time staff persons will be employed.

Other financial resources were not mentioned, but undoubtedly now that the EB has approved the \$2.2 million the DG will make a special appeal to multilateral and bilateral agencies.

The input of Russia still remains questionable and Dr. Venediktov mentioned that the USSR will bear expenses agreed upon such as:

1. Pay for all participant (government and WHO) hotel rooms;
2. Provide meeting place;
3. Provide complementary services, such as technical equipment;
4. Pay for the difference in travel to Alma Ata by giving a 30% discount on Aeroflot;
5. Provide participants with travel facilities for field trips to neighboring towns.

Overall PHC Conference Plan .

The overall WHO-PHC Conference Plan consists of basically three parts: 1) Pre-Conference activities; 2) the International Conference in Russia; and 3) Post-Conference activities.

1. Pre-Conference Activities

The pre-conference activities include a series of conferences, meetings, technical discussions in each of the six WHO regions to identify the current "state of the art"

of PHC. These reports together with reports from NGO (non-governmental organization) meetings and from the WHO-Geneva reports will then be assembled by WHO-Geneva into a single 500-page working document for the conference known as the "Director General's Report". WHO expects to distribute this in July 1978 to all participants.

2. International PHC-Conference - Alma Ata

The WHO Conference will begin, as presently scheduled, on Wednesday, September 6, 1978 and last for seven days. The format for the meeting will include:

- Day 1 - Wednesday - Review of D.G. Report
(Sept. 6)

- Day 2-3-4 - Thursday, - Three Separate Discussion Groups
Friday, and 1. Health & Development
Saturday 2. Technology
(morning) 3. Administration/Organization

- Day 4 and 5 - - Field Trip - Staff prepare
Saturday draft report
(afternoon)
and Sunday

- Day 6 - Monday - Finalize Discussion Group opinions

- Day 7 - Tuesday - Conference Recommendations
(Sept. 13)
 - 1. For Member Countries
 - 2. For WHO
 - 3. For Others - bilateral,
and multilateral, NGO's,
etc.

The final report will be 250 pages.

3. Post-Conference

WHO staff will prepare a 100-page report summarizing the Conference and specifically outlining the recommendations to WHO and the proposed next steps. This document will then be presented at the 1977 WHO Assembly.

The diagram on the next page illustrates the time-frame and sequence of activities.

Regional Pre-Conference Activities

In general, it appears that most of the Regional Offices, with the exception of PAHO and AFRO, were waiting until the EB meeting before fully developing their pre-conference plans. This same approach/attitude seemed to also occur in the WHO-Geneva office. (e.g., Special conference staff had not yet been hired or transferred from other departments.)

1. PAHO

Dr. Hector Acuna and his PAHO staff have the most organized conference plan of any region. APHA/WFPHA staff have worked with them as this plan developed. It consists of three parts: 1) Technical Discussion; 2) National Review; and 3) Ministers' Policy Conference.

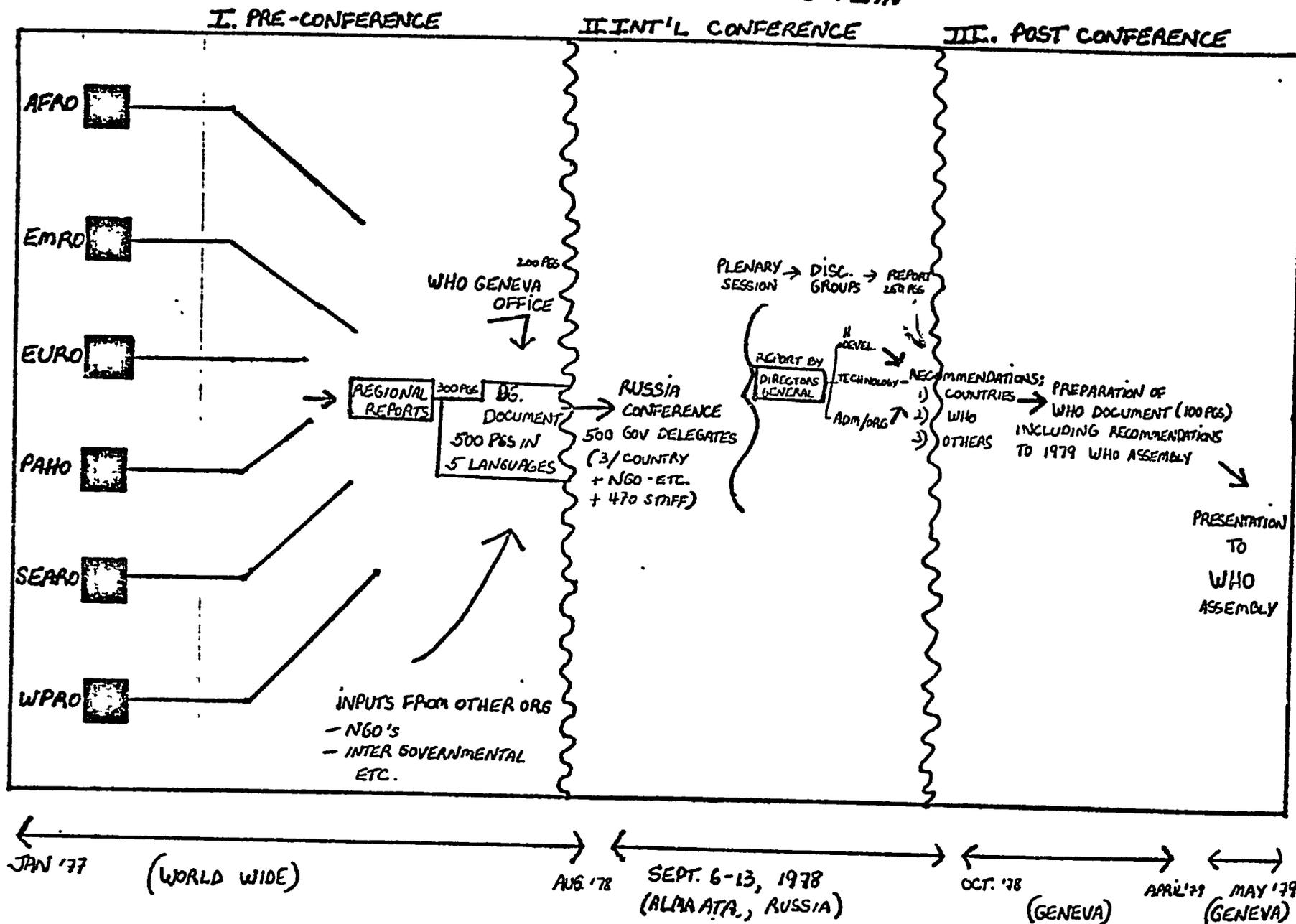
Three Technical Discussions - each two weeks in length and consisting of 15 Latin American experts - will focus on separate issues relating to PHC: #1. Systems; #2. Technology; and #3. Administration/Organization. The first conference will be in Mexico, February 21 to March 5, 1977; the second in El Salvador, April 11 to 23; and the third in Washington, May 8 to 21. APHA/WFPHA is providing three of the participants in each conference. A single comprehensive report will evolve from these conferences and will be sent to the Minister of Health in every Latin American country.

