

HEALTH AND SANITATION PROJECTS

Supported by

THE AGENCY FOR INTERNATIONAL DEVELOPMENT

In Fiscal Year 1965

A Report To  
The Office of International Health  
United States Public Health Service  
Department of Health, Education and Welfare

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Department of State

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Section 1.

## INTRODUCTION

The programs and projects in health and sanitation supported throughout the world by the Agency for International Development (A.I.D.) are a reflection of many factors. Programs of international health have involved Americans for more than a century. The medical missionaries have played an important and pioneering role during this period. Many of the basic concepts which are now widely accepted in Public Health and medical education programs were developed after years of experience by the Rockefeller Foundation. The United States Government has been involved in disaster relief and a limited technical assistance program in Public Health, particularly in Latin America, for more than fifty years. During the past twenty years the U. S. Government has participated in a large scale program involving thousands of U. S. technicians and has expended hundreds of millions of dollars in support of the program. In recent years the emphasis has been shifting to health programs that are an integral part of total development efforts. The emphasis has been on economic development and programs that can make a major contribution to this. With this has come increasing recognition of the multiple causes of poverty in developing countries and the variety of tools that must be used to overcome these. There has been greater recognition of the political, social and economic implications in addition to the humanitarian and technical considerations which influenced early programs and which should receive careful evaluation.

The Foreign Assistance Act of 1961 created the Agency for International Development (A.I.D.) to carry out the programs of economic and technical assistance as part of an integrated program of development assistance and coordinate these with military assistance programs. The creation of A.I.D. recognized the fact that the aid program is a multi-purpose instrument of foreign policy, not a single or simple approach to the problems in developing nations. The foreign aid objectives were also clarified and programs were planned within the framework of a broad analysis of each country's needs, resources and prospects for development. This analysis includes political, economic, sociocultural and other factors.

The primary objective of the U. S. foreign assistance program has been stated in many different ways, but basically the program seeks to assist those countries that are trying to maintain their independence and develop economically into self-supporting nations. Although the objective is clear-cut and the program is conceived to be directly in the national interest of the United States, it is also carried out within the long standing humanitarian tradition of this country.

The allocation of U. S. assistance to individual countries is guided by the following broad general principles: 1) the importance to the U. S. of strengthening the country's economy, political structure, social institutions or security conditions; 2) the effectiveness with which the country is using, or can use, available resources to promote social and economic development; and 3) the country's need for assistance and the

and the availability to it of assistance from other developed countries or international agencies. Once the basic decisions regarding the type of assistance (military, supporting or development) are made there are many considerations regarding the details of country assistance programs that are dependent on the levels of economic and human resource development. In the early stages of development priority is given to education; basic facilities for transportation, and communications; agriculture; water resource development; and health programs which are required to enable a country to create and effectively use capital, and the technology of industrial development. As incomes begin to rise and mortality rates decline there is likely to be a rapid rate of population growth and a critical need for food, especially for infants and preschool children. In the later stages money is needed for capital goods, raw materials and the other requirements of an industrializing economy.

The country programs supported by A.I.D. now involve more than eighty countries. The programs of economic aid are emphasized in thirty-two countries, but they are concentrated in seven countries; the military aid programs are concentrated in eleven countries bordering on the Sino-Soviet bloc and programs of supporting assistance are concentrated in four countries. There are three general categories of economic and supporting assistance programs according to the nature of our objectives and the magnitude of our assistance: 1) substantial programs directed to long-term economic and social development; 2) substantial programs dominated by the

immediate need to maintain external and internal security, but aiming at economic development in the long run; and 3) limited programs with restricted objectives.

There are thirty-two countries that receive almost 90 percent of all development loans which constitute the great bulk of economic development assistance. These are the countries that are judged to have good prospects for attaining self sustaining economic growth within a reasonable time if they make effective use of the resources available to them. These countries fall into three groups:

1. Countries approaching self-sustaining economic growth such as Venezuela, Mexico, Israel, Greece, and the Republic of China (Taiwan). Technical cooperation and development grants play a minor role at this stage of development and A.I.D. provides no direct support at present for health and sanitation programs in these countries.

2. Countries following reasonably effective development policies and making progress toward self-sustaining economic growth such as India, Pakistan, Turkey, Colombia and Nigeria. Technical cooperation and development grants still play an important role, although they constitute less than twelve percent of the total dollar assistance. The health programs supported by A.I.D. or predecessor agencies have sometimes made a very significant contribution to development. The malaria eradication program in India is one such program. In India more than \$62 million in development has been provided for the purchase of DDT, motor vehicles and scientific equipment as well as for the provision for U. S. technicians in the

malaria eradication program. In addition, the U. S. has financed \$111 million equivalent of Indian rupees for local costs of the program. These funds were generated by the sale of surplus U. S. agricultural commodities (Public Law 480). In 1962 the U. S. decided that it would not make further grants for commodity purchase for the malaria eradication program. Since that time two development loans have been made which include about \$9 million for malaria program commodities. Other significant health programs have been supported, or are being supported, in all these countries. In 1963 and 1964 over \$18 million in development loans were made to Pakistan for support of the malaria eradication program. In Turkey, long time private support, and in recent years government support, has been given for nursing. This has apparently had a very significant effect on the status of women. In recent years local currency generated under the PL 480 program has been used in Turkey to construct two nursing schools and other health facilities. In Tunisia development loans have been used for projects that will increase the municipal water systems of Tunis and Sfax. The bulk of technical assistance in Tunisia is provided by France and the U. S. gives no direct assistance in health programs. In Nigeria, no technical cooperation or development grant funds are programmed for health and sanitation projects during the next fiscal year. In December of 1963, however, a development loan of \$12.1 million was made to expand the water supply system of Ibadan. In Colombia, technical cooperation and development grants have provided significant assistance in medical and nursing education and development loans have been used to support large scale water

supply and sewerage projects. Thus, in all of these countries that are receiving major emphasis in the A.I.D. program health and sanitation projects have played a distinct, and often significant, role.

3. Countries with the potential for long-range economic development, but in which adequate self-help measures are not yet being demonstrated. There are now eleven countries in this category. Technical cooperation and development grants represent about 14 percent of the total economic assistance provided by A.I.D. to these countries. The health and sanitation programs supported directly by A.I.D. in these countries vary from long-term, major programs such as in Iran, Thailand, and Brazil, to countries such as Peru where no assistance is now given in health.

The programs in the countries that are receiving basic support for security and stability are funded primarily from supporting assistance. There are seven countries of importance to the United States in this category. In fiscal year 1965, 80 percent of the funds (\$273 million) are programmed for four countries -- Vietnam, Korea, Laos, and Jordan. In Fiscal year 1965 the largest A.I.D. health program in terms of U. S. personnel in the field will be in Vietnam. The focus of the program is on counterinsurgency with emphasis given to rural health services and surgical teams for the civilian casualties of the civil war. In addition, malaria eradication and medical education have received major support. The program in Laos has emphasized rural health services, sanitation and basic health education. The health and sanitation program in Jordan has included malaria

eradication, environmental sanitation and rural health services. These projects have been financed from technical cooperation and development grant funds. Korea is the only major country in this group that does not have health programs funded with direct A.I.D. support in fiscal year 1965. Technical assistance is given in Korea by the A.I.D. Public Health Advisor. The funding pattern for the seven countries in this group is as follows: supporting assistance \$303 million; development loans \$80 million; and, technical cooperation and development grants \$45 million.

In more than half of the countries receiving financial assistance through A.I.D., the U. S. commitments are quite limited in nature and involve only small expenditures. This includes thirty-seven countries which accounts for only 10 percent of all economic aid. In these countries the following funding is proposed for fiscal year 1965: \$81 million in development loans, \$73 million in technical cooperation and development grant funds, and \$40 million in supporting assistance. For the most part the United States is a minor contributor to a program in which the western European countries or international agencies are the dominant element in external economic aid or technical assistance. This is particularly true in Africa where the United States contributes less than half as much as the European countries.

In addition to the application of the principles for allocating development assistance described above, there are several trends which

must be kept in mind when considering the A.I.D. programs, including those in health and sanitation:

1. More emphasis in Latin America -- this region now receives the highest per capita economic assistance provided by A.I.D.;
2. More emphasis on private participation and contracting projects to universities and private organizations; at the present time A.I.D. has 8 university contracts in medical education; it has 3 contracts with U. S. universities for the development of special training programs in community water supply development; it provides an institutional development grant for the international health division of the Johns Hopkins School of Hygiene and Public Health; it has research grants with 3 universities and contracts in medical education, population studies or research are under discussion with universities. There are 27 private voluntary agencies that receive financial assistance from A.I.D., particularly in the form of ocean freight subsidies. The largest single grant in health and sanitation in fiscal year 1965 will be to the American University of Beirut for a teaching hospital (\$10.5 million). Grants will be given to Project Hope, the Admiral Bristol Hospital in Istanbul and the American Medical Center for Burma. These three institutions are included in the program of assistance to American Schools and Hospitals Abroad. In addition, A.I.D. has contracts with the Association of American Medical Colleges and the American Hospital Association. Close relationships have been established or continued with the American Medical Association, The American College of Physicians, CARE/MEDICO, the American Red Cross, the

Christian Medical Society, and other professional and voluntary agencies active in international health.

3. Increased emphasis on loans rather than technical cooperation and development grants (Table 2).

<u>Table 2</u> Developmental Assistance (In millions of dollars)			
Fiscal Year	Technical Cooperation and Developmental Grants	Development Loans	Developmental Assistance as a Percentage of total development, Sup- porting, Military and Contingency Fund Assistance
	Total	Total	
1961.	\$ 315	\$ 629	24%
1962	381	1,096	36%
1963	349	1,288	43%
1964 (estimate)	313	1,293	49%
1965 (proposed)	323	1,443	52%

In fiscal year 1963 more than half of the funds provided to support health programs were from loans rather than technical cooperation and development grant funds. Although the percentage figure is less in 1965 it still constitutes a significant percentage of the total.

4. Increased efforts to coordinate U. S. assistance with that of other developed countries, international lending agencies and the United Nations and its specialized agencies. Although greater progress has been made with respect to loans continuing efforts are being made to better coordinate technical assistance programs. There is close cooperation in

the world wide malaria eradication program coordinated by the World Health Organization (WHO). Efforts are being made by WHO to achieve a similar level of coordination in community water supply development, health manpower development, smallpox eradication, tuberculosis control and in other programs. Increased efforts are being made by A.I.D. to work closely with the U. S. Public Health Service to achieve this objective. In addition, efforts are being made to better coordinate efforts in the health field with France, Great Britain and other developed countries.

In view of the present A.I.D. objectives it is not difficult to justify interest in health projects or programs. It is clear that both food and health are at the very top of human preoccupations, hence programs in this sector can have a unique impact on people throughout the world. In addition, the achievement of reasonable standards of health is both a prerequisite for and an objective of national development. The high incidence of preventable infectious diseases, widespread malnutrition and rapid rates of population growth constitute serious obstacles to development. The diseases which cause the premature death of large numbers of people result in the loss of human capital. Those diseases which produce recurrent or chronic illness and disability may cause absenteeism, diminished productivity, lowered school performance, decreased initiative and energy, as well as stunted physical growth and possible mental retardation.

The A.I.D. support for health projects or programs will ordinarily be determined by the following factors: 1) the degree to which preventable

infectious diseases, malnutrition or rapid rates of population growth prevent or seriously inhibit economic and social development; 2) the stage of economic and human resource development within the country; 3) the priority assigned to health programs or projects by the host government; 4) the attitude and knowledge of the USAID Mission Director, Program Officers and Public Health Advisors as well as the Technical and Program personnel in the Regional Bureau offices in AID/Washington; 5) the need for impact social welfare programs (e.g., medical care) in situations of political unrest, insurgency or disaster; 6) the economic and human resources that can be invested in health programs; 7) the availability of assistance from international agencies (e.g., WHO, UNICEF) or other developed countries; and 8) the general principles applicable to all A.I.D. assistance.

Priorities in health programs supported by A.I.D. are generally based on the demonstrated ability of the health programs to do the following: 1) contribute to political objectives by reaching large numbers of people or groups in particular need such as the civilian casualties in Vietnam. Measures that bring better health to the whole population, or a large segment of it, lay a basis for a broader distribution of political power, for where only the elite are healthy and vigorous and most of the people are lethargic from sickness, power tends to remain concentrated; 2) contribute to economic and social development by improving the physical strength, energy, learning ability, morale or motivation of a significant number of people, improving the environmental conditions, and by eliminating health hazards and improving the potential for the development of agriculture, water and other natural resources; 3) demonstrate our humanitarian interests. This may be done through programs of disaster

relief, medical care, rehabilitation and communicable disease control or eradication projects.

This report does not include a description of projects funded with local currencies generated by the sale of surplus U.S. agricultural products (Public Law 480) with the exception of an illustration program in the United Arab Republic (p.57). A full description of these programs will be the subject of one of a series of supplementary reports which are being prepared on health and sanitation programs supported by the Peace Corps, Food for Peace (PL 480), Export-Import Bank, World Health Organization, UNICEF, Department of Technical Cooperation of Great Britain and other international health and sanitation projects and programs. An effort is also being made to prepare and up-to-date report on international health programs of private, voluntary organizations and private industry.

This report is divided into five main sections describing health and sanitation programs supported by A.I.D. through its four regional bureaus (Far East, Near East South Asia, Africa, Latin America) and the Office of Technical Cooperation and Research. Review of the programs reveals that, although varied in scope and character, they are consistent with the general principles outlined in this introduction and described in detail in the health sector guidelines (Appendix 3). It is also apparent, in view of the size of the programs in relation to the needs, that we have yet to achieve, within A.I.D., wholehearted acceptance of Disraeli's famous statement: "The health of the people is really the foundation upon which all their happiness and all their powers as a State depends."

Section 2.

AGENCY FOR INTERNATIONAL DEVELOPMENT

HEALTH AND SANITATION PROGRAMS -- FAR EAST

- I. Introduction
- II. Summary of AID Financial Assistance for Health and Sanitation Activities in the Far East (FE) Region for FY 1963 and as proposed for FY 1965
- III. USAID Public Health Positions in the Far East Region (May 25, 1964 and as proposed for FY 1965).
- IV. Description of Health and Sanitation Projects and Health Activities funded under Other Categories (e.g., Rural Economy), by Country in the Far East Region.
- V. Estimate of Possible Needs for U.S. Public Health Service (PHS) Assistance in FE Health Programs
  - a. Longterm assignment - USAID
  - b. Short term consultation - technical backstopping  
USAID's (man months)
  - c. Consultation - technical backstopping AID/W (man months)
  - d. Participant Training

July 27, 1964  
Health Service  
Office of Technical Cooperation and Research

FAR EAST (FE) REGION

I. INTRODUCTION

The health and sanitation programs in the Far East began in 1946 with a U.S. Public Health Service survey of health conditions in the Philippines. In the Philippine Rehabilitation Act of 1946 the U.S. Public Health Service was authorized to spend \$5 million to help alleviate the critical health conditions existing in the Philippines at that time. The public health programs included the provision of safe water supplies, mass smallpox inoculations, development of maternal and child health centers, health education and the establishment of public health training centers. This program was completed in June of 1950 and it was felt that it contributed significantly to improving the health conditions and aiding the post-war recovery of the Philippines.

During the past ten years special emphasis has been given to malaria eradication (Taiwan, Philippines, Thailand, Vietnam, Indonesia and Cambodia); medical education (Korea, Taiwan, Philippines, Vietnam, Thailand and Indonesia); the development of rural health services (Laos, Thailand, Taiwan, Vietnam and Philippines); public health administration (all countries) and counter-insurgency health programs (Vietnam).

Unlike the NESAs and LA Regions, technical cooperation and development grant funds are still used to provide the bulk of the financing for health and sanitation projects. This is particularly the case in the malaria eradication program where grant funds are used to purchase DDT and other commodities in addition to funding the technicians.