During the months of June, July and August, the Ministers are being asked to hold national forums in their countries to discuss and if necessary amend the report with regard to local conditions. APHA/WFPHA expects to assist several countries with this review process.

Then in September 1977, a two-day Ministerial Conference will be held in Washington to review the country positions on PHC and to determine a policy platform for the Americas.

WHO - PRIMARY HEALTH CARE CONFERENCE PLAN

Pg. 10.



The group will also be asked to identify the priority areas for PAHO technical cooperation. APHA/WFPHA will participate in this conference.

The estimated cost for the PAHO pre-conference activities is \$250,000. PAHO claims to have budgeted the full amount, but expects to receive at least \$50,000 from CIDA.

PAHO does not have an advisory committee but has organized a staff committee and hired a full-time consultant:

Dr. Garcia Gutierrez, SHS
Dr. Tentori Vargas, SHS
Dr. Alcocer, PAHO Consultant.

2. SEARO

Dr. Gunaratne and his staff have only briefly sketched out a format for pre-conference plans. On February 18 he will be holding a planning meeting in New Delhi and he has requested APHA/WFPHA to send a staff representative to participate.

The proposed SEARO plan consists of two parts. Between February and September 1977, national reviews will be encouraged in countries. At least seven countries are expected to participate. In October, there will be a Regional review of the national reports. It is anticipated that the report from this review will (1) be the Regional report from SEARO to the DG and (2) identify specific PHC projects for WHO-SEARO to initiate (e.g., produce training manuals; develop appropriate technology.)

Dr. Gunaratne has established a 4-member advisory group, consisting of:

Chairman, Dr. Sulianta, Indonesia
Dr. Somboon, Thailand
Dr. Retataba, Sri Lanka
Dr. Asiyaratne, Nepal.

Dr. Koko is the staff person responsible for overseeing the conference activities. To date, there is no fixed budget for the pre-conference activities. This will probably be determined at the February 18 meeting.

3. WPRO

Dr. Dy and his staff have conceptually organized their conference plan on exactly the same basis as the SEARO region. They expect 6 countries to participate in the national seminars, and their Regional Conference, consisting of 20-25 participants, will be held in September 1977.

While in Geneva, Dr. Dy suggested that since SEARO had invited the APHA/WFPHA representative to come to New Delhi, could the same individual go on to Manila immediately thereafter to discuss the planning of pre-conference activities with the WPRO staff.

Again, since the plans were not finalized, no actual budget was developed. There is no Advisory Committee, but rather a staff team responsible for the planning. This team consists of:

Dr. Ferrand
Dr. George Emery, New Zealand
Dr. Nugroho, Indonesia.

4. AFRO

Dr. Quenem and his staff sent out a memo on August 9, 1976 outlining the proposed format for the regional pre-conference activities.

The format is similar to that of SEARO and WPRO. The major difference is that Dr. Quenem's timetable anticipated that 10 national reviews would have taken place by November 1976 and that from these would be developed a "Working Paper" which would be reviewed by a Regional Expert Committee on 7-11 March 1977. (The participants for this Committee are already identified.) The report of the Regional Committee would then be sent to the 27th Session of the Regional Committee for final approval.

Dr. Quenem did not seem sure whether the actual timetable was being met, and he suggested an APHA/WFPHA representative come to Brazzaville to discuss the pre-conference activities in detail with his staff.

5. EMRO

Dr. Taba and his staff have been rather reluctant to develop any specific pre-conference format. They rejected the WHO guidelines and Dr. Taba said that some of the member countries felt PHC was "second-rate" health care and they could afford better.

Dr. Taba indicated that in June or July 1977 there will be an Inter-Agency Review of PHC (i.e., WHO, WB, UNICEF, UNDP, etc.). This will be followed by the collection of relevant data from different national PHC activities in the region (e.g., Iran, Sudan, etc.). In January 1978 there will be a Regional Review which will result in a document to be sent to the DG.

The EMRO Regional Director suggested that an APHA/WFPHA staff representative come to Alexandria in late March - early April to meet with his staff regarding possible technical consultants to assist in the design and implementation of the plans. Dr. Taba explained that technical expertise - not money - was the problem.

The EMRO staff responsible for the development and implementation of the Conference Plans include:

Dr. Rifka
Dr. S. Hassan
Dr. Robertson.

6. EURO

Dr. Kaprio explained that in his region there were several activities being undertaken to organize information:

- a. Individual Country Reviews
- b. Special Consultant Study of Comparative Approaches (Dr. Robert Korn)
- c. Regional Office Technical Sessions (e.g., Role of Nurses in PHC, etc.).

In March 1977 there will be a meeting of the Program Committee for the Region to review the draft document. Then in October/November 1977 there will be a Regional Committee Review and a final document prepared for the DG.

In addition to the Regional Pre-Conference activities, there are a number of other related activities taking place:

- a. World Federation of Public Health Associations are holding their II International Congress in Halifax, Nova Scotia May 24-26, 1978. The theme is "International Perspectives on P.H.C."
- b. National Academy of Sciences (NYC) is sponsoring a symposium on "industrialized country" approaches toward P.H.C. in mid-October 1977.
- c. International Council of Nurses have informed WHO that they are very concerned with the WHO emphasis on P.H.C. and they expect to hold a conference to spell out the role of nurses in P.H.C.

WHO is publishing a booklet entitled "Health for All by Year 2000" which it will distribute. Apparently however the Public Information staff and the Conference Staff are not coordinated on this effort and disagree with the content.

Another WHO effort is designed to get several films produced on health projects which highlight primary health care activities. The first of these films - "Seeds of Health" is a 42 minute film on the Behrhorst project in Chimaltenango, Guatemala. Spec's: Cost - \$80,000; 3 languages; 42 minutes; + \$500 for each additional copy. Est. 4 months for completion.

WHO has drafted a proposal to do 21 such films, including the Lampang Province Project but they have no funds.

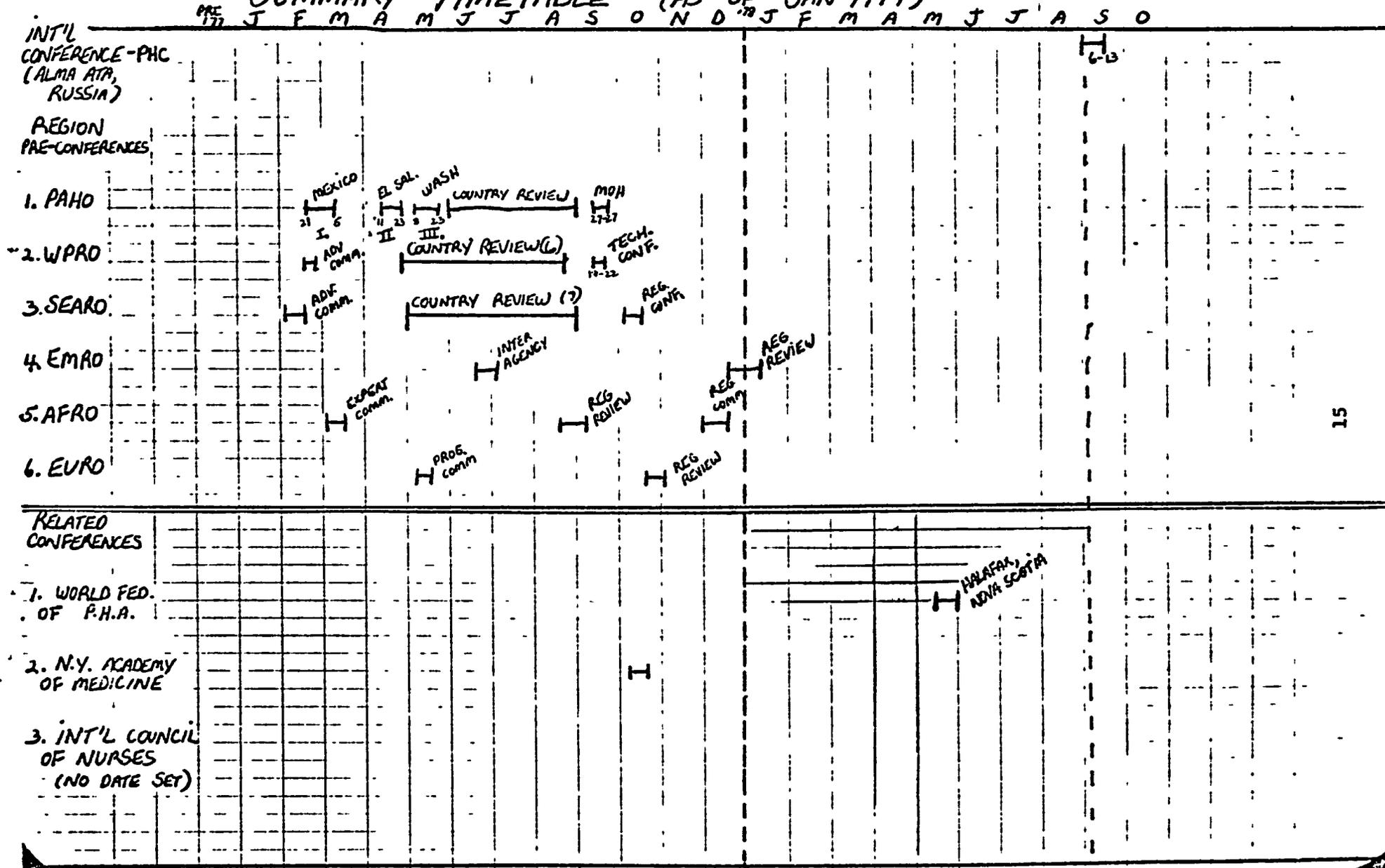
Summary:

Financing for the entire WHO plan is still a question. With the exception of PAHO, most of the regional pre-conference plans are not yet completed.

In looking at what is currently proposed, (see next page for summary chart) there should be concern on the part of WHO Geneva regarding the 10-month time gap. (January

WHO - PRIMARY HEALTH CONFERENCE PLAN AND RELATED CONFERENCE ACTIVITIES

SUMMARY TIMETABLE (AS OF JAN 1977)



1978 to September 1978) between the completion of the pre-conference activities and the International Conference in Russia.

Several other potential problems exist with the current WHO Conference plans:

- There is no organized mechanism for informing interested groups in the regions where and how they can participate;
- There is no public information/education component in the entire conference plan, except for the booklet;
- There is no specifically identified role or input from the non-governmental sector.

(Note: This latter point was of particular concern to Dr. Tejada who asked APHA/WFPHA if they would be interested in taking the leadership role in mobilizing the non-governmental sector input.)

Problems Encountered by APHA

As discussions continued with WHO-Geneva staff, it became increasingly clear that they were still uncertain as to the exact role and relationship between the APHA and the AID-U.S. government input into the P.H.C. conference. This matter could easily be clarified by AID writing a letter to WHO.

Considering now the dual objectives of the APHA Conference Management Activities - and the expanded role of supporting the five (5) WHO regional pre-conference activities - AID should review the current level of support, both manpower (currently 1 professional and 1 assistant) and financial, which APHA has available, and consider whether this is sufficient to meet the increased demand.