Community water supply development has not been a major component of health and sanitation activities in the FE Region even though water-borne diseases are a major problem in almost all of the countries represented by the FE Region.

Future trends are difficult to predict because of the political situation in Laos, Cambodia, Vietnam and Indonesia. Malaria eradication will undoubtedly be continued. The counter-insurgency health program in Vietnam may have to be expanded. Family planning has been adopted by the Government of Korea as official policy and a program is under way in Taiwan. Population problems are being considered in other countries. It is likely these will also receive more A.I.D. attention in the future.

It should be noted that all projects are funded under health and sanitation/technical cooperation and development grants unless otherwise specified. These projects have been submitted by USAID Missions in each country, but final approval for funding must await passage of the Foreign Assistance Appropriations Act. New projects may be added and some of these described eliminated during FY 1965, but this is the best current estimate that can be made.

The health programs in the Far East have requirements for 184 technical or direct supporting personnel in FY 1965. This is an increase of more than 40 positions, all in Vietnam, during the past year. This requirement is greater than the total of the Near East South Asia, Africa and Latin American Regions.

II. SUMMARY OF AID FINANCIAL ASSISTANCE FOR HEALTH ACTIVITIES IN THE FAR EAST IN FY 1963 AND AS PROPOSED FOR FY 1965\*

<u>Country</u>	<u>Health and Sanitation FY 1963</u>	<u>Health and Sanitation FY 1965</u>	<u>Total Health Activities (All Categories) FY 1965</u>
Burma	-	-	-
Cambodia	\$ 402,000	-	-
China, Republic	10,000	-	-
Indonesia	4,469,000	\$2,835,000	\$2,835,000
Korea	-	-	110,000
Laos	-	1,791,000	1,941,000
Philippines	585,000	668,000	668,000
Thailand	2,543,000	2,717,000	3,082,000
Vietnam	2,505,000	2,680,000	2,680,000
Regional	309,000	260,000	260,000
<b>TOTAL</b>	<b>\$10,823,000</b>	<b>\$10,951,000</b>	<b>\$12,076,000</b>

III. USAID PUBLIC HEALTH POSITIONS IN THE FAR EAST REGION

a. As of May 25, 1964

BURMA

Rangoon

1 - Sanitary Engineer

TOTAL Burma - 1.

INDONESIA

Djakarta

1 - Chief Public Health Advisor  
1 - Malaria Advisor  
1 - Malaria Specialist (Training)  
1 - Malaria Specialist  
\*\* 1 - Health Education Advisor  
1 - Equipment Operations Maintenance Specialist  
1 - Medical Supply Advisor (Malaria)  
\*\* 1 - Malaria Specialist (Entomology)  
1 - Malaria Specialist (Epidemiologist)  
1 - Malaria Specialist (Laboratory)  
1 - Public Health Program Assistant (Malaria)  
1 - Malaria Specialist (Entomology)  
\*\* 1 - Malaria Specialist (Sanitarian)

Bandung

1 - Malaria Advisor  
\*\* 1 - Malaria Specialist (Entomology)  
1 - Malaria Specialist Management Area

Surabaya

1 - Malaria Specialist Management Area  
\*\* 1 - Malaria Specialist (Sanitarian)  
1 - Malaria Advisor Area

Malang

\*\* 1 - Malaria Specialist (Sanitarian)\*

Semarang

1 - Malaria Advisor Area  
1 - Malaria Specialist Management Area

TOTAL Indonesia - 22

\* Public Health Service officer.  
\*\* Scheduled for phase-out.

KOREASeoul

1 - Medical Officer Public Health Physician

TOTAL Korea - 1

LAOSVientiane

1 - Chief Public Health Advisor  
 1 - Assistant Public Health Advisor  
 \*\* 1 - Well Driller  
 1 - Medical Technician  
 \*\* 1 - Medical Technician  
 1 - Health Administration Advisor

TOTAL Laos - 6

PHILIPPINESManila

1 - Chief Public Health Advisor  
 1 - Hospital Administration Advisor  
 4 - Malaria Advisors  
 1 - Medical Educator

TOTAL Philippines - 7

REGIONAL (Headquarters Manila, Philippines)

1 - Regional Malaria Advisor  
 1 - Malaria Advisor (Administration)

TOTAL Regional - 2

THAILANDBangkok

1 - Chief Public Health Advisor\*  
 3 - Sanitarians  
 1 - Malaria Advisor

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\* Public Health Service.  
 \*\* Scheduled for phase-out.

- 19 -

Bangkok (cont'd)

- 3 - Malaria Specialists
- 1 - Health Education Advisor (Malaria)
- 1 - Health Administration Advisor
- 1 - Public Health Program Assistant

Chiangmai

- \*\* 1 - Medical Education Advisor
- 1 - Malaria Specialist
- 1 - Nurse Education Advisor

Songkla

- 1 - Sanitarian
- 1 - Malaria Specialist (Entomology)

Khonkaen

- 1 - Malaria Specialist

TOTAL Thailand - 17

VIETNAMSaigon

- 1 - Chief Public Health Advisor\*
- 1 - Deputy Chief Public Health Advisor (Physician)\*
- 1 - Health Education Advisor
- 1 - Sanitary Engineer
- 1 - Sanitarian
- 3 - Public Health Nurses\* (2)
- 1 - Public Health Physician
- 1 - Nurse Education Advisor
- 1 - Malaria Advisor
- 3 - Malaria Specialists
- 1 - Malaria Specialist (Entomology)
- 1 - Malaria Specialist (Epidemiologist)
- 1 - Equipment Operations Maintenance Specialist
- 1 - Hospital Equipment Engineer
- \*\* 1 - Nurse Advisor Hospital Nursing Service
- 8 - Medical Educators
- 1 - Nurse Advisor Hospital Nursery Service
- 1 - Medical Supply Advisor

\* Public Health Service.

\*\* Scheduled for phase-out.

Saigon (cont'd)

- 1 - Hospital Administration Advisor
- 1 - Health Administration Advisor

Hue

- 1 - Nurse Advisor Hospital Nursing Service
- 1 - Malaria Specialist

Tourane

- 1 - Malaria Specialist

Nha-Trang

- 1 - Malaria Specialist

My-tho

- 1 - Malaria Specialist

Quon Nhon

- 1 - Malaria Specialist

Can Tho

- 1 - Nurse Advisor Hospital Service
- 1 - Malaria Specialist

SURGICAL TEAMS (ALL PUBLIC HEALTH SERVICE)Can Tho

- 1 - Chief Surgeon
- 1 - Assistant Surgeon
- 2 - Anesthesiologists
- 1 - Nurse Anesthetist
- 1 - Operating Room Nurse
- 1 - Surgical Nurse
- 2 - Medical Technicians

Nha Trang

- 1 - Chief Surgeon
- 1 - Assistant Surgeon
- 2 - Operating Room Nurses
- 1 - Medical Technician
- 1 - Nurse Anesthetist
- 1 - Surgical Nurse
- 1 - Anesthesiologist

Danang

1 - Chief Surgeon  
 1 - Assistant Surgeon  
 1 - Anesthesiologist  
 1 - Medical Technician  
 1 - Surgical Nurse  
 1 - Operating Room Nurse  
 1 - X-Ray Technician  
 1 - Nurse Anesthetist

TOTAL Vietnam - 64

TOTAL FAR EAST - 120

CONTRACT PERSONNELINDONESIASurabaya (Airlangga University)

Chief of Party  
 Associate Professor of Microbiology  
 Associate Professor of Chemistry  
 Associate Professor of Anatomy  
 Associate Professor of Virology  
 Associate Professor of Surgery  
 Administrative Assistant  
 Professor of Medicine

Campus Coordinator - University of California: Dr. Francis S. SmythTHAILANDChiangmai (College of Medicine)

Professor of Preventive Medicine and Public Health  
 Chief of Party  
 Advisor in Clinical Pathology  
 Advisor in Internal Medicine  
 Advisor in Surgery  
 Advisor in Microbiology  
 Advisor in Anatomy  
 Advisor in Pediatrics  
 Administrative Officer  
 Secretary  
 Medical Technician  
 Advisor in Pharmacology

Campus Coordinator - University of Illinois: Dr. James Plagge

CONTRACT

22

TOTAL ALL HEALTH PERSONNEL 142  
 (direct hire, PHS, Univ. contract)

## b. Projected for FY 1965

EURMARangoon

\*\*1 Sanitary Engineer

TOTAL Burma - 1

INDONESIADjakarta

- 1 - Chief Public Health Advisor/Malaria Advisor
- \*\*1 - Malaria Specialist
- 1 - Equipment Maintenance (Malr)
- 1 - Medical Supply Advisor (Malr)
- 1 - Malaria Specialist (Ent.)
- 1 - Malaria Specialist (Epid.)
- 1 - Malaria Specialist (Lab.)
- 1 - PH Program Assistant (Malr.)
- 1 - Malaria Specialist (Training)

Bandung

- 1 - Malaria Advisor (Area)
- 1 - Malaria Specialist Management (Area)

Surabaya

- 1 - Malaria Advisor (Area)
- 1 - Malaria Specialist Management (Area)

Semarang

- 1 - Malaria Advisor (Area)
- 1 - Malaria Advisor Management (Area)

TOTAL Indonesia- 15

KOREASeoul

\*\*1 - Medical Officer Public Health Physician

LAOSVientiane

- 1 - Chief Public Health Advisor
- 1 - Assistant Public Health Advisor
- 1 - Medical Technician
- 1 - Medical Technician
- 1 - Health Administration Advisor

TOTAL Laos - 5

PHILIPPINESManila

- 1 - Chief Public Health Advisor
- 1 - Hospital Administration Advisor
- 4 - Malaria Advisors
- 1 - Medical Educator

TOTAL Philippines - 7

REGIONAL

- 1 - Regional Malaria Advisor
- 1 - Malaria Advisor (Administration)

TOTAL Regional - 2

THAILANDBangkok

- 1 - Chief Public Health Advisor
- 1 - Chief Sanitarian
- 1 - Malaria Advisor
- 2 - Malaria Specialists
- 1 - Health Education Advisor (Malr)
- 1 - Public Health Program Assistant (Malr)

Chiengmai

- 1 - Malaria Specialist
- 1 - Nurse Education Advisor

Songkla

- 1 - Malaria Specialist

Khonkaen

- 1 - Malaria Specialist
- 1 - Sanitarian

Udorn

- 1 - Sanitarian

TOTAL Thailand - 13

VIETNAM

NOTE: Positions now effective but during FY 65 between 60-100 new positions (not including surgical teams) will become effective.

Saigon

- 1 - Chief Public Health Advisor
- 1 - Deputy Public Health Advisor
- 1 - Health Education Advisor (Malr)
- 1 - Sanitary Engineer
- 3 - Public Health Nurse
- 1 - Public Health Physician
- 2 - Nurse Advisors Hospital Nursing Service
- 1 - Nurse Educator Advisor
- 1 - Malaria Advisor
- 4 - Malaria Specialists
- 1 - Malaria Specialist (Epid.)
- 1 - Equipment Maintenance Specialist (Malr.)
- 1 - Hospital Equipment Engineer
- 8 - Medical Advisors
- 1 - Hospital Administration Advisor
- 1 - Health Administration Advisor

Hue

- 1 - Nurse Advisor Hospital Nursing Service
- 1 - Malaria Specialist

Danang

- 1 - Malaria Specialist

Nhatrang

- 1 - Malaria Specialist

Mytho

- 1 - Malaria Specialist

Quon Nhon

1 - Malaria Specialist

Can Tho

1 - Nurse Advisor Hospital Nursing Service

1 - Malaria Specialist

SURGICAL TEAMS (ALL PUBLIC HEALTH SERVICE)

At present up to 12 additional surgical teams are projected for FY 1965. These will be provided by third-country sources or other U.S. sources such as the Veterans' Administration

Can Tho

2 - Surgeons

1 - Anesthesiologist

1 - Nurse Anesthetist

1 - Operating Room Nurse

1 - Surgical Nurse

2 - Medical Technicians

Nha-Trang

2 - Surgeons

2 - Operating Room Nurses

1 - Medical Technician

1 - Nurse Anesthetist

1 - Surgical Nurse

Danang

2 - Surgeons

1 - Anesthesiologist

1 - Medical Technician

1 - Surgical Nurse

1 - Operating Room Nurse

Additional Health Personnel (late July 1964)

Deputy Chief Public Health Division (Operations)  
Chief, Rural Health Program \*  
Health Educator, Rural Health Program \*  
Health Administration Advisor, Rural Health Program \*  
Public Health Nurse Advisor, Rural Health Program \*  
Secretary, Rural Health Program  
Sanitarian, Rural Health Program  
Director - Coordinator - Surgical Teams \*  
Six Health Administrators (Surgical Teams)  
Medical Equipment Maintenance Specialist  
Medical Depot Supervisor  
Supply Advisor  
Health Educator, Public Health Training Program  
Sanitarian, Public Health Training Program  
Public Health Nurse, Public Health Training Program \*  
Six General Practitioners, Rural Health Program  
Six Regional Nurses, Rural Health Program (1 PHS)  
Six Regional Health Educators, Rural Health Program (3 PHS)  
Six Regional Sanitarians

SURGICAL TEAMS (Special)

- A. 2 Surgeons
  - 1 Anesthesiologist
  - 1 Operating Room Nurse
  - 1 Surgical Nurse
  - 2 Medical Technicians
  
- B. 2 Surgeons
  - 1 Anesthesiologist
  - 1 Operating Room Nurse
  - 1 Surgical Nurse
  - 2 Medical Technicians

TOTAL VIETNAM 116

Contract Personnel

FE

INDONESIA

Surabaya (Airlangga University/University of California)

Chief of Party  
Associate Professor of Microbiology  
Associate Professor of Chemistry  
Associate Professor of Anatomy  
Associate Professor of Virology  
Associate Professor of Surgery  
Associate Professor of Biochemistry  
Associate Professor of Pharmacology  
Associate Professor of Medicine  
Laboratory Technician

Chiangmai (College of Medicine/University of Illinois)

Chief of Party  
Professor of Preventive Medicine and Public Health  
Advisor in Clinical Pathology  
Advisor in Internal Medicine  
Advisor in Surgery  
Advisor in Microbiology  
Advisor in Anatomy  
Advisor in Pediatrics  
Advisor in Pharmacology  
Professor of Biochemistry  
Associate Professor of Physiology  
Medical Technician  
Professor of Obstetrics  
Administrative Officer  
Secretary

Contract

25

TOTAL HEALTH PERSONNEL 184  
(Direct Hire, PHS, University)

IV. DESCRIPTION OF HEALTH AND SANITATION PROJECTS AND HEALTH ACTIVITIES FUNDED UNDER OTHER CATEGORIES (E.G., RURAL ECONOMY), BY COUNTRY IN THE FAR EAST

Burma

Rangoon Water Supply. - To improve water supply system and provide for construction of reservoir. FY 1965 funding - none. Expenditures to date - \$259,000. Scheduled for completion in FY 1965. One sanitary engineer (one public works engineer).

Cambodia

None.

China (Taiwan)

None.

Indonesia

1. Malaria Eradication (Java, Madura and Bali only). - A program to eradicate malaria from the islands of Indonesia having the greatest percentage of the population support for extension of the program to the outer islands is still under study. Funding: estimated FY 1965 \$2,435,000; future years \$1,114,000. Total cost to complete (1951 to 1967) \$43,506,000. Personnel: 14 U.S. technical and administrative personnel. Commodities: insecticides, drugs, vehicles and other miscellaneous equipment and supplies.

2. Development of medical colleges. - To improve medical education at Airlangga University in Surabaya. This project is carried out through a contract with the University of California School of Medicine. Funding: Estimated FY 1965 - \$400,000; expenditure to date \$2,133,000; future

expenditure will depend on possible extension of contract. Phase-out planned for FY 1966. Personnel: About 12 U.S. faculty members (\$90,000) and 40 participants (\$250,000). Commodities: supplies and equipment for medical laboratories (\$50,000).

### Korea

Although the U.S. does not provide direct support for any health or sanitation project, it does provide support for about 30 percent of the total ROK budget. The U.S. provides a single Public Health Advisor to assist the Republic of Korea Ministry of Health in sound planning and administration of health programs.

### Laos

1. Public Health Development.-- Increase support to Royal Laos Government by extending health services in rural areas (100 village dispensaries and rural health centers). Combined with AID-financed Operation Brotherhood. FY 1965 - \$1,741,000. Future obligations to be reviewed annually. Provides commodities such as drugs, medical supplies, vehicles, laboratory and technical equipment, and other supplies.

2. Development of the Rural Economy.-- (not listed as health and sanitation). a) Self-help construction includes dispensaries; b) rural public works involved construction at provincial level; c) well-drilling provides for one of the most pressing needs of Lao villagers. FY 1965 - \$2,171,000 (estimate: 10% health related). Program involves approximately 25 U.S. technicians; commodities, such as cement and other imported construction materials, well-drilling machinery, tools, hardware, seeds, livestock, insecticides and fruit trees.

Philippines

1. Malaria Eradication.- To eradicate malaria and develop a long range program of surveillance. FY 1965 - \$530,000; future years - \$795,000. Estimated expenditures to date - \$5,376,000; estimated to complete - \$7,308,000. One U.S. technician. Funds primarily for purchase of commodities (DDT).

2. Medical Education Improvement.- To improve the caliber of Philippine medical education by training basic science instructors in the U.S., and also by upgrading medical school libraries and other facilities. FY 1965 - \$138,000, future - \$20,000 (probably for a technician). Obligated to date - \$1,538,000 (\$691,000 unliquidated). Estimated total cost to complete - \$1,696,000. U.S. provides one medical education advisor. Delivery of scientific instruments, laboratory equipment and medical textbooks, funded by A.I.D. in prior years, will be completed during 1964.

Thailand

1. Malaria Eradication.- To eradicate malaria in Thailand by 1972. Malaria has been the single greatest cause of sickness, debility, and death in Thailand. FY 1965 - \$1,941,000. Future years - \$6,422,000. Total expenditures to date - \$5,712,000. Estimated to complete (by 1972) - \$14,122,000. U.S. to provide 8 technicians, train 27 specialists, and provide insecticides, laboratory equipment, and motor vehicles.

2. Village Health and Sanitation.- To assist the government in establishing an effective village health and sanitation program covering all the villages of Northeast by the end of 1966, and 6,000 villages outside Northeast by the end of 1965. Provide safe water supplies, build privies,

and general village sanitation. FY 1965 - \$239,000. Future - \$100,000. Total expenditures to date - \$1,307,000. Total to completion - \$2,319,000. U.S. provides 4 sanitarians and money for pumps, pipe fittings, pipe, vehicles, bicycles and audiovisual equipment.

3. Medical Education.- To develop facilities that will increase number of doctors, nurses, and auxiliary health personnel. FY 1965 - \$537,000; future - \$625,000; estimated expenditures to date - \$3,771,000. To completion - \$6,133,000. Fund university contract (2 years in advance), and nurse advisor.

4. Government Statistical Services (Census - not included in health).- To assist the Thai Government develop a national statistical organization to provide basic information for effective economic planning and government management. With the U.S. Bureau of Census, Thai Central Statistical Office since FY 1960 has achieved 1960 population census, survey of family income and expenditures in Bangkok, and textile and agriculture data has been compiled. Other surveys are in process in agricultural and industrial areas. FY 1965 - \$119,000. Future - \$75,000. Total cost to completion (in FY 1966) - \$883,000. Personnel - five statistical advisors. No commodities programmed.

5. Accelerated Rural Development.- Projects include water wells. Total cost - FY 1965 - \$1,908,000 (primarily for other projects, but estimated 10% health related).

6. Rural Development, North and South.- Projects include extension of rural medical clinics. Commodities (\$222,000) include demonstration equipment, medical supplies for rural clinics. \$1,750,000 for contract personnel (estimated 10% health related).

7. Technical Support.- Includes public health (technicians and support personnel not project-related; not separately identified).

Vietnam

1. Malaria Eradication. - To assist the government in carrying out effective anti-malaria activities (pre-eradication). FY 1965 - \$2,055,000; future - \$4,000,000 through 1967; estimated expenditures to date - \$7,070,000. Estimated total to completion - \$13,773,000. U.S. provides 14 malaria specialists. Mainly equipment and commodities.

2. Rural Health Services. - This program is presently under review and a new program is in the process of submission which will emphasize rural health services and will perhaps include as many as 40 additional health personnel. Funding estimates in the summary do not include the costs of this program because they have not yet been submitted in final form. A supplement to this report will be provided with personnel and project costs, when the final documents have been prepared.

3. Medical Education. - To strengthen medical teaching staffs and develop the Saigon Medical Center. Project begun in 1957. FY 1965 - \$625,000; future - \$9,056,000; estimated expenditure to date - \$1,864,000. Presently estimated for completion - \$13,000,000. U.S. may provide personnel under contract. Eight U.S. medical educator advisors are programmed.

Regional

1. Malaria Advisors. - To provide regional consultation and coordination of all U.S.-assisted country malaria programs. One malaria advisor, one malaria eradication administration consultant, plus travel. Started in 1960; expenditure to date - \$121,000. FY 1965 - \$60,000.

2. SEATO Cholera Research. - To undertake a program of basic research to develop, improve, and demonstrate measures to prevent, control, and

- 31 -

eventually eradicate cholera. FY 1965 - \$200,000. Future - \$400,000.

Expenditures to date - \$775,000. Estimated total to complete - \$1,650,000.

Project under direct supervision of NIH. Three U.S. laboratories cooperate.

V. ESTIMATE OF POSSIBLE NEEDS FOR U.S. PUBLIC HEALTH SERVICE (PHS) IN FAR EAST HEALTH AND SANITATION PROGRAMS

The role of the PHS in the Far East may differ from that in other regions because of the present political situation (Vietnam, Burma, Cambodia, Indonesia), the ecological conditions in the Far East and the differing stages of development as well as program needs (e.g., Family Planning in Korea; Medical Education in Philippines; treatment of civilian casualties in Vietnam; malaria eradication in Thailand). Public Health Service Officers have participated in and made significant contributions to programs in Korea, Taiwan, Philippines, Vietnam, Thailand and Indonesia particularly.

a. Full-time USAID Positions

The number of U.S. nationals in health and sanitation activities was 103 in FY 1963 (direct-hire, 57; Participating Agency Service Agreement, 28; contract hire, 18). At present 184 are programmed for FY 1965. This number includes those on medical education contracts in Thailand and Indonesia, as well as the direct-hire medical educators in Vietnam and planned for the Philippines. The Public Health Service already is providing four senior public health advisors in the FE (Thailand 1, Vietnam 2, and Korea 1). In addition, it is providing the surgical teams in Vietnam, as well as other health personnel there and in Thailand.

Due to the changing conditions in Vietnam there will be an additional 40 to 60 health positions activated, not including surgical teams, during FY 1965. The recruitment for these personnel is currently being carried out with the assistance of the Public Health Service and other U.S. Government agencies. It is difficult at this time to estimate the number of PHS personnel

that will be required for this program. It is likely however that at least 10 of them will be filled by PHS personnel. At present, in addition to Vietnam, personnel are likely to be required in Thailand and Laos for the general public health programs, and may be needed for the Malaria Eradication Training Center, as well as other aspects of the malaria program. This will be the subject of a special report by the Malaria Eradication Branch/Health Service/TCR.

The situation in Vietnam presents special problems created by the present situation which require the continued close working relationship with the Bureau of Medical Services, Office of International Health, as well as other units of PHS (such as the Office of Personnel), in order that it receive the priority attention it deserves.

b. Short-term Consultants for USAID's (man months)

The estimated requirements are as follows: communicable disease control (6); public health administration (0); demography and vital statistics (0); health education (2); public health nursing (3); sanitary engineering (2); nutrition (3); other (2).

c. Short-term consultations - AID/W (man months)

The following services are likely to be required in AID/W to serve for general technical backstopping in the FE Region: communicable disease control (2); public health administration (0); demography and vital statistics (2); health education (2); public health nursing (0); sanitary engineering (0); nutrition (0); other (2).

d. Participant Training

The health participant training program needs continuing review. In view of the growing recognition of population problems this would appear to be a particularly fruitful area for review. Such participants need not be project related.

The following is the estimated number of health participants based on the experience of recent years:

	<u>FY 1965</u>
Full academic year	75
Short-term (1 - 6 months)	25
	<hr/>
	100

AGENCY FOR INTERNATIONAL DEVELOPMENT

HEALTH AND SANITATION PROGRAMS

NEAR EAST and SOUTH ASIA

- I. Introduction
- II. Summary of AID Financial Assistance for Health and Sanitation Activities in the Near East and South Asia (NESA) Region for FY 1963 and as Proposed for FY 1965
- III. USAID Public Health Positions in NESA (as of May 25, 1964) and Projected FY 1965
- IV. Outline of Health and Sanitation Projects and Health Activities funded under Other Categories (e.g., Agricultural and Natural Resources), by Country in NESA Region.
- V. Estimate of Possible Needs for U.S. Public Health Service (PHS) Assistance in NESA Health Programs
  - a) Long-term assignment - USAID
  - b) Short-term consultants - USAID (man months)
  - c) Consultation - Technical backstopping (man months)
  - d) Participant Training

July 27, 1964  
Health Service  
Office of Technical Cooperation and Research

NEAR EAST AND SOUTH ASIA REGION (NESA)

I. INTRODUCTION

Bilateral programs of technical cooperation in health and sanitation have been carried out in the NESA Region since 1947 when the Truman Doctrine was first put into effect. Major programs of assistance have been carried out in Greece, Turkey, Lebanon, Iran, Jordan, Yemen, Nepal, Pakistan, India and Ceylon. Major emphasis has been placed on malaria eradication, public health administration, community water supply development, and health manpower development. Although the NESA region has the largest population of any of the regions within the AID program, its present program of technical cooperation and development grants is smaller than that of any other region. Large development loans, however, have been made in Pakistan and India. Because of rapid rates of population growth and present government concern in Turkey, Pakistan and India, problems in this area will undoubtedly receive greater AID attention in the future. Because of the importance of development in relation to population growth, we have included a brief description of census and vital statistics projects in Section IV, even though these are not considered health or sanitation projects.

The projects included in this section have been submitted by the USAID Missions in each of the countries concerned, but final approval for funding must await passage of the Foreign Assistance Appropriation Act. New projects may be added and some of those described eliminated during FY 1965, but this is the best current estimate that can be made.

It should be noted that all projects described in Section IV are funded under health and sanitation technical cooperation and development grants unless otherwise specified.

II. SUMMARY OF AID FINANCIAL ASSISTANCE FOR HEALTH AND SANITATION  
ACTIVITIES IN THE NEAR EAST SOUTH ASIA (NESA) REGION

<u>Country</u>	<u>Health and Sanitation FY 1963</u>	<u>Health and Sanitation FY 1965</u>	<u>Total Health and Sanitation Activities (All Categories) FY 1965</u>
Afghanistan	\$ 26,000	-	-
Ceylon	4,000	-	-
Cyprus	95,000	-	-
Greece	-	-	-
India	686,000	\$ 545,000*	545,000*
Iran	674,000	522,000	522,000
Iraq	1,000	-	-
Israel	-	-	-
Jordan	302,000	217,000	1,150,000
Lebanon	-	-	-
Nepal	721,000	804,000	804,000
Pakistan	9,163,000 (8.4 loan)	325,000 *	325,000 *
Syria	-	-	-
Turkey	-	-	56,000
UAR (Egypt)	-	-	-
Yemen	-	700,000	700,000
CENTO	26,000	20,000	20,000
Regional	<u>48,000</u>	<u>400,000</u>	<u>400,000</u>
Total	\$11,746,000 (8.4 loan)	\$3,533,000 *	\$4,522,000 *

\* Loan funds obligated in FY 1964 provide funds to be used in FY 1965 for India (\$3,150,000) and Pakistan (\$5,300,000).

III. USAID PUBLIC HEALTH POSITIONS IN THE NEAR EAST and SOUTH ASIA REGION

a. As of May 25, 1964

INDIA

New Delhi

- 1 - Chief Public Health Advisor (Physician)
- 1 - Health Administration Advisor
- 1 - Hospital Administration Advisor
- 1 - Public Health Nurse
- 1 - Health Education Advisor
- 1 - Public Health Physician - Epidemiology
- 2 - Malaria Advisors
- 1 - Public Health Physician - Epidemiology
- 1 - Chief Public Health Engineer

Hyderabad

- 1 - Public Health Nurse, Maternal and Child Health
- 1 - Nursing Education Advisor\*
- 2 - Nursing Education Advisors
- 1 - Nursing Advisor
- 1 - Nursing Advisor (Medical-Surgical)
- 1 - Nursing Advisor - Hospital Nursing Service
- 1 - Health Education Advisor

Trivandrum

- 1 - Health Administration Advisor, Medical Records
- 1 - Medical Educator, Hospital Administration
- 1 - Health Education Advisor

Jaipur

- 2 - Nursing Education Advisors\*
- 2 - Nursing Education Advisors

Total - India ----- 25

IRAN

Tehran

- 1 - Chief Public Health Advisor (Physician)
- 1 - Hospital Administration Advisor
- 1 - Public Health Nurse\*\*
- 2 - Nursing Education Advisors
- 1 - Sanitation Engineer
- 1 - Malaria Advisor

\* Public Health Service

\*\* Scheduled for phase-out.

IRAN (Cont'd)

Shiraz

- 1 - Medical Educator
- 1 - Public Health Physician
- 1 - Nursing Advisor - Hospital Nursing Service
- 1 - Sanitation Engineer
- 1 - Public Health Nurse\*
- 2 - Malaria Specialists - Entomology

Meshed

- 1 - Nursing Advisor - Hospital Nursing Service

Total - Iran ----- 15

Pahlavi University Medical Center-  
University of Pennsylvania Contract Personnel, Shiraz, Iran

- Chief of Party & Professor of Internal Medicine
- Hospital Administrator
- Laboratory Technician - Supervisor
- Physiologist
- Radiologist
- Chief of Obstetrics
- Professor of Biochemistry
- Librarian
- Campus Coordinator

Total Iran Contract---9

JORDAN

Amman

- 1 - Public Health Nurse
- 1 - Malaria Advisor
- 1 - Sanitary Engineer
- 1 - Sanitary Engineer (Water Sewage)

Total - Jordan ----- 4

NEPAL

Kathmandu

- 1 - Public Health Administrator (Physician)
- 2 - Malaria Specialists - Entomology
- 1 - Malaria Advisor
- 1 - Health Education Advisor
- 1 - Public Health Nurse
- 1 - Malaria Specialist

Total - Nepal ----- 7

\* Public Health Service.

\*\* Scheduled for phase-out.

PAKISTAN

Karachi

- 1 - Chief Public Health Advisor (Physician)
- 1 - Health Administration Advisor
- 1 - Health Education Advisor\*
- 1 - Malaria Advisor
- 1 - Nursing Education Advisor
- 1 - Nursing Education Advisor\*\*

Lahore

- 1 - Chief Public Health Advisor
- 1 - Sanitarian
- 1 - Malaria Specialist
- 1 - Supply Advisor (Malaria)
- 1 - Health Education Advisor
- 1 - Nursing Advisor
- 1 - Sanitary Engineer

Dacca

- 1 - Chief Public Health Advisor (Physician)
- 1 - Sanitary Engineer
- 1 - Health Education Advisor
- 1 - Sanitarian
- 1 - Nursing Advisor
- 1 - Equipment Maintenance Specialist (Malaria)
- 1 - Malaria Specialist

Total - Pakistan ----- 20

Postgraduate Medical Center - Indiana University  
Contract Personnel, Karachi, Pakistan

- Chief of Party & Professor of Medicine
  - Professor of Physiology
  - Professor of Microbiology
  - Professor of Medicine
  - Professor of Pediatrics
  - Professor of Surgery
  - Administrative Assistant
  - Campus Coordinator - Dr. William Headlee, Indiana University
- Total ----- 8

Pakistan-SEATO Cholera Research Laboratory Personnel  
AID/NIH, Dacca, East Pakistan

- Director
  - Medical Officer
  - Surgeon (Clinical Research)
  - Executive Officer
  - Nutritionist
  - Chief Epidemiologist
- Total ----- 6

\* Public Health Service

\*\* Scheduled for phase-out.