Next Steps by APHA

As currently planned APHA will undertake the following activities within the next few months:

1. Staff will travel to SEARO and WPRO regional offices (February 18-27) to assist in development of regional plans and identification of possible technical assistance. A similar trip will be scheduled for EMRO and AFRO in late March, early April.

2. Technical Consultants will be assigned to assist in the implementation of regional conference plans, as agreed upon with WHO and member governments.

3. A special series of the WFPHA newsletter will focus on the entire WHO-PHC activities and will include an outline of regional plans and opportunities for government and non-government input; interviews with key individuals (e.g., Dr. Mahler, Dr. Venediktov, etc.) to determine positions and descriptions of outcomes from the regional conferences.

4. Together with others, the APHA/WFPHA will develop a low-cost strategy for stimulating the input of the non-governmental sector into the P.H.C. regional conferences, the DG report and as active participants in the International Conference.

PERSONS INTERVIEWED
by R. Morgan in
WHO and other organizations
Geneva, Switzerland
17-21 January 1977

1. ACUNA, Dr Hector
WHO/Regional Director
Region of the Americas
2. AMARU, Mrs B.
WHO/Fellowships Officer
3. ANNEHEIM, Mr E. S.
WHO/Chief of Distribution and Sales
4. BARMES, Dr David
WHO/Chief of Oral Health
5. BARROW, Miss Nita
Director, Christian Medical Commission
6. BEHAR, Dr M.
WHO/Chief of Nutrition
7. BINTA, Mr Jeff
AID Mission, Geneva
8. CANAPERIA, Dr Giovanni
Italy, President, Italian Public Health
Association
9. CH'EN, Dr Wen-chieh
WHO/Assistant Director-General (Chinese)
10. DALAMINI, Dr Z. M.
Chairman, WHO Executive Board Standing
Committee on Non-Governmental Organizations
11. DEROLLAND, Mr Roger
WHO/Public Information Office
12. DOWLING, Dr M. A. C.
WHO/Chief Medical Officer, Educational
Communication Systems
13. DUDROW, Mr Ralph
WFPHA, Honorary Secretary & Treasurer
14. DY, Dr Francisco J.
WHO/Regional Director
Western Pacific Region
15. FLACHE, Dr Stanislas
WHO/Director of Coordination

16. FULOP, Dr T.
WHO/Director of Health Manpower Development
17. FURTH, Dr Warren
WHO/Assistant Director-General, Administration
18. GUMARATNE, Dr V. T. H.
WHO/Regional Director
South-East Asia Region
19. HAMMER, Miss Vicki
WHO/Division of Family Health
20. KAPLUN, Mrs Annette Le Meitour
Director, IUNE Directory
21. KLEIN, Mr
AID Mission, Geneva
22. LITSIOS, Dr Socrates
WHO/Strengthening of Health Services
23. MEJIA, Dr Alfonso
WHO/Health Manpower Planning
24. MAHLER, Dr Halfdan
WHO/Director-General
25. NOCHI, Dr A.
WHO/Assistant Director of Coordination
26. QUENUM, Dr Comlan A. A.
WHO/Regional Director
African Region
27. TABA, Dr A. H.
WHO/Regional Director
Eastern Mediterranean Region
28. TAYLOR, Dr C. N. Derek
WHO/Chief, Health Education
29. TEJADA, Dr David
WHO/Assistant Director-General, Planning
30. TOMICHE, Mr F.
WHO/Director of Public Information
31. VENEDIKTOV, Dr D. D.
Russian delegate
32. WEYERS, Mr Helmut
UNDP Geneva, Vol. Programme

INTERVIEW SCHEDULE - R. MORGAN
 GENEVA, Jan. 17-21, 1977.

ATTACHMENT-B

1

	MONDAY (17)	TUESDAY (18)	WEDNESDAY (19)	THURSDAY (20)	FRIDAY (21)	SATURDAY (22)
8:00	8:00-8:30 DR. ACUNA		8:15-8:45 DR. FURTH	8:30 DR. KAPPAO	8:30-9:15 KLEIN (MISSION)	
8:30		8:30-9:00 DR. GUNARTNE 8:45-9:00 DR. DY	9:00 DR. DEHAR	9:30-10:00 DR. TABA		ENGLAND
9:00	ARRANGE APPTS.	WHO EXECUTIVE BOARD	10:00-11:00 LITSIOS	10:30-11:00 DR. FULOP	10:00 JERRY STAMBERG	
9:30	↓	PHC. CONF.	↓	11:15 - MOFIDI	11:00 DR. VENEDIKTOV MA DEROLLAND (PUB. INFO)	
10:00	10:55 DR. MAHLER (CALL TEJADA)	↓	CALL 11:15 WEYERS	11:30 - WEYERS	DR. DY-TELEGRAM	
10:30	11:45 MAS. AMAAN SIT		11:30 MOCHI			
11:00	LITSIOS	12:15 WEYERS (WHO LOBBY)		12:15 - 12:30 KAPLUN	DR. TESADA LUNCH	12:05 LV. LONDON PAA 107
11:30	↓	EX. BD. PHC. CONF	11:30 DR CHEN 6079	↓	PHC. Conf. Rev.	↓
12:00	LUNCH		2:00-2:30 DR. QUENEM	2:00 DR. BEHAR	LUNCH	
12:30	↓		↓	2:30 ANNEHEIM	2:30 TAYLOR	
1:00	TEJADA		4:00 TOMICHEE	3:30 MA. DURDOW PUBLIC INFO	3:30 LITSIOS	3:30 PM ARR. WASH, DC.
1:30	↓			4:30 DEREK TAYLOR	4:00 MOCHI	
2:00					↓	
2:30					5:30 DUDROW	
3:00						
3:30						
4:00	4:00 MA. STACY SAHEL	5:00 DAVE EHRLICH (EX-BD)	5:00 NITA BARROW			
4:30						
5:00						
5:30						
6:00						
	7:00 PM AALPA DUDROW AT HOTEL		7:00 LITSIOS (DINNER)	E.B COCKTAIL - ↓ TAYLOR-DINNER	7:20 PM LV. FOR LONDON BEA 579	



EXECUTIVE BOARD

Fifty-ninth sessionAgenda item 13PROGRESS REPORT ON THE INTERNATIONAL CONFERENCE
ON THE PROMOTION OF NATIONAL HEALTH SERVICES
AND PRIMARY HEALTH CARE

A. SUMMARY OF BACKGROUND

The Twenty-eighth World Health Assembly in WHA28.88 (Promotion of National Health Services relating to Primary Health Care) in operative paragraphs 5 and 6:

"5. CONSIDERS it desirable, in view of the great importance of the problem of organizing primary health care within the framework of comprehensive national health systems and services, to hold as soon as possible an international meeting or conference under WHO auspices to exchange experience on the development of primary health care as part of national health services, especially as regards the aspects of planning and evaluation; and

6. INSTRUCTS the Executive Board to consider and determine at its fifty-seventh session the date, place, and concrete programme for such a conference."