TURKEY

Ankara

- 1 - Sanitary Engineer (Water Sewage)
- 1 - Sanitarian

Istanbul

- 1 - Nursing Education Advisor

Total - Turkey ----- 3

YEMEN

Taiz

- 1 - Sanitary Engineer
- 1 - Sanitary Engineer (Water Sewage)
- 1 - Construction Supervisor
- 1 - Well Driller
- 1 - Engineering Draftsman - Design

Total - Yemen ----- 5

REGIONAL

- 1 - Malaria Advisor - New Delhi
- 1 - Community Water Supply Advisor - Regional\* Pakistan

Total - Regional ---- 2

TOTAL NESA HEALTH PERSONNEL  
(Direct Hire, PHS, University)-----104

\* Public Health Service.

\*\* Scheduled for phase-out.

III. Continued

USAID PUBLIC HEALTH POSITIONS IN THE NEAR EAST and SOUTH ASIA REGION

b. Projected for FY 1965

AFGHANISTAN

None

CEYLON

None

CYPRUS

None

GREECE

None

INDIA

New Delhi

- 1 - Chief Public Health Advisor (Physician)
- 1 - Health Administration Advisor
- 1 - Hospital Administration Advisor
- 1 - Public Health Physician - Epidemiologist\*
- 1 - Public Health Nurse \*\*
- 2 - Malaria Advisors (one Public Health Service officer)\*
- 1 - Health Education Advisor\*
- 1 - Chief Public Health Engineer\*
- 1 - Veterinarian\*\*
- 1 - Biostatistician\*\*

Hyderabad

- 1 - Public Health Nurse\*\*
- 6 - Nursing Education Advisors (3 Public Health Service Officers)\*\*
- 1 - Health Education Advisor

Jaipur

- 3 - Nursing Education Advisors\*\*

Trivandrum

- 1 - Medical Educator (Hospital Administration)

\* Public Health Service.

\*\* Position not firm for FY 1965.

INDIA - Cont'dBangkor

- 1 - Health Administration Advisor (Medical Research)\*\*

Total - India ----- 24

IRANTehran

- 1 - Chief Public Health Advisor - Physician  
(Public Health officer requested)
- 1 - Hospital Administration Advisor
- 1 - Malaria Advisor\*\*
- 1 - Sanitary Engineer
- 2 - Nursing Education Advisors
- 1 - Public Health Nurse (Public Health Service officer)\*

Shirez

- 1 - Medical Educator
- 1 - Public Health Physician
- 1 - Nursing Advisor, Hospital Nursing Service
- 1 - Malaria Specialist\*\*
- 1 - Sanitary Engineer
- 1 - Public Health Nurse\*

Total - Iran ----- 13

IRAQ

None

ISRAEL

None

JORDANAmman

- 1 - Malaria Advisor\*
- 2 - Sanitary Engineers
- 1 - Public Health Nurse\*\*

Total - Jordan ----- 4

LEBANON

None

\* Public Health Service.

\*\* Position not firm for FY 1965.

NEPAL

Kathmandu

- 1 - Public Health Physician
- 1 - Malaria Advisor
- 3 - Malaria Specialists
- 1 - Public Health Nurse
- 1 - Health Educator

Total - Nepal ----- 7

PAKISTAN

Karachi

- 1 - Chief Public Health Advisor
- 1 - Malaria Advisor
- 1 - Health Educator\*
- 1 - Health Administration Advisor

Dacca

- 1 - Chief Public Health Advisor
- 2 - Malaria Specialists

Lahore

- 2 - Malaria Specialists
- 1 - Nursing Education Advisor\*
- 1 - Health Educator\*

Total - Pakistan ----- 11

SYRIA

None

TURKEY

Ankara

- 1 - Sanitarian
- 1 - Sanitary Engineer

Istanbul

- 1 - Nursing Education Advisor

Total - Turkey ----- 3

\* Public Health Service.

\*\* Position not firm for FY 1965.

UAR (Egypt)

None

YEMEN

Taiz

- 1 - Sanitary Engineer
- 1 - Construction Superintendent
- 1 - Well Driller
- 1 - Engineer-Draftsman Designer
- 1 - Engineering Advisor
- 1 - Engineering Technician

Total - Yemen ----- 6

REGIONAL

- 1 - Sanitary Engineer
- 1 - Malaria Advisor (Public Health Service Officer)

Total - Regional ----- 2

TOTAL - NESA ----- 60

Postgraduate Medical Center - Indiana University  
Contract Personnel, Karachi, Pakistan  
 (Contract ends October 1965)

- Chief of Party & Professor of Medicine\*\*
- Professor Physiology
- Professor of Microbiology
- Professor of Medicine
- Professor of Pediatrics
- Professor of Surgery
- Administrative Assistant

Pakistan - SEATO Cholera Research Laboratory  
Personnel, AID/NIH, Dacca, East Pakistan

- Director
- Medical Officer
- Executive Officer
- Nutritionist
- Surgeon (Clinical Research)
- Chief Epidemiologist

\*\* Position not firm for FY 1965.

IRAN

Pennsylvania University  
Contract Personnel, at Pahlavi University, Shiraz, Iran

Radiologist  
Chief of Obstetrics  
Librarian

At present the Penn/AID contract is being broadened to cover many fields in medical education, and in over-all development of the Pahlavi University (other than old contract applicable to only the Medical College). Therefore, more positions will probably become effective before the end of FY 1965.

TOTAL HEALTH PERSONNEL 76  
(Direct Hire, PHS, University)

IV. OUTLINE OF HEALTH AND SANITATION PROJECTS AND HEALTH ACTIVITIES FUNDED UNDER OTHER CATEGORIES (e.g., AGRICULTURAL AND NATURAL RESOURCES), BY COUNTRY IN NEAR EAST AND SOUTH ASIA (NESA) REGION. (PROJECTED FOR FY 1965)

Afghanistan

1. Feasibility Studies (Technical Cooperation). To assess projects feasible for Second Five-Year Plan. Includes study for water systems, Jalalabad, Herat, and Kandahar. Totals: Proposed FY 1965 - \$310,000; future - \$900,000; estimated expenditure to date - \$75,000; to complete - \$1,587,000.

Ceylon - None.

Cyprus - None.

Greece

Program Loan (Development Loan). To finance the foreign exchange costs of eligible commodities. Includes pharmaceuticals. \$10,000,000 approved for 20 years. No estimate of the value of pharmaceuticals in FY 1965.

India

1. Nursing College Development. To establish two schools of nursing with 4-year B.S.-degree program as models for other Indian schools of nursing. FY 1965 - \$160,000; future - \$250,000. Estimated expenditures to date - \$982,000; estimated to complete - \$1,522,000. Initial 1958. Scheduled final obligation - FY 1957. Personnel - 3 Public Health Nurse Educators at Osmania College will complete their teaching duties by June 30, 1965; 4 Public Health Nurse Educators at Jaipur College will continue teaching and curricula work through FY 1967. Commodities - None.

2. Medical Education Training. To help improve the quality of education at two demonstration medical schools, and train Indian medical educators from other institutions. Assistance at Trivandrum and Osmania. FY 1965 - \$150,000; future - \$150,000. Estimated expenditures to date - \$1,418,000; estimated to complete - \$1,955,000. Initial obligation - 1958; scheduled final obligation - 1966. Two advisors at Trivandrum to remain (a medical college dean and senior hospital administrator). Five short-term consultants will conduct program at both colleges. Commodities: None.

3. Communicable Disease Control. To help the National Institute of Communicable Disease (NICD) become the central facility in India for the collection, evaluation, and dissemination of technical information relating to control of major communicable diseases. FY 1965 - \$100,000; future - \$300,000; estimated expenditures to date - \$50,000; to complete - \$545,000. Initial - 1963; scheduled final obligation - FY 1968. In FY 1965, an epidemiologist, a biostatistician, and a public health engineer were assigned from PHS Communicable Disease Center (CDC) in Atlanta, Georgia. Three consultants and four participants. Commodities - None.

4. Malaria Eradication. To eliminate malaria as a hazard by 1970. We will continue to provide technical assistance through the attack and surveillance phase of the program which will be completed by the end of FY 1966. The cost of the program from FY 1958 through FY 1963 was \$271 million, of which the Indian Government financed about 40%. The U.S. covered most foreign exchange costs of the program but ceased granting DDP and equipment in FY 1963. (Now financed from general loan.) The U.S.

financed \$111 million equivalent of local costs by P.L. 480 Section 104(e) grants. Initial obligation - FY 1958. Final - FY 1966. FY 1965 - \$75,000; future - \$75,000; estimated expenditures to date - \$62,352,000; estimated to completion - \$62,567,000. Personnel: One entomologist, one epidemiologist, and one malariologist; from PHS, seven short-term advisors.

5. Public Health Education. To strengthen the Central Health Education Bureau (CHEB) and organize Health Education Bureaus within State Health Ministries. Initial obligation - FY 1958; scheduled final obligation - FY 1966. FY 1965 - \$60,000; future years - \$60,000. Estimated expenditures to date - \$294,000; estimated to completion - \$437,000. Personnel: Two Public Health education advisors; six participants.

6. Technical Support. Includes funds for Public Health Advisor.

### Iran

1. Pahlavi Medical Center. To create a teaching, research, and social services center in Shiraz. Initial obligation - 1953; scheduled final obligation - FY 1967. FY 1965 - \$305,000; future - \$450,000; estimated expenditures to date - \$1,628,000; estimated to completion - \$2,782,000. Personnel: One direct-hire medical education advisor and 6 medical educators under University of Pennsylvania contract.

2. General Nursing Services. To help develop and train qualified nurses to staff a public health nursing service in Iran. Initial - 1956. Scheduled final obligation in 1965. Estimated FY - 1965 - \$8,000. Estimated expenditures to date - \$465,000; to completion - \$488,000. U.S. technician - three-months service one public health nurse.

3. Environmental Sanitation. To help the general department of sanitary engineering of the Ministry of Health develop a nationwide sanitary engineering and environmental sanitation program. Initial 1956. Scheduled final obligation 1965. FY 1965 - \$15,000; estimated expenditures to date - \$645,000; to completion - \$678,000. One U.S. sanitary engineer for six months.

4. Nursing Education. To help Iran create nurse training educational institutions and establish the nursing profession on a sound basis. Initial 1955. Scheduled final year 1965. FY 1965 - \$40,000; estimated expenditure to date - \$305,000; to completion - \$373,000. Personnel: Two American nurse educators.

5. Malaria Eradication. To achieve eradication in responsive zone by 1964 and in the refractory zone by 1967. To carry out training demonstration project in Fars Province. Initial year 1956. Final obligation FY 1965. FY 1965 - \$39,000. Future years - 0; estimated total expenditures - \$4,504,000. Plan to terminate June 30, 1965. Personnel: Two malaria advisors; reduce to one, beginning of FY 1965.

6. Hospital Administration. To help Iran improve the effectiveness of the Ministry of Health hospital-care program. Initial FY 1956. Scheduled final obligation FY 1965. FY 1965 - \$20,000; estimated expenditures to date - \$213,000; estimated total cost - \$252,000.

7. General Health Services. To help the Ministry of Health work out solutions to organizational and administration problems raised by the planned decentralization of its authority. A team of three Americans,

one public health physician, one sanitary engineer, and one public health nurse, will work in Fars Province. Initial FY 1965; scheduled final year 1967. FY 1965 - \$95,000; future years - \$230,000. Estimated total for completion - \$325,000.

8. Technical Support. Includes the public health division chief.

### Israel

Program Loan II. A \$35-million loan includes commodities for pharmaceutical industries. No estimate of amount for pharmaceuticals in FY 1965.

Program Loan III. A \$21-million loan includes commodities for pharmaceutical industries. No estimate of amount for pharmaceuticals in FY 1965.

### Jordan

1. Assistance to Central Water Authority (called Agriculture and Natural Resources). To provide technical advice and financial assistance to the Central Water Authority (CWA) in locating and developing ground surface water sources. In three years of operation water was located and made available in 10 major cities, 10 municipal water projects were planned and designed, 117 springs completed, 28 cisterns; 5 water storage dams and 1375 springs located and inventoried. Initial 1960. Scheduled final obligation 1968. FY 1965 - \$972,000. Future - \$650,000. Estimated total for completion - \$5,759,000. U.S. technicians include general engineer, a ground water geologist, a water and sanitary engineer and three short-term consultants.

2. East Ghor Rural Development (Technical Cooperation Development Grant). Includes financing for a small hospital and clinic, as part of a multi-purpose center, at Wadi Yabes; also six filtration plant chlorinators (at estimated cost of \$20,000). Sanitary drinking water facilities are planned for 10 villages. Approximately half of funds as loan not to exceed 20 years. Total project: Proposed FY 1965 - \$716,000; estimated expenditure to date - \$320,000; estimated to completion - \$1,437,000.

3. Malaria Eradication. To eradicate malaria by 1967. Initial obligation 1958; scheduled final obligation 1967. Of particular significance is new area opened in Jordan valley for farming. FY 1965 - \$103,000. Future - \$105,000. Estimated expenditures to date - \$870,000. Total to complete - \$1,152,000. Personnel: One malaria advisor on reimbursable detail from PHS. Commodities include vehicles and spare parts and a limited amount of drugs.

4. Environmental Sanitation. To assist the Ministry of Health organize and train staff, and administer an environmental public health program. Initial 1953; scheduled final obligation 1965. Have helped organize Ministry, train their sanitarians, and safe water developed with average 6 - 10 improved springs or wells per month. FY 1965 - \$75,000. Future - 0. Estimated expenditures to date - \$836,000; to complete - \$981,000. Personnel: Two sanitary engineers. Commodities include scientific

equipment, professional instruments, laboratory supplies, one motor vehicle.

5. Public Health Nursing.-- To help establish nursing program with preventive and curative medicinal services. Initial obligation FY 1955; scheduled final obligation FY 1965. Nursing services, maternal and child health, tuberculosis care, and immunization now provided. Expect to establish school health program. Fourteen nurses/midwives trained at American University of Beirut; one received advanced administration training in the U.S. Ministry of Health local clinics upgraded, now total 200. Personnel: To be phased out December 1964.

Lebanon

None.

Nepal

1. Malaria Eradication.-- To eradicate malaria in Nepal by 1970. This is the first nationwide health program attempted by Nepal. Initial obligation 1954; scheduled final year 1970. FY 1965 \$678,000. Future \$2,520,000. Estimated expenditure to date \$2,444,000; estimated to complete \$6,534,000. Personnel: four malaria specialists; commodities: DDT, drugs, sprayers, entomological and surveillance supplies and equipment and spare parts.

2. Public Health Administration.-- To improve the organization and administration of Nepal's Public Health Service. Initial 1954. Scheduled final obligation FY 1967. Proposed FY 1965 \$48,000; future \$72,000; estimated expenditure to date \$330,000; to complete \$473,000.

Personnel: one public health advisor. Commodities: medical supplies and equipment, jeep, and office machines.

3. Health Education.-- To assist Nepal's Ministry of Health develop and implement a national health education program. Initial 1957.

Scheduled final obligation 1966. FY 1965 - \$44,000; future \$36,000.

Estimated expenditure to date \$316,000; estimated to complete \$419,000.

Personnel: one health educator. Commodities: offset printing and audiovisual equipment and spare parts.

4. Nurses and other Paramedical Workers' Training.-- To improve the quality of nurses and other paramedical personnel of Nepal's Public Health Service. Initial 1954. Scheduled final obligation 1967. FY 1965 - \$34,000; future \$32,000. Estimated expenditure to date \$441,000; estimated total \$537,000. Personnel: one nursing advisor. Commodities: medical models, technical devices and supplies for demonstration purposes.

5. Statistical Development (Public Administration).-- To help Nepal develop a national statistical organization to collect and tabulate reliable data. Proposed FY 1965 \$64,000; future, \$123,000. Expenditures to date \$107,000. Estimated for completion, \$316,000.

Personnel: one Bureau of Census advisor, short-term consultants.

Commodities: simple statistical processing equipment and printing equipment. Tabulation of the 1961 Population Census will be published in FY 1965.

6. Technical Support.-- Includes Public Health Division Chief.

Pakistan

1. Rural Health Development.-- To help the Central and Provincial Government expand rural health services, with special emphasis on preventive medicine, improved sanitation, and health education. Proposed FY 1965 \$170,000; expenditures to date \$1,398,000; estimated for completion, \$2,167,000.

Personnel: Chief Public Health Advisor, Sanitary Engineer, Chief Health Education Advisor, Health Education Advisor and two Nurse Advisors.

Commodities: none.

2. Malaria Eradication (Development Grant).-- To strengthen the planning, administrative and logistic capabilities of agencies responsible for malaria eradication. Initial 1963; scheduled final obligation 1968.

FY 1965 - \$111,000; future - \$450,000. Estimated expenditure to date, \$113,000; to completion, \$675,000. Personnel: five technicians in entomology, supply and procurement, motor vehicle maintenance, and malariology. Commodities: financed by Development Loan (see below).

3. Malaria Eradication (Development Loan).-- To provide foreign exchange costs of commodities and services required to carry out the third year of a 14-year program for complete eradication of malaria in Pakistan. Loan signed February 28, 1963. Amount: \$3,800,000 - disbursed \$757,000.

Note: the total cost of the 14-year program is \$109.3 million, of which \$68.5 million is local currency and \$40.8 million is in foreign exchange. The 1963-64 cost is \$7 million, the foreign exchange requirement of which is \$3.8 million. All items (especially DDT) of U.S. source and origin.

4. Nursing Education and Facilities.-- To assist Pakistan develop a college of nursing which will prepare nurses for teaching and administrative positions in nursing schools, health agencies and hospitals

throughout the country. Initial 1955; scheduled final obligation 1966.

FY 1965 - \$33,000; future - \$18,000. Estimated expenditures to date -

\$579,000; to completion - \$656,000. Personnel: One nurse educator.

Commodities: None.

5. Postgraduate Medical Center. To set up a medical teaching and research center to train medical educators and related professional personnel, carry out research, and provide guidance on curriculum and research to other medical institutions in Pakistan. Initial 1955; scheduled final obligation FY 1965. FY 1965 - \$21,000. Estimated expenditures to date - \$1,098,000; estimated total to complete - \$2,071,000. Contract with Indiana University.

6. Statistical Services (Public Administration). To improve the collection, compilation and publication of basic statistics essential to effective planning and management of central and provincial development programs. Includes developing population projections, work plans for decennial census, and techniques for evaluation and appraisal. Initial 1955. Final obligation 1969. Total program FY 1965 - \$207,000; future - \$812,000. Estimated expenditures to date - \$938,000; to complete - \$2,018,000. Personnel: Nine advisors from Census. Commodities: None.

7. Technical Support. Includes Division Chiefs, staff supplemented by specialized consultant services in rural and urban health problems, and engineering in health plus other specialties.

Byria - None.

Turkey

1. Nursing Education (Education). To assist Florence Nightingale School of Nursing to develop a well-rounded curriculum, a professionally qualified faculty, and high-quality instructional materials. Initial 1955; scheduled final year FY 1966. FY 1965 - \$56,000. Estimated expenditures to date - \$245,000; to completion - \$395,000. Personnel: One U.S. Public Health Nurse Advisor. A hospital nursing administrator will arrive in July 1965 and remain for one year. No commodities.

2. Development Statistics. To develop the State Institute of Statistics. Initial 1963. Final obligation 1967. Includes assistance in 1960 population census; planning for 1965 census (additional population statisticians to be added in FY 1965). FY 1965 - \$200,000. Future - \$300,000. To complete - \$672,000. U.S. personnel: Eight statisticians.

United Arab Republic

1. Assistance in Construction of Health Centers (Local Currency Funding). A.I.D. will provide assistance in construction and partial equipping of 109 rural health units in the U.A.R. The total U.S. contribution will be limited to payment of construction costs and purchase of supplies in the local currency equivalent of approximately \$1,633,920. The agreement also provides for the procurement of supplementary supplies for 500 health units, including those constructed under the U.A.R.'s regular health center program. This program is not included in funding summary (p. 37) because it is in local currency. This will be included in separate PL-480 report.

Yemen

1. Water Supply and Environmental Sanitation (Supporting Assistance). To construct a water system and teach Yemeni to operate and maintain

it. To develop a water department and improve water supplies in selected villages. Initial FY 1961. Scheduled final obligation FY 1966. FY 1965 - \$700,000; future - \$200,000. Estimated expenditure to date - \$2,025,000; to complete - \$3,828,000. Personnel: Seven technicians. Commodities: Training aids and specialized equipment for small water systems.

CENTO

1. Support of Specific Technical Assistance Requests (General and Miscellaneous). To provide support for conferences, seminars, and expert studies on common problems. In health sector, assistance in preventive medicine, nursing and hospital administration. A conference is now planned on population problems. Initial FY 1958; total estimated expenditures, FY 1965 - \$202,000; estimated total expenditures to date - \$783,000; continuing obligation.

Regional

1. American University of Beirut. To use AUB facilities for academic training of NESA and African participants. FY 1965 - \$2,225,000. Estimated expenditures to date - \$21,499,000 -- completion not applicable. In the period 1951-1962, 1,843 participants -- 708 from public health. (In FY 1965 estimated 60 of 600 in Public Health.)

2. Regional Activities. To carry out regional programs of value to more than one country. One regional advisor on water supply; one regional malaria advisor. FY 1965 - \$175,000 (includes salaries and travel for malaria and water advisors). Estimated expenditures to date - \$607,000. Expected completion - not applicable.

V. ESTIMATE OF POSSIBLE NEEDS FOR U.S. PUBLIC HEALTH SERVICE (PHS) ASSISTANCE IN HEALTH AND SANITATION PROGRAMS

The programs of malaria eradication and health manpower development continue to be the most important programs receiving U.S. support in the NESA Region. It is anticipated that programs related to the rapid rates of population growth in Turkey, Pakistan and India will become increasingly important in the years ahead.

a. Full-Time USAID Positions

The positions presently occupied by PHS Officers and those under discussion are noted in Section II.

b. Short-term consultation - USAID's (man months)

The following are the estimated requirements: Communicable disease control (9); public health administration (3); demography and vital statistics (1); health education (15); public health nursing (3); sanitary engineering (12); nutrition (0); other (0).

c. Consultation AID/W (man months)

Consultation in AID/W will serve primarily for general technical backstopping services in those fields not covered by TCR/HS, contracts with American Hospital Association and American Association of Medical Colleges. The following are the estimated requirements: Communicable disease control (1); public health administration (0); demography and vital statistics (2); health education (2); public health nursing (1); sanitary engineering (0); nutrition (1); other (2).

d. Participant Training

We anticipate a participant training program in health at a level not to exceed FY 1964. Although there are major needs for training in all aspects of population dynamics, it is unlikely that these non-project needs will be reflected in a program that has been traditionally tied to AID-supported projects. The estimated total number of participants for FY 1965 is 128.

AGENCY FOR INTERNATIONAL DEVELOPMENT  
HEALTH AND SANITATION PROGRAMS -- AFRICA

- I. Introduction
- II. Summary of A.I.D. Financial Assistance for Health and Sanitation Activities in Africa for FY 1963 and as Projected for FY 1965
- III. USAID Public Health Positions in Africa ---- May 25, 1964 and as Proposed FY 1965)
- IV. Description of Health and Sanitation Projects and Health Activities Funded under other Categories (e.g., Agriculture), by Country in Africa Region
- V. Estimate of Possible Needs for U.S. Public Health Service (PHS) Assistance in Health Programs
  - a. Long-term assignment - USAID
  - b. Short-term consultation - USAIDs (man months)
  - c. Consultation - Technical Backstopping AID/W (man months)
  - d. Participant Training

July 27, 1964  
Health Service  
Office of Technical Cooperation and Research

AFRICA (AFR) REGION

1. INTRODUCTION

Although the many newly emerging countries of Africa are plagued with a multiplicity of disease problems, limited financial resources and few skilled health personnel, the U.S. Government has had only a small program of technical cooperation in health in most of Africa. The major sources of support for the African countries have been France, Great Britain and the International Agencies (World Bank, UN). The U.S. has participated in long-term technical cooperation health projects in Liberia and Ethiopia particularly. In East Africa, the Sudan and Nigeria major development loans have been made for the development of community water supplies. Emphasis in the grant-supported projects has been on health projects related to rural community development, health manpower development (auxiliaries), public health administration, communicable disease control and health planning. Grant funds to support these projects have been at about the same level for FY 1963, 1964 and 1965. There is not likely to be any major shift in the immediate future, although a study of programs may be undertaken in cooperation with the National Academy of Sciences which might result in changing program emphasis.

It should be noted that all the projects described under Section IV are funded under health and sanitation/technical cooperation and development grants unless otherwise specified. The projects have been submitted by the USAID missions in each of the countries concerned, but final approval of funding must await passage of the Foreign Assistance Act. New projects may be added and some of those included may be eliminated in FY 1965, but this the best current estimate that can be made.

II. Summary of Proposed AID Financial Assistance for Health and Sanitation Activities in Africa -- FY 1963 and FY 1965 (Proposed)

<u>Country</u>	<u>FY 1963 Health and Sanitation</u>	<u>FY 1965 Health and Sanitation</u>	<u>FY 1965 All Health and Sani- tation Activities</u>
Algeria	\$ 673,000	-	-
Burundi	-	-	-
Cameroon	10,000	\$ 20,000	\$ 20,000
Central African Republic	142,000	88,000	88,000
Chad	823,000	290,000	290,000
Congo (Brazzaville)	-	-	-
Congo (Leopoldville)	-	-	-
Dahomey	38,000	-	-
Ethiopia	1,464,000	1,465,000	1,465,000
Gabon	145,000	120,000	120,000
Ghana	163,000	-	20,000
Guinea	-	-	-
Ivory Coast	65,000	-	175,000
Kenya	2,200,000 (2.2 loan)	-	-
Liberia	5,458,000 (5.3 loan)	395,000	395,000
Libya	158,000	108,000	108,000
Malagasy Republic	228,000	88,000	88,000
Mali	100,000	-	-
Mauritania	100,000	-	-

<u>Country</u>	<u>FY 1963</u> <u>Health and</u> <u>Sanitation</u>	<u>FY 1965</u> <u>Health and</u> <u>Sanitation</u>	<u>FY 1965</u> <u>All Health &amp; Sanit.</u> <u>Activities</u>
Morocco	-	-	-
Niger	\$ 200,000	\$ 87,000	\$ 87,000
Nigeria	12,245,000 (12.1 loan)	-	56,000
Rhodesia and Nyasaland	-	-	-
Senegal	-	160,000	160,000
Sierra Leone	292,000	345,000	345,000
Somali Republic	316,000	-	768,000
Sudan	3,800,000 (3.8 loan)	-	-
Tanganyika	3,795,000 (3.5 loan)	-	40,000
Togo	295,000	25,000	25,000
Tunisia	-	-	24,000
Uganda	-	-	-
Upper Volta	181,000	45,000	45,000
Regional	230,000	1,180,000	1,180,000
	-	-	-
TOTAL	\$32,163,000 (26.9 loans)	\$4,416,000	\$5,299,000

III. USAID Public Health Positions in Africa

a. May 25, 1964

CAMEROUN (WEST)

Victoria

1 - Sanitary Engineer

Total Cameroun - 1

Chad

1 - Public Health Physician

1 - Medical Clinician

1 - Public Health Nurse\*

Total Chad - 3

ETHIOPIA

Addis Ababa

1 - Chief Public Health Advisor Physician

1 - Health Administration Advisor\*

1 - Sanitary Engineer

1 - Public Health Nurse\*

1 - Health Education Advisor

Malaria Disease Control Branch

1 - Malaria Advisor

4 - Malaria Specialists

Public Health Demonstration and Evaluation

2 - Public Health Physicians

1 - Public Health Nurse\*

1 - Sanitary Engineer

1 - Sociologist

Gondar

1 - Public Health Physician-Training\*

3 - Nursing Advisors

1 - Nursing Advisor Hospital Nursing Services

ETHIOPIA (Cont'd)

Asmara

Nurse Training School

- 4 - Nursing Education Advisor
- 1 - Nursing Advisor

Dessie

- 1 - Public Health Physician

Makelle

- 1 - Public Health Physician

Total Ethiopia - 27

GHANA

Accra

- 1 - Health Education Advisor

Total Ghana - 1

LIBERIA

Monrovia

- 1 - Chief Public Health Advisor Physician

Gbarnga

- 1 - Public Health Nurse
- 1 - Sanitarian
- 1 - Medical Clinician

Total Liberia 4

\*\*LIBYA

Tripoli

- 1 - Chief Public Health Advisor\*
- 1 - Pharmacist
- 1 - Public Health Nurse
- 1 - Malaria Advisor
- 1 - Statistician Public Health

Total Libya. 5

MALAGASY REPUBLIC

Tananarive

1 - Well Driller (Cable/Tool)

Tulear

1 - Sanitary Engineer

Total Malagasy - 2

SIERRA LEONE

Freetown

1 - Chief Public Health Advisor Physician\*

1 - Sanitary Engineer Water Supply

1 - Well Driller (Cable/Tool)

Total Sierra Leone - 3

SOMALI REPUBLIC

Mogadiscio

1 - Sanitary Engineer Water Supply

Total Somali Republic - 1

UPPER VOLTA

Ougadougou

1 - Chief Public Health Advisor Physician

1 - Health Education Advisor

Total Upper Volta - 2

Total Africa - 49

\*Public Health Service

\*\*Jobs scheduled for phase-out

III. USAID Public Health Positions in Africa

b. Proposed for FY 65

CAMEROUN (WEST)

1 - Sanitary Engineer

Total West Cameroun - 1

Chad, Republic of

1 - Public Health Physician

1 - Public Health Nurse

1 - Public Health Educator

1 - Sanitarian\*

Total Chad - 4

ETHIOPIA

Addis Ababa

1 - Chief Public Health Advisor (Physician)

1 - Health Administration Advisor\*

2 - Sanitary Engineers

2 - Public Health Nurse\* (2 PHS officers)

1 - Health Education Advisor

4 - Public Health Physicians

1 - Malaria Advisor

4 - Malaria Specialists

1 - Sociologist

Gonder

1 - Public Health Physician\*

1 - Public Health Nurse

1 - Nurse Advisor (MCH)

1 - Nurse Advisor (Hosp. Nur. Serv.)

1 - Nurse Advisor (Ed. Dir.)