The fifty-seventh session of the Executive Board in resolution EB57.R27 in operative paragraphs 2 and 3:

"2. DECIDES that the International conference on the development of primary health care as part of national health services, especially as regards the aspects of planning and evaluation be held in 1978; and

3. DECIDES to establish an ad hoc committee of the Executive Board consisting of five members which would meet prior to 1 April 1976 in order to decide on the detailed objectives, the agenda, the place, the date, the participants and the nature of the preparatory steps necessary to fulfil the objectives of the conference."

B. PREPARATIONS FOR THE INTERNATIONAL CONFERENCE

The ad hoc committee of the Executive Board met on 29-31 March 1976¹ and decided that the objectives of the Conference would be:

"(i) exchange of experience and information on the development of Primary Health Care within the framework of comprehensive national health systems and services;

(ii) promotion of primary health care concept in Member countries;

(iii) preparation of a report which shall include recommendations to be submitted to the World Health Assembly."

¹ Ad hoc report attached as Annex I.

The ad hoc committee also stated:

"The Conference would be governmental but technical and intersectoral in nature."

In the discussion of the preparatory process considerable concern was expressed with the contradiction between the desired extensive review and reporting of national experience versus the associated costs, extensive volume of paper required, and the feasibility of handling this material effectively. It was agreed that:

- (i) the Director-General would prepare a working paper for the Conference;
- (ii) regional reports would be the prime mechanism for reporting to the International Conference the different national experiences and approaches. It was emphasized that regional reports are not expected to develop "within region" solutions, the reports should present a summary of critical and the most important issues met at national level.

(iii) the ad hoc committee also decided:

"These regional reports will be presented to the International Conference and used as background documents for the discussions."

- (iv) national reports that governments wish to make available to the Conference would be translated and reproduced at national expense in one or more of the five conference languages according to the possibilities of the government.

The ad hoc committee attempted to define the main areas of the general agenda, these were:

"(a) the conceptual aspect of Primary Health Care, its relationship with the national health service and overall socioeconomic development;

(b) operational and technical aspect."

C. INTERNATIONAL CONFERENCE PHASES

WHO's plans for the Conference have three phases. These phases relate to all WHO activities and not only the conference arrangements shown in Annex III.

Phase I - Preparatory steps: These have been described as being at two levels - National dialogues and Regional meetings - but could well take many different forms including subregional meetings, expert committees, task force reports, etc. This is considered to be the crucial phase as it is at this phase that the main information will be generated and also the groundwork laid for Phase III follow-up activities.

Phase II - Conference: The Steering Committee on Primary Health Care/HQ agreed that the thrust of the Conference should be to promote national actions in primary health care and to help WHO and UNICEF structure their Primary Health Care Programmes. Therefore, the regional reports, the Director-General's presentation and the recommendations should relate to these outcomes.

The Conference would start with a plenary session upon the Director-General's presentation. This would be followed by meetings of three working committees of the whole. Each committee would have a separate agenda. The agenda of each of the committees would not be all-embracing but would be selective and restricted to five to six carefully selected topics.

Phase III - Follow-up phase. This would include a debate at the World Health Assembly (1979) upon the recommendations of the Conference plus a series of actions to support PHC development in countries identified in Phase I (and others) and would continue indefinitely as part of the programmes of both WHO and UNICEF.

These phases have been expressed in the figure given in Annex II.

D. VISIT OF A WHO TEAM TO THE USSR - SUMMARY OF DISCUSSIONS

In accordance with the Report of the Ad Hoc Committee of the Executive Board on the International Conference on Primary Health Care (Geneva, 29-31 March 1976) and agreement between the USSR health authorities and the WHO Secretariat, a WHO team travelled to the USSR to discuss and, ultimately, to decide on the duration of the Conference, the actual starting day and the place of the Conference, and to examine the physical facilities and the budgetary aspects for the Conference.

The discussions took place with the following representatives of the USSR health authorities: Dr D. D. Venediktov, Deputy Minister of Health of the USSR, Professor O. P. Ščepin, Chief, External Relations, Ministry of Health of the USSR, and Dr N. N. Fetisov, Deputy Chief, External Relations, Ministry of Health of the USSR. The WHO team was composed of: Dr D. Tejada-de-Rivero, Assistant Director-General, Mr A. Imbruglia, Chief, Budget, Division of Budget and Finance, and Mr B. Edwards, Administrative Officer in the Division of Personnel and General Services.

The programme of activities during the visit to the USSR was as follows:

- Meetings with the USSR health authorities in Moscow;
- Meetings with the health authorities of the Republics of Uzbekistan and Kazakhstan in Tashkent and Alma Ata respectively;
- Visits to two proposed Conference sites to examine the facilities on the spot and to determine grosso modo the arrangements which would be required in order that the facilities could be made suitable for the Conference.

The main items discussed and agreed upon were as follows:

- (i) Application of the Convention on Privileges and Immunities
- (ii) Visas
- (iii) Reimbursement of air tickets in the USSR to participants as may be requested
- (iv) Payment of per diem to participants
- (v) Currency exchange facilities at the site of the Conference
- (vi) Registration procedures
- (vii) Security
- (viii) Duration of the Conference
It was agreed that the Conference would last seven days, five to five-and-a-half of which would be working days. The possibility of an additional working day may need to be considered at a later stage.
- (ix) Actual starting day of the Conference
It was agreed that the Conference would start on Wednesday, 6 September 1978.