1 - Nurse Advisor

Asmara

3 - Nurse Educational Advisor

1 - Nurse Educational Advisor (Midwife)

1 - Nurse Advisor (Public Health)

Total Ethiopia - 28

\*Public Health Service

\*\*Position not firm FY 65

LIBERIAMonrovia

1 - Chief Public Health Advisor (Physician)

Gbarnga

1 - Public Health Nurse  
 1 - Sanitarian  
 1 - Medical Clinician  
 \*\*1 - Rural Health Physician  
 \*\*1 - Chief Nurse  
 \*\*1 - Health Educator  
 \*\*1 - Senior Medical Educator  
 \*\*1 - Hospital Administrator  
 \*\*1 - Basic Science Educator  
 \*\*2 - Nurse Educators  
 \*\*1 - Maintenance Engineer

Total Liberia - 13

LIBYA

None

MALAGASY REPUBLIC

1 - Well Driller  
 1 - Sanitation Engineer

Total Malagasy - 2

SIERRE LEONE

\*\*1 - Well Driller  
 \*\*1 - Nurse Educator

Total Sierra Leone - 2

SOMALI REPUBLIC

\*\*1 - Project Manager  
 \*\*1 - Administrative Specialist  
 \*\*1 - Ground Water Hydrogeologist  
 \*\*1 - Master Mechanic  
 \*\*1 - Master Storekeeper  
 \*\*2 - Master Drillers  
 \*\*1 - Heavy Equipment Operator  
 \*\*1 - Radio Installation and Maintenance Specialist  
 \*\*1 - Sanitary Engineer

Total Somali - 10

UPPER VOLTA

Bobodialaso

1 - Health Education Advisor

Total Upper Volta - 1

Total Africa - 51

IV. Description of Health and Sanitation Projects and Health Activities  
Funded under Other Categories (e.g., Agriculture) by  
Country in Africa Region

Algeria

None.

Congo (Leopoldville)

None.

East Africa

A. Kenya

None.

B. Tanganyika

1. Public Works Service (General and Miscellaneous) -- To provide technical and professional services to Ministry of Communication, Power, and Works (MCPW). Two programs: a) highways, b) municipal water systems -- in 88 communities. Initial 1962. Final 1967. FY 1965, \$160,000; expenditures to date, \$180,000; estimated to completion, \$950,000. All personnel on contract.

C. Uganda

None.

D. Zanzibar

None.

Ethiopia

1. Public Health College and Training Center -- To assist in developing college level public health training center with demonstration health facilities. Initial 1954. Final scheduled 1970. FY 1965, \$144,000; expenditures to date, \$1,162,000. Estimated to completion, \$2,301,000. U. S. personnel: 5 professionals; participant training, 10; commodities -- laboratory equipment, audiovisual teaching aids. Local expenses will be fully absorbed by Ethiopian Government after FY 1965.

2. Public Health Advisory Services -- To assist in developing an institutional structure and staff suitable for administering a system of improved and expanded health services in Ethiopia. Initial, 1953. Final scheduled 1970. FY 1965, \$280,000; expenditures to date, \$1,091,000; estimated to completion, \$3,021,000. Personnel: 7 U. S. public health advisors; participants, 12; commodities, small amount, and local expenses of U. S. personnel.

3. Nurse Training and Advisory Services -- To improve health care in Eritrea through the establishment of a School of Nursing capable of graduating 20-25 nurses a year. Initial, 1954. Final scheduled 1969. FY 1965, \$121,000; expenditures to date, \$507,000; estimated total to completion, \$1,190,000. Personnel: 5 U. S. nurses; participants 4. Commodities -- modest amount of training material.

4. Malaria Eradication -- To assist the Ethiopian Government in the eradication of malaria. Initial, 1958. Final scheduled 1976. FY 1965, \$730,000; expenditures to date, \$1,680,000; estimated to completion, \$10,963,000. Personnel: 6 U. S. technicians; participants, 5; commodities, \$600,000 -- (DDT and field equipment).

5. Public Health Demonstration and Evaluation -- To assist Ethiopian Government in remedying deficiencies in Ethiopian health statistics and evaluate program effectiveness. Initial, 1960; final scheduled 1965. FY 1965, \$190,000; expenditures to date, \$400,000; estimated to completion, \$741,000. Personnel: 6 U. S. technicians. Contract with Johns Hopkins University and Walter Reed Army Institute of Research to finance local travel and equipment.

Ghana

1. Rural Public Works (Community Development) -- To help develop Technical Advice Centers for training, evaluation and advice on design, engineering, and contract administration of local public works; goal, to establish eight centers. Two Centers have been organized, in Eastern and Ashanti Regions, to advise on implementation of local public works project including schools, housing, roads, water supply, sanitary facilities, bridges, post offices, markets and community centers. Project has included supervision to completion of health centers (number not specified, in total of 196 construction projects). Initial FY 1960; final FY 1967. Estimated expenditure FY 1965, \$170,000; expenditures to date, \$144,000; to completion \$374,000. Personnel: one U.S. technician for Western Region, two technicians to complete centers in remaining regions. Commodities: none.

Liberia

1. Public Health Administration -- To improve Department of Public Health. Initial, 1961. Final scheduled 1967. FY 1965, \$51,000. Expenditures to date, \$275,000; estimated to completion, \$456,000. Personnel: 1 advisor from USPHS. Participants: 2. Commodities: 0.

2. Rural Health Services -- This project is a component of a larger composite project of same title provided for in FY 1964. To assist in provision of health services in rural areas. Initial, 1955. Final scheduled 1967. FY 1965, \$185,000; expenditures to date, \$391,000; estimated to completion, \$926,000. Personnel: 4 technicians (physician, public health nurse, sanitarian, health educator). Commodities: none specified.

3. National Medical Center -- To help Liberia increase the number of well-qualified medical and auxiliary workers by establishing the first high standard training institution (combining Tubman National Institute of Medical Arts, General Training Hospital, and Maternity Center). Initial, 1961. Final scheduled 1975. Construction will be financed by a \$5.3 million Development Loan approved in FY 1963. Personnel: 6 USPHS specialists, including one senior education direction director, one hospital administrator, one basic educator, and two nurse educators.

4. National Medical Center (Development Loan) -- To construct and equip 250-bed hospital with facilities for training 75 students (see above). Construction scheduled to begin by end of 1964; expect one-third to one-half of loan to be disbursed FY 1965. Government contributing total of \$1,235 million. U. S. procurement of goods/services except local labor/lumber. Loan total \$5.3 million, repayable over 40 years.

Libya

None.

Mali

1. Training for Development Needs (Education) -- To train Malians in fields which complement AID-sponsored projects. Initial, FY 1961; final scheduled 1967. FY 1965, \$28,000; expenditures to date, \$504,000; estimated to completion, \$604,000. Training: FY 1962 -- 5 participants; FY 1963 -- 25. Included 4 in public health and sanitary engineering. Six participants in FY 1965 in business administration, engineering, and public health.

2. Village Development (Community Development, Social Welfare, and Housing) -- To supplement rural "self-help" projects. First village scheduled for completion FY 1966. As of June 1963, had completed 28 dwellings, dug and capped sanitary wells and pits, and drainage ditches. Initial, FY 1962; scheduled for completion, FY 1966. FY 1965, \$105,000; expenditures to date, \$199,000; estimated for completion, \$394,000. Mali Government provides counterpart for local costs/labor. Personnel: 3 U.S. advisors, 2 participants.

Morocco

None.

Nigeria

1. Hadejia Valley Development (Agriculture) -- To assist Nigeria Health officials in the eradication of tsetse fly from the Hadejia Valley in 1965, in order to open an area of 500,000 acres to livestock raising and cultivation. Initial, 1962. Final, 1966. FY 1965, \$56,000; to date, \$327,000; to completion, \$500,000. Personnel: entomologist and agricultural engineer, Commodities: DDT, spraying supplies.

Northern Rhodesia, Southern Rhodesia

None.

Nyasaland

1. Economic and Statistical Service Development (Public Administration and Public Safety) -- To assist the Government of Nyasaland establish a Central Statistical Office staffed by trained local personnel. Initial, FY 1962; Scheduled Final FY 1968. Proposed FY 1965 \$155,000; Estimated

expenditures to date, \$25,000; Estimated total to completion, \$604,000.

Includes plans for three specialists from U.S. Bureau of the Census to assist in collecting, compiling, and publishing basic statistics.

Commodities: FY 1965 funding will provide two-year rental of multi-purpose tabulating equipment together with related material.

2. Community Development (Community Development, Social Welfare, and Housing) -- To provide advisory services and training in rural community development in primary areas, such as health, agriculture, etc. Initial, FY 1963; Scheduled Final, 1967. Proposed FY 1965, \$75,000; estimated expenditures to date, \$78,000; estimated total to completion, \$292,000. Personnel: Research advisor. FY 1965 will include self-help training in construction of dispensaries and other structures. Commodities: Demonstration supplies.

### Sierre Leone

1. Public Health Education -- To assist central and local governments to improve public health education directed toward simple, environmental sanitation and preventive medicine. Initial, 1961. Final scheduled 1967. FY 1965, \$155,000; expenditures to date, \$155,000; estimated to completion, \$776,000 (more than one-half unobligated through 1964). Personnel: 4 nurse educators. Commodities: projectors, slides, laboratory and infirmary equipment.

2. Water Resource Development. .... To assist in program for exploration and use of ground water and surface water resources. Initial, 1962. Final scheduled 1967. FY 1965, \$190,000; expenditures to date, \$50,000 (only 25% of obligated funds); estimated to completion, \$490,000. Personnel: one well driller; contract survey team well drillers.

3. Human Resources Development (Education) -- To provide training for selected participants, not covered in other projects. Eleven participants to date, including public health. Initial, FY 1962; final scheduled FY 1968. FY 1965, \$95,000; expenditures to date, \$40,000; estimated to completion, \$508,000. Funds spent on health not designated; probably less than 10 percent.

4. Economic Research and Statistics (Public Administration and Public Safety) -- To assist Government in establishing a Central Statistics Office capable of collecting, compiling, and publishing statistics. Initial, FY 1960; final scheduled FY 1967; FY 1965, \$115,000; expenditures to date, \$228,000; estimated to completion, \$799,000. Four statistical advisors from U. S. Bureau of Census supervised Sierra Leone's first census, May 1963. Commodities: supplies and equipment.

5. District Council Aided Self-Help (Community Development, Social Welfare, Housing) -- To help rural population improve sanitation, health, roads, etc. FY 1964, planned construction includes 20 rural clinics. Initial, FY 1962. Final scheduled FY 1965. FY 1965, \$340,000. Expenditures to date, \$200,000. Estimated to completion, \$791,000. Two U. S. technicians under contract. Commodities: building commodities including cement; roofing and hand tools.

Somali Republic

1. Water Resources Development (Agriculture and Natural Resources) -- To assist the Ministry of Public Works in conducting a national water supply program while helping to build a well-drilling and maintenance organization. Initial, 1959. Final scheduled 1968. FY 1965, \$768,000. Expenditures to date \$1,065,000. Estimated to completion, \$3,049,000. Funding -- training

personnel on contract; AID general engineer; commodities -- e.g., trucks, spare parts, pumping units, etc.

Sudan

None.

Tunisia

1. Water Resources Development (Agriculture and Natural Resources) -- To assist in developing 50 production-type wells by September 1965 in order to supply water for irrigation and domestic uses as one-time effort to help Tunisia make better use of its ground water reserves. Initial, 1959. Final scheduled 1965. FY 1965, \$24,000. Obligations, \$2,101,000, with only \$372,000 expended. Unobligated, \$1,729,000 -- largely obligated for drilling and equipping (casing, pumps, etc.) of wells. Should be liquidated over FY 1964-1965 period.

UAM and Burundi

a. Burundi

None.

b. Cameroon

1. Water Supply Development -- Initial, 1963. Final scheduled 1966. To improve existing urban water systems. FY 1965, \$20,000. Expenditures to date, \$30,000; estimated to completion, \$70,000. Personnel -- one engineer. Cameroon Government contribution: \$145,000, FY 1964; \$150,000 in FY 1965.

c. Central African Republic

1. Health Planning Assistance -- To assist CAR develop a national health plan. The WHO will furnish the Public Health Planning Advisor and

part-time services of other specialists. FY 1965, \$88,000 (one-year project). CAR Government contribution, office space and personnel to assist data gathering and processing, training in evaluation, and preparation of reports.

d. Chad

1. School Health Education -- To help the Chad Ministry of National Education establish an adequate health service for school children. Initial, 1963. Final scheduled 1967. FY 1965, \$290,000; expenditures to date, \$200,000; estimated total to completion, \$900,000. Personnel -- 4 contract technicians. Commodities -- mobile X-ray unit, films, simple dental equipment and additional medical supplies.

e. Congo (Brazzaville)

None.

f. Dahomey

None.

g. Gabon

1. Assistance to Endemic Disease Service -- To improve health and sanitation facilities and expand medical services. Initial, 1963. Scheduled final, 1965. FY 1965, \$120,000; expenditures to date, \$45,000; estimated to completion, \$265,000 (obligation). Funds for equipment. No personnel.

h. Ivory Coast

1. Ground Water Resources (Agriculture and Natural Resources) -- Determine most effective and economic means of locating sites for drilling small capacity domestic wells. Initial, 1962. Scheduled final, 1966. Expenditures to date, none. FY 1965, \$175,000; total obligation to completion, \$345,000. Personnel -- contract; commodities -- geophysical equipment. Ivory Coast contribution estimated \$50,000 a year, FY 1964 and FY 1965.

Malagasy Republic

1. Ground Water Development for Village Water Supplies (Health) --

lot project to construct village wells. Initial, 1962. Scheduled final, 1967. FY 1965, \$88,000. Expenditures to date, \$203,000. Total to completion, \$26,000. Personnel -- 2 technicians; participants, 4; commodities (\$23,000) -- needed to construct wells.

j. Mauritania

1. Improvement of Health Services -- By supplying vehicles for mobile health units and utility vehicles. FY 1964 only, for \$75,000, but only \$25,000 was expended. \$50,000 unobligated. Estimated total to completion, \$75,000; one-year project. Personnel: none.

k. Niger

1. Control of Endemic Diseases -- Primarily provides commodities. Initial, 1961. Scheduled final, 1966. To date, \$187,000 obligated; only \$89,000 expended; FY 1965, \$87,000. Estimated total to completion, \$363,000. Personnel -- none; commodities -- medicinal and pharmaceutical preparations, scientific instruments, portable generators, and miscellaneous equipment.

l. Rwanda

None.

m. Senegal

1. Water Resources Survey -- Assist in location of water. Initial, 1964. Scheduled final, 1965. To date, only \$70,000 of \$270,000 expended. 1965, \$160,000; estimated to completion, \$730,000. Personnel -- contract.

2. Participant Training -- Participants in health, commerce, and Initial, FY 1962; scheduled final, FY 1968. FY 1965, program for

25 participants planned. FY 1965, \$80,000. Expenditures to date, \$133,000. Estimated total to completion, \$503,000.

n. Togo

1. Rural Health Improvement -- To provide drugs and equipment to support Peace Corps activities. Initial, FY 1963. Scheduled final, FY 1965. Expenditures to date, \$174,000 (\$76,000 unliquidated). FY 1965, \$25,000. Estimated to completion, \$275,000. Personnel: none.

2. Participant Training -- Includes participants in medicine and public health. Initial, FY 1961. Scheduled final, FY 1969. FY 1965, \$146,000. Expenditures to date, \$328,000. Estimated to completion, \$972,000.

3. Rural Development (Community Development, Social Welfare, and Housing) -- To assist in establishment of National Rural Development Service for training in agriculture, sanitation, etc. Initial, FY 1962. Scheduled final, FY 1969. FY 1965, \$290,000. Expenditures to date, \$340,000. Estimated to completion, \$1,303,000. FY 1965, 4 contract technicians to train at the Center, including health training to village leaders. Commodities: seeds and plant materials, pesticides, bicycles, handpumps, windmills, pump sprayers, hand dusters, garden tractors.

o. Upper Volta

1. Health Improvement - Endemic Disease Control -- To expand endemic disease service. Initial, 1961. Scheduled final, FY 1966. FY 1965, \$45,000. Expenditures to date, \$295,000 (expended). Estimated total to completion, \$462,000. Personnel -- one health educator. Participant -- one. Commodities -- training materials. Inland transportation and miscellaneous local costs.

Africa Regional Programs

1. Measles Control - To aid six tropical African countries (Ivory Coast, Guinea, Mauritania, Mali, Niger and Dahomey) to reduce high mortality from measles. Initial, FY 1963. Scheduled final, 1965. Expenditures to date, \$880,000. FY 1965, \$1,000,000. Estimated total for completion \$1,980,000 (obligated), \$2,980,000 (to 6/30/64--\$1,100,000 unliquidated). Personnel: None. Participants: None. Commodities: FY 1964 funding for vaccine (\$1,400,000); equipment such as jet injector guns, refrigerators, vehicles (\$315,000); and training (\$35,000). Additional FY 1965 funding -- \$1 million for vaccine only.

2. OCCGE - Regional Health Training -- To help upgrade local training. Initial, FY 1965. Scheduled final, FY 1966. FY 1965, \$180,000. Estimated to completion (total), \$280,000. U. S. will provide health educator, sanitary engineer and general health administration advisors (on contract); aid toward cost of construction of field training station (\$50,000), and provide supplies and equipment (\$30,000).

3. Regional Education Grants(Education) -- Provides scholarships to African institutions. Have included Makerere and Ibadan (medical). Initial FY 1961; Scheduled final FY 1967. Proposed FY 1965 \$1,400,000; estimated expenditures to date, \$1,328,000; estimated total to completion, \$11,165,000. Funding pre-FY 1963 on a four-year scholarship basis; practice since that time of forward funding new scholarships only up to two years. FY 1965 financing (\$760,000) includes completion of financing 560 scholarships awarded in FY 1963, and (\$640,000) for two-year funding approximately 500 additional one to four-year

scholarships at selected institutions. The number of students in health and sanitation was not noted because (1) these grants are given to African institutions and no attempt is made to record in advance the specific areas of student interest and (2) these are undergraduate grants and the final field of endeavor can rarely be chosen with finality at that time.

IV. Estimate of Possible Needs for U. S. Public Health Service (PHS) Assistance in Africa Region

Major emphasis in Africa has been given to the development of community water supplies, special programs of disease prevention such as the measles immunization program in West Africa, the development of health manpower and the organization of health services and financial assistance for health planning (advisors provided by WHO).

a. Full time USAID positions

The Africa Bureau is actively working with the PHS to solve USAID personnel and program requirements in Somali and Liberia. A variety of program needs and personnel are under discussion (see Section II).

b. Short-term consultants USAIDs (man months).

The following are the estimated requirements for FY 1965: communicable disease control (3); public health administration (0); demography and vital statistics (0); health education (2); public health nursing (0); sanitary engineering (3); nutrition (6); other (0).

c. Consultation AID/W (man months).

Although most AID/W consultations are of a short term, intermittent nature, the following requirements should cover the requirements for the year: communicable disease control (0); public health administration (1); demography and vital statistics (0); health education (2); public health nursing (0); sanitary engineering (0); nutrition (0); other (0).

d. Participant Training

The number of health and sanitation participants may decline slightly in FY 1965.

1. Full academic year	50	* Includes new arrivals, 21; balance constitutes carry-overs from FY 1964
2. Short term (1-6 months)	20	
Total	70*	

Section 5.

AGENCY FOR INTERNATIONAL DEVELOPMENT

HEALTH PROGRAMS -- LATIN AMERICA

- I. Introduction.
- II. Summary of AID Financial Assistance for Health Activities in the Latin American (LA) Region for FY 1963 and as proposed for FY 1965.
- III. US AID Health Positions in Latin America May 25, 1964, and projected FY 1965.
- IV. Description of Health and Sanitation Projects and Health Activities Funded Under Other Categories (e.g., Education) by Country in Latin America.
- V. Estimate of Possible Needs for U.S. Public Health Service (PHS) Assistance in Health Programs.
  - a) Long term assignment - US AID
  - b) Short term consultation - US AID (man months)
  - c) Consultation - technical backstopping - AID/W (man months)
  - d) Participant training

July 27, 1964  
Health Service  
Office of Technical Cooperation and Research

LATIN AMERICA (LA) REGION

(Alliance for Progress)

I. INTRODUCTION

The countries of Latin America and the United States have worked cooperatively in bilateral health programs and in multilateral programs through the Pan American Sanitary Bureau (and Pan American Health Organization) for more than fifty years. The Rockefeller Foundation has also played a very significant role in Public Health in Latin America. There have been thousands of physicians, engineers, nurses, and other health personnel from Latin American countries who have received training in the United States. Government to government technical cooperation projects in health were initiated more than twenty years ago through the Institute of InterAmerican Affairs. Some of these projects have been in continuing existence for more than fifteen years. Although there has been a sharp drop in the number of direct hire U. S. technicians in the field in Latin America the proposed projects for fiscal 1965 still exceed those of any other region in terms of dollars. The major project areas in recent years have been community water supply development, malaria eradication, rural health services and health manpower development. The Pan American Health organization receives a special voluntary contribution of \$2 million annually to support the malaria eradication and community water supply projects.

The trends in A.I.D. will probably continue to reflect themselves during the next few years in health projects in Latin America.

There will be continual support of malaria eradication and the development of community water supplies. The provision of technical assistance in many health areas will be through the Pan American Health Organization. It is likely that the rapid rate of population growth will receive increasing attention in Latin America with A.I.D. making specialized resources available on request. The Latin America Bureau has been the first of the A.I.D. Regional Bureaus to establish a population unit and provide regional funding (\$500,000) to support its planned activities in FY 1965.

The projects included in this section have been submitted by the USAID Missions in each of the countries concerned, but final approval for funding must await passage of the Foreign Assistance Appropriations Act. New projects may be added and some of those described eliminated during FY 1965, but this is the best current estimate that can be made.

II. SUMMARY OF AID FINANCIAL ASSISTANCE FOR HEALTH AND SANITATION  
ACTIVITIES IN LATIN AMERICAN REGION FY 1963 AND PROJECTED FY 1965

<u>Country</u>	<u>Health and Sanitation FY 1963</u>	<u>Health and Sanitation FY 1965</u>	<u>Total Health and Sanitation Activities Projected FY 1965</u>
Argentina	-	-	-
Bolivia	\$ 469,000	\$ 165,000	\$4,022,000 (\$3,000,000 loan)
Brazil	4,525,000	996,000*	10,373,000* (\$9,373,000 local currency)
British Guiana	295,000	-	-
Chile	513,000	-	-
Colombia	3,815,000 (3.7 loan)	-	125,000
Costa Rica	509,000	150,000	257,000
Dominican Republic	100,000	-	-
Ecuador	576,000	250,000	525,000
El Salvador	256,000	412,000	412,000
Guatemala	599,000	269,000	369,000
Haiti	1,400,000 (SA)	1,400,000 (SA)	1,400,000 (SA)
Honduras	1,736,000 (1.05 loan)	170,000	170,000
Jamaica	2,309,000 (2.2 loan)	101,000	101,000
Mexico	25,000	-	-
Nicaragua	594,000	130,000	130,000
Panama	6,120,000 (6.0 loan)	161,000	161,000
Paraguay	417,000	130,000	280,000

\* Loan obligated in FY 1964 provides \$3,400,000 to be used in FY 1965

<u>Country</u>	<u>Health and Sanitation FY 1963</u>	<u>Health and Sanitation FY 1965</u>	<u>Total Health and Sanitation Activities Projected FY 1965</u>
Peru	\$ 119,000	-	\$ 30,000
Surinam	35,000	-	-
Trinidad & Tobago	1,000	-	-
Uruguay	-	-	-
Venezuela	2,000	-	-
ROCAP	2,201,000	-	291,000
Regional	134,000	2,100,000	2,543,000
	<hr/>	<hr/>	<hr/>
Total	25,344,000 (12.95 loan)*	6,434,000	21,179,000 (12,373,000 local currency and loans)

\*Vintinner report for FY 1963 adding DG, DL and U.S. use  
local currency total \$66,930,000

III. US AID HEALTH POSITIONS IN LATIN AMERICA, MAY 25, 1964, PROJECTED FY 1965  
 a. As of May 25, 1964

BOLIVIA

La Paz

- 1 - Industrial Hygiene Advisor
- 2 - Sanitary Engineers

Total Bolivia - 3

BRAZIL

Rio de Janeiro

- 4 - Sanitary Engineers
- 1 - Malaria Advisor\*
- 1 - Special Advisor (Malaria)
- 1 - Mechanical Engineer (Malaria)
- \*\* 1 - Health Education Advisor (Malaria)
- 1 - Malaria Advisor (Administration)
- 1 - Malaria Specialist

Recife

- \*\* 1 - Chief Public Health Advisor
- \*\* 1 - Health Education Advisor
- 1 - Sanitary Engineer (Contract)
- 1 - Sanitary Engineer

Total Brazil - 14

COLOMBIA

Bogota

- 1 - Chief Public Health Advisor (Sanitary Engineer)
- \*\* 1 - Nurse Advisor (Inservice Training)

Total Colombia - 2

Catholic University Contract Personnel

Nurse Educator

Campus Coordinator, Catholic  
 University - Sister Charles Marie  
 Frank

- \* Public Health Service.
- \*\* Scheduled for phase-out.

COSTA RICASan Jose

- \*\* 1 - Hospital Administration Advisor
- 1 - Sanitary Engineer

Total Costa Rica - 2

Louisiana State University/Costa Rica  
Contract Personnel

Chief of Party

Campus Coordinator, Louisiana State  
University, Dr. William W. FryeECUADORQuito

- 1 - Malaria Advisor
- 1 - Development Officer (Sanitary Engineer)

Total Ecuador - 2

EL SALVADORSan Salvador

- 1 - Nurse Education Advisor
- 1 - Public Health Advisor (non-physician)

Total El Salvador - 2

GUATEMALAGuatemala City

- 1 - Medical Officer
- \*\* 1 - Malaria Specialist

Total Guatemala - 2

HAITIPort-au-Prince

- 1 - Malaria Advisor
- 1 - Malaria Specialist
- 1 - Malaria Specialist (Entomology)
- 1 - Business Manager

Total Haiti - 4

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\*\* Scheduled for phase-out.

JAMAICAKingston

- 2 - Sanitary Engineers (Water Supply)
- \*\* 1 - Health Education Advisor

Total Jamaica - 3

MEXICOMexico City

- 1 - Vocational Rehabilitation Specialist

Total Mexico - 1

NICARAGUAManagua

- 1 - Chief Public Health Advisor (Physician)
- 1 1 - Malaria Advisor
- \*\* 1 - Health Education Advisor

Total Nicaragua - 3

PANAMAPanama City

- \*\* 1 - Nurse Advisor (Tuberculosis)

Total Panama - 1

PARAGUAYAsuncion

- 1 - Chief Public Health Advisor (Physician)
- 1 - Public Health Nurse
- 1 - Public Health Advisor
- 1 - Sanitary Engineer (Water Supply)

Total Paraguay - 4

University of Buffalo/Paraguay Contract

Chief of Party  
Nurse Advisor

Campus Coordinator, State University  
of New York (formerly University of  
Buffalo) - Dr. Peter F. Regan

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\*\* Scheduled for phase-out.

PERU

Lima

1 - Sanitary Engineer

Total Peru - 1

WEST INDIES AND EASTERN CARIBBEAN

Antigua

\*\*1 - Well Driller

Total West Indies - 1

REGIONAL OFFICE - CENTRAL AMERICA AND PANAMA (ROCAP)

Guatemala City

1 - Chief Public Health Advisor Non-physician

Managua, Nicaragua

1 - Sanitarian Regional

San Salvador, El Salvador

\*\*1 - Public Health Nurse Regional

Panama City,

1 - Health Education Advisor Regional

Total ROCAP - 4

TOTAL LA HEALTH PERSONNEL  
(Direct hire, PHS, University)

52

\*\* Scheduled for phase-out

B. Projected FY 1965, Latin America

BOLIVIA

La Paz

- 1 - Occupational Health Engineer
- 1 - Sanitary Engineer

Total Bolivia - 2

BRAZIL

Rio de Janeiro

- \*\* 1 - Sanitary Engineer
- 2 - Sanitary Engineers
- 1 - Mechanical Engineer (Malaria)
- 1 - Malaria Advisor
- 1 - Malaria Specialist
- 1 - Supply Advisor (Malaria)
- 1 - Malaria Specialist (Administration)
- 1 - Public Health Physician (Epidemiologist - contract)

Recife

- 1 - Chief Health Advisor
- \*\* 1 - Health Education Advisor
- 1 - Sanitary Engineer (contract)
- 1 - Sanitary Engineer

Total Brazil - 13

COLOMBIA

Bogota

- \*\* 1 - Chief Public Health Advisor

Total Colombia - 1

COSTA RICA

San Jose

- \*\* 1 - Hospital Administration Advisor
- \*\* 1 - Sanitary Engineer - Generalist
- 1 - LSU Chief of Party

Total Costa Rica - 3

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\*\* Position not firm for FY 1965.

ECUADOR

Quito

\*\* 1 - Assistant to Mission Director

Guayaquil

1 - Malaria Advisor

Total Ecuador - 2

EL SALVADOR

San Salvador

\*\* 1 - Nurse Education Advisor

1 - Public Health Generalist

Total El Salvador - 2

GUATEMALA

Guatemala City

1 - Chief Health Advisor (ROCAP)

1 - Medical Officer (Regional)

(Central America Mobile Rural Health)

Total Guatemala - 2

HAITI

Port-au-Prince

1 - Malaria Advisor

2 - Malaria Specialists

1 - Business Manager (Malaria)

Total Haiti - 4

JAMAICA

Kingston

2 - Sanitary Engineer Advisors

Total Jamaica - 2

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\*\* Position not firm for FY 1965.

MEXICO

Mexico City

\*\* 1 - Vocational Rehabilitation Specialist

Total Mexico - 1

NICARAGUA

Managua

1 - Sanitarian (Public Health Generalist)  
1 - Malaria Advisor

Total Nicaragua - 2

PARAGUAY

Asuncion

1 - Sanitary Engineer  
\*\* 1 - Chief Public Health Advisor

Total Paraguay - 2

University of Buffalo/Paraguay Contract

Chief of Party

PERU

Lima

1 - Sanitary Engineer Advisor  
1 - Public Health Statistician

Total Peru - 2

TOTAL LA HEALTH PERSONNEL 39  
(Direct hire, PHS, University)

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\*\* Position not firm for FY 1965.

IV. DESCRIPTION OF HEALTH AND SANITATION PROJECTS AND HEALTH ACTIVITIES FUNDED UNDER OTHER CATEGORIES (I.E. EDUCATION) BY COUNTRY IN LATIN AMERICA

Argentina

None.

Bolivia

1. Occupational Health and T.B. Eradication (Industry and Mining). --

To improve health and raise production and productivity in the mining sector. Attempt to eliminate tuberculosis and reduce silicosis by 50% by 1967. Initial FY 1963, final FY 1967. FY 1965 \$95,000. Expenditure to date \$170,000; estimated completion \$465,000. Personnel: one U.S. technician helping to administer the project. Commodities: a small amount of diagnostic laboratory equipment, medical supplies and specialized scientific apparatus.

2. Health Assistance -- To assist the government of Bolivia to reduce the country's most serious communicable diseases; eradicate malaria; improve health facilities in the new colonization areas; and increase the planning and technical training competence of the Ministry of Health. Initial FY 1943. Final Fy 1965. FY 1965 \$165,000. Expenditures to date \$3,971,000; estimated for completion \$4,267,000. Malaria eradication in the frontier area partly financed by counterpart funds (\$242,000). AID providing short-term malaria adviser. During FY 1964, AID is providing short-term experts in biostatistics and hospital administration; AID financing commodities and drugs for Hemorrhagic fever study; in 1965 AID will fund

commodities (\$140,000) to help equip 30 small health posts and mobile tuberculosis units. Other contributions; MARU \$32,000 for Hemorrhagic fever program, and U.S. military group \$100,000. Commodities: medical supplies, mobile X-ray units, drugs, health equipment (from excess property stocks) for colonization project.