(x) Site of the Conference

Based on the existing facilities and on the understanding that appropriate measures would be taken to make these facilities suitable for the requisite meetings and attendant activities, Alma Ata, capital of the Kazakh SSR was selected as the site for the Conference.

(xi) Conference Working Committees

The USSR health authorities were informed of the establishment of a WHO Working Group for the Conference under the guidance of the Steering Committee on Primary Health Care. The WHO team was informed that a similar group would be arranged by the USSR health authorities. It was agreed that a working relationship would be established between these two groups. Issues of importance and policy would be dealt with by direct communication between the WHO and USSR established "focal points" for the International Conference.

- (xii) Space and related requirements
- (xiii) Local staff
- (xiv) Temporary staff
- (xv) International transportation for participants
- (xvi) Transportation of WHO staff and equipment

E. BUDGETARY QUESTIONS

1. The WHO mission to the USSR reported the following:

The budget was reviewed and revised in accordance with Annex III (attached). Further details, particularly regarding the in-session requirements, were given to the USSR health authorities. Whilst it was agreed that the total amount of US\$ 2 206 000 would be included in the WHO regular budget for 1978, an indication would be made in the budget document that there will be a USSR contribution towards it, the amount of which had not yet been finalized.

The contribution of the USSR could take the form of providing either free or fixed reduced-rate accommodation for participants and WHO staff; transportation of WHO staff from Geneva; transportation of material and equipment; free rental of premises and offices; and other services including car and bus services, interpretation facilities for participants and staff, printing and duplicating, etc.

2. The contribution by UNICEF as co-sponsor of the Conference includes:

- (i) A contribution of US\$ 100 000 to the Conference itself
- (ii) A contribution of US\$ 250 000 to the preparatory processes leading up to the Conference itself. This contribution would not replace the budgetary provisions already made by WHO and presented in the Director-General's proposals for the International Conference. Instead these funds would be used to further assist National dialogues, Regional meetings and other preparatory processes.

REPORT

of

Meeting of the Ad Hoc Committee of the Executive Board
on the International Conference on Primary Health Care

Geneva, 29-31 March 1976

I. INTRODUCTION

1. In accordance with Executive Board resolution EB57.R27, the ad hoc Committee of the Executive Board on the International Conference on Primary Health Care met in Geneva from 29 to 31 March 1976. In addition to the five members of the ad hoc committee and the WHO Secretariat, two representatives of the Government of the USSR as well as Dr Venediktov as an interested member of the Executive Board participated (attached as Annex I is the List of Participants).

2. The Chairman, in his introduction, referred to the mandate from the Board requiring that the ad hoc committee meet prior to 1 April 1976, in order to decide on the detailed objectives, the agenda, the place, the date, the participants and the nature of the preparatory steps necessary to fulfil the objectives of the Conference. The adopted agenda for the ad hoc meeting is shown in Annex II.

II. CONSIDERATION OF DETAILED OBJECTIVES OF THE CONFERENCE

1. Objectives of the International Conference on Primary Health Care

It was decided that the objectives of the Conference should be as follows

- (i) exchange of experience and information on the development of primary health care within the framework of comprehensive national health systems and services,
- (ii) promotion of primary health care concept in Member countries,
- (iii) preparation of a report which shall include recommendations to be submitted to the World Health Assembly.

2. Nature of the International Conference

The legal implications of the various options presented in the Secretariat working paper for the meeting were explained. The advantages and disadvantages of each option with respect to the agreed upon objectives of the Conference were fully discussed. The Committee agreed that:

- (i) the Conference should be governmental in order to lend more weight to recommendations that emerge from the Conference;
- (ii) the participants would be appointed by governments to serve as representatives with such expertise as governments would consider to be relevant to the aims of the Conference;
- (iii) the Conference should be technical and intersectoral in nature to lead to a deeper consideration of the primary health care concept and this concern should be stressed in the invitation in order to provide guidance on the types of expertise desired.

Annex I

3. Number and type of participants and the nature of their participation

A discussion took place on the desired number of participants from countries, on the involvement of the United Nations and other agencies, and on what restrictions might be placed on either the number or the degree of participation of the different types of participants. It was agreed that:

- (i) the expenses of only three participants per country would be covered by WHO (tourist or economy class airfare and standard per diem);
- (ii) for effective planning of the Conference, a deadline would be established by which time governments would be expected to notify the Secretariat of the number of their participants;
- (iii) host country participation in the planning and organization of the Conference would be complementary;
- (iv) recognized national liberation movements would be invited to participate in accordance with the decisions of the United Nations General Assembly and with the policies of the United Nations system. One participant from each liberation movement would be paid for by WHO;
- (v) participation of United Nations agencies, other intergovernmental organizations having effective relations with WHO, and nongovernmental organizations in official relations with WHO would be at their own expense. The established rules in relation to the participation of such United Nations agencies, intergovernmental organizations, and nongovernmental organizations in official relations with WHO will be followed,
- (vi) the participation of foundations, bilateral and funding agencies that lack official relationship with WHO, would be desirable from the standpoint of sensitization and orientation of their country activities, in order to make them more relevant to community needs especially those of the rural populations. It was further decided that the Director-General should be given the responsibility to select those agencies to be invited. These would be invited to send a limited number of participants to the Conference with restricted participatory rights, i.e. in observer status allowing them statement only at the discretion and with the permission of the Conference presiding officer. These agencies would be expected to pay for their own expenses;
- (vii) the Executive Board may wish to consider the participation of the Board in the Conference and the nature of this participation.

4. Preparatory process, scope and expected outcome

During the discussion on this topic, considerable concern was expressed with the contradiction between the desired extensive review and reporting of national experiences versus the associated costs, extensive volume of paper required, and the feasibility of handling this material effectively.

The decisions taken were as follows:

- (i) the Secretariat was requested to prepare by the next Assembly a set of critical questions related to a set of topics, such as listed in Annex IV, to form the basis for discussions that could take place as part of the preparatory process for the Conference at national level during appropriate workshops, seminars, etc. This document should not exceed 10 printed pages;

Annex I

- (ii) it was agreed, after discussion and clarification by the Secretariat, that regional reports would be the prime mechanism for reporting to the International Conference the different national experiences and approaches. It was emphasized that regional reports are not expected to develop "within region" solutions. The reports should present a summary of critical and the most important issues met at national level;
- (iii) these regional reports will be presented to the International Conference and used as background documents for the discussions;
- (iv) the total conference documentation (pre-session, in-session and conference report) should not exceed 1200 printed pages, preferably less, in the five languages in which documents are now translated for the World Health Assembly,
- (v) the total amount of pre-conference documentation should not exceed, if possible, 500 pages. This would be made up of the six regional reports plus the Director-General's report(s);
- (vi) national reports that governments wish to make available to the Conference would be translated and reproduced at national expense in one or more of the five conference languages according to the possibilities of the government.

5. Consideration of provisional programme and agenda

An extensive discussion took place of the WHO Secretariat's suggestion, as presented on the working paper, that the conference programme consist of plenary sessions plus three committees of the whole. It was decided that it was premature to fix the details of topics to be discussed as well as the number of committees desired. However, it was agreed that for the expediency of planning, three committees of the whole was reasonable. A decision would be made, following the preparation of regional reports, as to the actual numbers of committees, the topics for discussion and whether the committees should discuss the same or different topics. The committee attempted to define the main areas of the general agenda, these were

- (a) the conceptual aspect of PHC, its relationship with the national health service and overall socioeconomic development,
- (b) operational and technical aspect.

The list of initial critical topics for discussion at the Conference shown as Annex IV could serve as the basis for future development of a detailed agenda. It would be necessary for the Secretariat to modify this list taking into consideration the discussion of the committee on this item.

6. Duration

The Secretariat's suggestion for a five-and-one-half working day Conference was considered. It was agreed that some degree of flexibility should be introduced into the proposed schedule (see Annex V attached) to allow for field visits and for the preparation and consideration of the draft and the final reports of the committees. Consideration was also given to the possibility of starting the meeting mid-week in order to take advantage of the weekend for the above-mentioned activities. It was left to the Secretariat and the host country to decide whether or not the duration should be increased by one day and on the actual starting day.

III. CONSIDERATION OF HOST COUNTRY AND DATE OF CONFERENCE

The Secretariat presented the three invitations to host the Conference received from the Governments of Costa Rica, Egypt and the USSR and informed the committee that the invitation from Egypt had been withdrawn in the meantime. The suggestion of the Belgian

Annex I

Government (copy attached as Annex VI) to hold the Conference in Geneva if the financial implications of such a decision will be less for the Organization was also mentioned to the committee. Dr Orlov, the representative of the USSR, reaffirmed his Government's invitation to host the Conference and confirmed the obligations promised by his Government as contained in the letter of invitation dated 6 January 1976 (copy attached as Annex VII). He proposed several sites within the USSR: Moscow, Minsk, Kiev, Bakou, Alma Ata and Tashkent.

With regard to the offer received from the Government of Costa Rica (copy attached as Annex VIII), the ad hoc committee was informed by the Secretariat that while that Government maintained its invitation to host the Conference, it was not in a position to offer significant financial support towards the costs.

The ad hoc committee unanimously decided that it was unsuitable to hold the Conference at WHO headquarters, Geneva. A full discussion on the two countries which had offered to be host revolved around issues of accommodation, possibilities of field visits and the budgetary implications. It was resolved unanimously, taking into account all these factors together, that the Soviet Union would be the host country. The desire was expressed by the ad hoc committee that the Conference should preferably be held in one of the Asian Republics at a site to be determined after consultation of the host country by the Secretariat. It was agreed that the Conference should be held in late August - early September 1978.

IV. ADMINISTRATIVE, LEGAL AND OTHER CONFERENCE ARRANGEMENTS

Following a discussion on this item, it was agreed that:

- (i) arrangements would be made by the Director-General to establish a full-time secretariat to handle the preparatory steps before the Conference;
- (ii) WHO would service the plenary and committee meetings that will take place during the Conference;
- (iii) arrangements for conference documentation and interpretation would be made similar to those made for the World Health Assembly;
- (iv) no verbatim or summary records would be prepared or distributed during the Conference. However, a recording of all discussions would be made which would be used as part of post-conference document preparation (in addition to the actual report of the Conference proper). The nature of such documentation would be decided at a later date;
- (v) the Rules of Procedure of the World Health Assembly would where relevant be used to cover the conduct of the Conference. It will be necessary to make express provision with regard to such specific matters as elective offices to be filled (President, Vice-Presidents, Rapporteurs, Committee Chairmen and Rapporteurs), as well as other matters of organization of the Conference such as the establishment of a Coordinating Committee;
- (vi) as indicated earlier, the Director-General would prepare a working paper for the Conference;
- (vii) some United Nations organizations and nongovernmental organizations may also wish to submit documentation.

V. BUDGETARY IMPLICATIONS

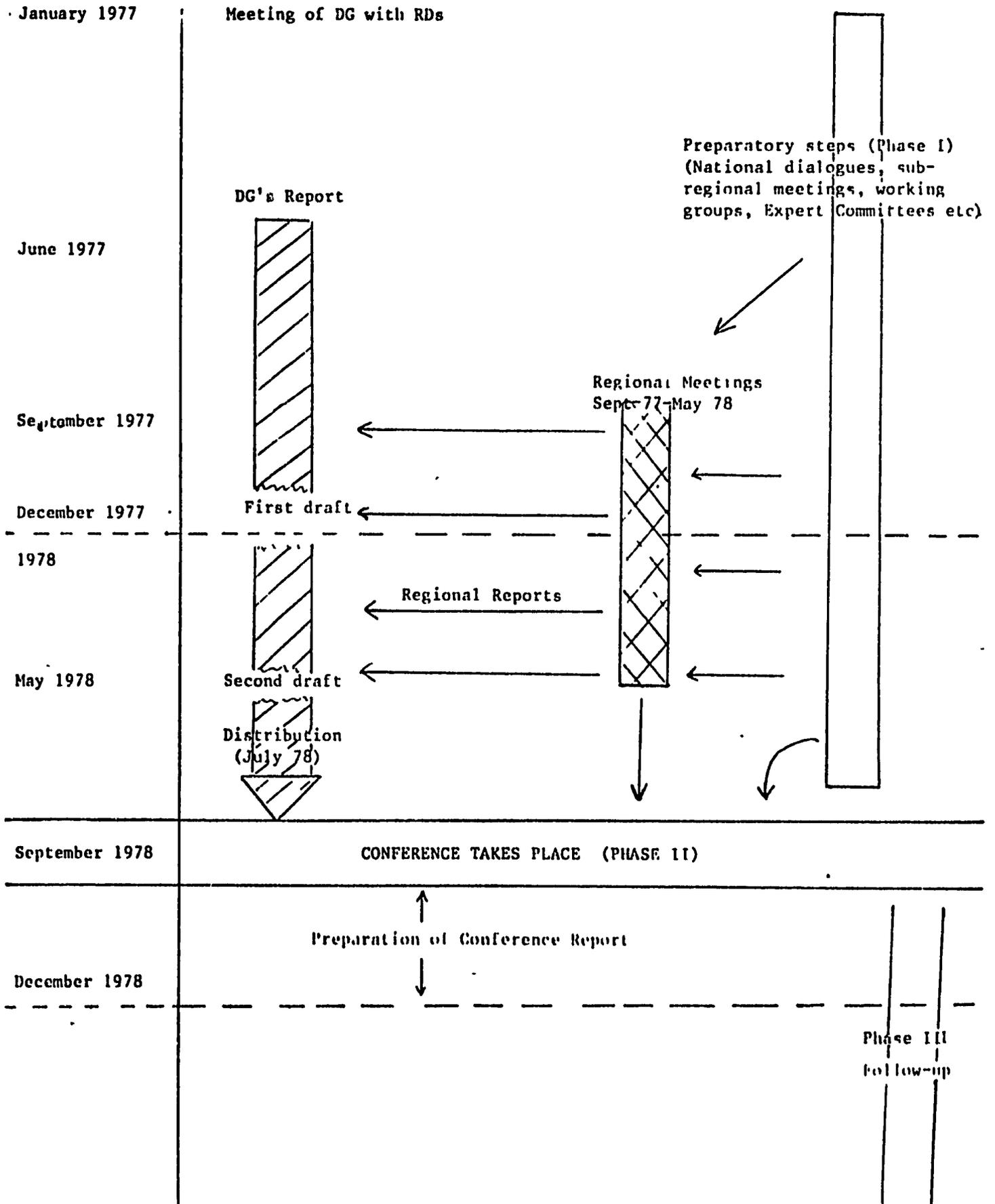
The ad hoc committee noted the budgetary estimates submitted by the Secretariat for holding the Conference in the three alternative locations proposed: Geneva, Moscow and Costa Rica. The approximate estimates for holding the Conference in these alternative sites were:

Geneva

US\$ 2 000 000

ANNEX II

TIMETABLE FOR THREE PHASES OF CONFERENCE



ANNEX III

INTERNATIONAL CONFERENCE ON PRIMARY HEALTH CARE

Summary

	Estimated cost	
1. <u>Pre-session requirements (Switzerland)</u>		
Temporary staff	219 000	Based on a preparatory phase of seven months in 1978 and production of six regional reports of 50 pages each - 300 pages, other reports by headquarters, 200 pages, i.e. a total of 500 pages in five languages.
Space requirements	15 000	
Supplies	6 000	
Maintenance of equipment	1 000	
Purchase or rental of equipment	65 000	
Postage	5 000	
	<u>311 000</u>	
2. <u>In-session requirements (USSR)</u>		
Participants	1 006 000	Based on an estimated number of pages to be produced of 250, including draft and final reports of committees. Production in five languages.
Staff requirements	635 000	
Space requirements	60 000	
Supplies	20 000	
Postage	6 000	
Miscellaneous	29 000	
Transport of documentation and equipment	30 000	
Other costs	16 000	
	<u>1 802 000</u>	
3. <u>Post-session requirements (Switzerland)</u>		
Temporary staff	20 000	Based on a report of 100 pages produced in five languages.
Printing of report	45 000	
Distribution costs	20 000	
Supplies for despatch	8 000	
	<u>93 000</u>	
4. Total	2 206 000	

NEWSLETTER

MAILING LIST BREAKDOWN

As of January 19, 1977

1. AID Missions (2,500 groups 1 & 2 combined)*
 Represents both:
 - a. Subscriptions delivered to AID, Washington, and sent on to the missions from there..... 51
 - b. AID related agencies or projects which are sent directly from APHA..... 4
2. LDC Field Health Personnel (2,500 groups 1 & 2 combined)
 Includes both respondents and non-respondents to the State of the Art Study and doctors, nurses and para-professionals working at the grass roots level..... 612
3. PHO (Public Health Official-Governmental) (1,000 groups 3 & 4 combined)
 Covers individuals who hold a health care post within the government structure, e.g. the various ministers of health..... 240
4. NGO (Non-Governmental Agency Officials) (1,000 groups 3 & 4 combined)
 Encompasses an officer of a health care related agency or professional association, e.g. the director of the Planned Parenthood Association of Sierra Leone and the president of the Sierra Leone Nurses' Association..... 227
5. Multilateral/Bilateral Agencies (500)
 Consists of international organizations, their specialized agencies and representatives at the regional and country levels, e.g. WHO and UNDP representatives..... 326
6. Training Institutes LDC (500)
 Takes in universities, medical schools, health auxiliary training schools, nursing schools and other institutions whose major purpose is to train health workers..... 240

* Maximum recipients allowed under AID contract.

7. Training Institutes - Health Data Centers - Others (500)
Embraces the same institutions described in #6, but located in developed nations, e.g. The Johns Hopkins University School of Hygiene & Public Health. Further entries are non-governmental agencies which provide technical, professional and/or financial assistance to LDC health care programs, e.g. The Ford Foundation. "Others" contains recipients who did not fall into any of the above categories, e.g. interested parties not affiliated with a project or agency, journalists in less developed nations.....329

Total.....2029