3. Self-help Community Water Supply (Community Development; Social Welfare and Housing) -- To provide safe, potable water supplies over a 5-year period to as many of Bolivia's 517 towns (500 - 15,000 population) as are willing to furnish 30-50% of the cost via self-help. Initial FY 1963. Final 1968: FY 1965 \$275,000; expenditures to date \$250,000; estimated total cost to complete \$1,428,000. U.S. personnel: two sanitary engineers. Commodities: purchase in U.S. those not available locally, e.g. pipe, pumps and tanks.

4. Special Development Activities (Community Development) -- To encourage and support community self-help projects which require a small amount of outside assistance; e.g., schools, health centers, and roads which campesinos already have begun. Initial FY 1964. Final FY 1967. FY 1965 \$50,000. Expenditure to date \$40,000. Estimated to completion \$200,000. Personnel: none. Commodities: roofing material, pumps, pipes, etc.

#### Brazil

1. Community Health, NE -- To improve health conditions throughout Northeast Brazil through construction of 461 health centers by

the end of FY 1965. FY 1965 \$12,000; expenditure to date \$155,000; estimated total to complete \$264,000. Personnel: two direct hire (phase-out). Commodities: none.

2. Malaria Eradication. - To eradicate malaria in Brazil by 1970. Initial FY 1958. Final obligation schedule FY 1968. FY 1965 \$150,000; expenditures to date \$13,459,000; estimated to completion \$14,504,000. Plus obligation of US-owned foreign currency \$1,375,000. Personnel: six technicians including senior malaria advisor, epidemiologist, malaria specialist. Commodities: DDT (in past) will be funded by loan.

3. National Water Supply and Sewerage. - To assist Brazil provide safe potable water supply for 70% of urban and 50% of rural population. Capital assistance provided through use of PL 480 funds. Brazilians contributing about \$62 million in 1965. Forty million people in 700 cities and towns will be affected. Initial FY 1961. Scheduled final FY 1970. FY 1965 \$834,000 (\$9,377,000 local currency); expenditure to date \$923,000 (\$25,077,000 in local currency); estimated to complete \$7,179,000. Personnel: four direct hire sanitary engineers, 15 specialized engineers on contract. Commodities: test pumps, drilling machines, tools, welding equipment and water meters, not produced in Brazil.

British Guiana

None

Central America

a) Costa Rica

1. Rural Mobile Health. - To provide improved medical and health services to rural areas. Initial FY 1963. Final FY 1967. FY 1965 \$150,000, to date \$214,000. To completion \$723,000. Personnel: one public health advisor. Commodities: medical supplies and some repair parts for vehicles.

2. University of Costa Rica Medical School. - To establish a first-class medical school at the University of Costa Rica. Initial FY 1958. Scheduled final FY 1966. FY 1965 \$77,000; expenditures to date \$511,000; estimated to completion \$855,000. Personnel: contract with Louisiana State University. Commodities: none.

3. Technical Support. - Across-the-board activities not chargeable to individual projects. Includes one U.S. sanitary engineer.

b). El Salvador

1. Rural Health and Education. - To provide medical services for rural areas where such services had not previously existed. FY 1965 \$412,000; expenditure to date \$422,000; to completion \$1,687,000. Initial FY 1963; final scheduled FY 1969. Personnel: one public health manager; contract services: 4 short-term consultants (sanitary engineering, health education, and field support). Commodities: medicine, pharmaceuticals, instruments, vehicle spare parts, and mobile unit replacements.

c) Guatemala

1. Rural Mobile Health. - To help Guatemala provide curative and preventive medical services to rural and urban underprivileged masses. FY 1965 \$269,000; expenditures to date \$379,000; estimated to completion \$708,000. Personnel: fulltime U.S. public health advisor. Commodities: pharmaceuticals, medical supplies, instruments and mobile unit replacement parts.

2. Civic Action. (General and Miscellaneous). - To assist Guatemalan army to help meet social and economic needs of country. Results in road and bridge construction, medical care and evacuation, the construction of water systems, schools. Initial FY 1963. Scheduled final FY 1965. FY 1965 \$193,000; expenditures to date \$350,000; estimated total to completion \$558,000. Personnel: one well driller (contract). Commodities: pipe, drill points and pumps.

d) Honduras

1. Mobile Rural Health. - To achieve a significant reduction of disease among Hondurans living in small and isolated villages by providing preventive services and medical care. Initial FY 1963. Scheduled final FY 1967. FY 1965 \$170,000; expenditures to date \$345,000; estimated to completion \$643,000. Personnel: one public health advisor. Commodities: spare parts, drugs and medical supplies.

e) Nicaragua

1. Rural Mobile Health. - To provide rural medical services where such services had not previously existed. Initial FY 1963. Scheduled for termination FY 1967. FY 1965 \$130,000; expenditures to date \$504,000; estimated to completion \$1,011,000. Personnel: one public health generalist. Commodities: pharmaceuticals, medical supplies, instruments, vehicles, spare parts.

2. National Census (Public Administration) - To obtain up-to-date statistics for national planning. Population census completed June 1963. Initial FY 1962. Scheduled for completion FY 1965. FY 1965 expenditures \$60,000. Expenditures to date \$171,000; estimated total to completion \$549,000. Personnel: one full-time statistics advisor.

f) ROCAP (Central American Economic Community)

1. Improvement of Statistics and Census (Public Administration). - To provide data for regional planning. Initial FY 1963. Terminal FY 1968. FY 1965 \$400,000; expenditures to date \$258,000; estimated to completion \$1,900,000. Personnel: six statistical advisors from Census and one consultant on University Contract. Commodities: data processing equipment and supplies.

2. Technical Support. - Initial FY 1963. Scheduled for completion FY 1970. Includes regional health officer for analysis and reporting of regional public health problems and guidance to rural units.

Chile

None.

Colombia

1. Civic Action (Community Development, Social Welfare and Housing). To provide locally procured commodities in support of four civic action projects. a) Colombian military forces will build 22 rural health centers (Government of Colombia contribution \$150,000 in FY 1965); b) road improvement (Government of Colombia contribution \$400,000); c) well drilling to provide potable water to small, remote villages (Government of Colombia to provide \$36,000); and d) highway construction (Government of Colombia to provide \$1,700,000). Initiated FY 1963; scheduled final FY 1969. In FY 1965 \$634,000; expenditures to date \$1,041,000; estimated to completion \$4,118,000. FY 1965 funding includes local expenses, \$110,000 in drugs, medicines and other supplies for rural health centers.

2. Technical Support. - Includes public health advisor.

3. Special Development Activities (General and Miscellaneous). - To provide financing for small but significant projects having economic and social impact. Valuable where self-help effort has been considerable. Often assistance in form of commodities from U.S. Government surplus, e.g., request is in for an ambulance and water pumps. Initial FY 1964; scheduled final FY 1967. FY 1965 \$50,000; expenditures to date \$50,000; estimated to completion \$200,000. Estimate \$15,000 in FY 1965 for health or sanitation activities.

Dominican Republic

1. Technical Support. - Funding for costs not properly chargeable to any specific activity. Includes short-term U.S. specialists in health and sanitation.

Ecuador

1. Malaria Eradication. - To consolidate the gains made in the malaria eradication campaign. Initial FY 1958, Scheduled final FY 1966. FY 1965 \$250,000. Expenditures to date \$1,676,000; estimated to complete \$2,427,000. Local expense: 39% of operating cost. Total estimated cost to completion \$14.4 million (Ecuador, \$7 million; United Nations, \$4.6 million; U.S., \$2.4 million). U.S. personnel: one malarialogist. Commodities: visual aid and transportation equipment, spare parts, scientific and professional instruments.

2. Civic Action (Community Development). - To reduce internal tension and maintain internal security at the community level. Initial FY 1962. Final FY 1968. FY 1965 \$550,000. Expenditures to date \$331,000; estimated total to completion \$2,950,000. Programs include 1,500 yards sewerage pipe, water supplies to villages with 20,000 population. To build water system for slum area of Guayaquil; five dispensaries in rural areas. Commodities: road building equipment, water pipe, finished steel products.

3. Assistance to Universities (Education). - To improve capability of selected universities for producing specialized manpower. Under contract services, at present through three U.S. universities, including St. Louis University - assistance to Catholic University of Quito in basic sciences, education, English, nursing, social service, administration. Initial FY 1962; scheduled completion FY 1969. FY 1965 \$1 million; expenditures to date, \$400,000; estimated to completion \$6,998,000.

4. Technical Support. - For activities not charged to an individual project. Includes a sanitary engineer (who is chief public health advisor).

Haiti

1. Malaria Eradication (Supporting Assistance). - To eradicate malaria by 1968. Initial FY 1961. Scheduled completion FY 1968. FY 1965 \$1,400,000. Expenditures to date \$3,124,000. Estimated for completion \$7,226,000. U.S. funding: 3 malaria specialists and a business manager; local expenses; insecticide, sprayers, vehicles, provided by UNICEF (\$365,000); 4 technicians, fellowships and supplies, by PAHO (\$120,000).

Jamaica

1. Community Water Supply Construction. - To assist the Government of Jamaica in ten-year program to provide safe and adequate water supply for 80% of rural and 100% of urban population (through a \$3.7 million AID loan). Present project for advisory services and training. Government of Jamaica expenditures for water now exceed \$2 million a year. Initial FY 1961. Scheduled final FY 1966. FY 1965 \$101,000. Expenditures to date \$359,000; estimated to completion \$623,000. Technicians - one engineer advisor. Participants, 8; contract - 4 consultants; commodities - technical materials; local expenses for U.S. personnel.

Mexico

None.

Panama

1. Mobile Rural Health Program. - To bring health services to isolated rural areas. Initial FY 1964; final FY 1966. FY 1965 \$161,000;

expenditures to date \$75,000; estimated to completion \$444,000. No U.S. personnel. Commodities: equipment, medical instruments, medical supplies and drugs. Local expenses - personal services of doctors, nurses, etc. Small local aircraft hire.

Paraguay

1. Rural Health and Water Supply. - Improve health of rural population. Initial FY 1942. Scheduled completion FY 1967. FY 1965 \$130,000. Expenditures to date \$2,466,000. Estimated for completion \$3,050,000. Personnel: one physician and one sanitary engineer. Commodities: equipment for rural health centers - generators and pumps, surgical tables, hospital beds, stethoscopes, other medical equipment. Local expenses: contribution to construction costs of 5 health centers and renovation of 23 health centers, shipping and maintenance. Bulk paid by Government of Paraguay.

2. National University (Education). - To assist National University's program for raising academic standards to complete special programs - faculties of agriculture, public administration, medicine and nursing by FY 1968. FY 1965 \$504,000; expenditures to date \$782,000; estimated for completion \$2,493,000. U.S. technicians none in medicine direct-hire. Participants - 12 professors to U.S. for up to one year (some in medicine); 17 medical, nursing and midwifery teachers to third countries; contract with University of Buffalo, April 1965-March 1967, to provide one medical education advisor, one nursing education adviser, 16 man months of short-term consultants. Commodities include \$20,000 in medical books and teaching aids. Local expenses primarily for maintenance of medical and nursing students for 12-18 months, during their hospital and rural service internship. Estimate \$150,000 for medical education program.

Peru

None.

Surinam

None.

Trinidad and Tobago

None.

Uruguay

None.

Venezuela

None.

Regional

1. Pan American Health Organization (PAHO). - To develop the technical and administrative capability of PAHO, especially in malaria eradication and community water supply programs. Initial FY 1951. Scheduled final obligation 1967. FY 1965 \$2,100,000. Expenditures to date \$17,075,000; estimated total to completion \$23,625,000. FY 1965 funding - 132 PAHO staff including 8 PHS officers to work in malaria eradication, 19 including 4 PHS officers in community water programs. In-country training of 75 national technicians. Commodities - limited amounts for drugs, laboratory supplies.

2. Regional Scientific Programs (Education). - To identify the most significant areas for concentration of LA science efforts to strengthen the capability of LA institutions, to conduct research and training in such areas. The LA Science Board in National Academy of Sciences established by NAS-AID agreement in 1963, advises on projects and institutions. Contract activities FY 1964 include demographic and related research; research on

hot-climate and altiplano agriculture, both related to population pressures; problems of colonization, and rural economic development. Under review: Veterinary and animal husbandry in LA institutions. FY 1965 fundings; 12 man-years, contract services; follow-up; investigations in marine resources, training in health, sciences, grain legume improvement.

3. Other Government Agency Activities in Support of the Alliance. -

(General and Miscellaneous). To mobilize the technical resources of appropriate Federal domestic agencies to assist AID economic and social development programs abroad. FY 1965 funding includes 4 Bureau of Census technicians to organize and conduct workshops. Totals: Initial FY 1953; scheduled final FY 1969. FY 1965 \$1,082,000; expenditures to date, \$1,344,000; estimated to completion \$5,868,000.

4. Consultants and Seminars (General and Miscellaneous). - To

provide a flexible fund for activities of region-wide importance, involving small amounts of money, for completion in one FY; and for projects not foreseen at time of Congressional Presentation. Current FY includes consultants in health planning and collection of statistical data. Implemented by contract services.

IV. ESTIMATE OF POSSIBLE NEEDS FOR U.S. PUBLIC HEALTH SERVICE (PHS) ASSISTANCE IN LATIN AMERICAN HEALTH AND SANITATION PROGRAMS.

The shifting emphasis in the A.I.D. programs in Latin American has resulted in a decrease in the number of A.I.D. technicians in the field from 92 in FY 1961 to 47 in FY 1964. The number will be further decreased in FY 1965. The phase-out of projects has been particularly in health education, public health nursing, nursing education, hospital administration and rehabilitation. There has been continued emphasis on a few program areas: malaria eradication, community water supply development, community health services, particularly in the rural and slum areas and training of health personnel. There has been an increasing emphasis on the provision of technical advisory services through the Pan American Health Organization.

a) Long Term USAID Assignments

The needs for FY 1965 and 1966 in terms of long-term public health advisors and other technicians are as follows:

	Man Years	
	<u>FY 1965</u>	<u>FY 1966</u>
Public health physician, Recife, Brazil	1	1
Public health physician, other	2	2
Sanitary engineers assigned to PAHO	3	3
Sanitary engineers USAID	1	1
Malariologists assigned to PAHO	5	5
Malariologists assigned to Central America	2	2

Special Problems. - The malaria eradication program in Central America presents certain technical and administrative problems which will require the closest possible cooperation between PHS and A.I.D. in order to develop a sound program.

The relationship of PAHO to PHS and A.I.D. requires careful study. There are over 1,000 technicians employed by PAHO, while A.I.D. has less than 50. The need to closely integrate programs supported by PAHO, UNICEF, A.I.D. and those supported by private foundations and other U.S. institutions, requires a detailed knowledge of ongoing programs and close working relationships in Washington and in the field. Because of the long-standing relationship of PHS to PAHO-PASB, it is essential that the A.I.D.-PHS relationships be strengthened in A.I.D.

b) Short term consultation - USAIDs (man months)

In view of the increasing cooperation between the PHS and A.I.D., the need for increased participation by PHS in program development, coordination with multilateral agencies, evaluation and technical backstopping, it is hoped that the PHS can provide the following man-months of service for programs in Latin America: Communicable disease control (4), Public health administration (3), Demography and Biostatistics (4), Health Education (3), Nutrition (ICNND) (3), Production of Biologicals (1), Other (3).

c) Consultation - AID/W (man months)

The following are the possible requirements for FY 1965: Communicable Disease Control (1), Health education (3), Nursing (3), Hospital administration (1), Other (2).

d) Participant Training. - (Not including Puerto Rico). A careful review and evaluation of the participant training program will be initiated during the next year in order to give appropriate emphasis to major program areas (community water supply development) as well as new developments (population). A.I.D.-PHS will need to continue to work closely together on the programs.

The following is the estimated number of health participants, based on projections from FY 1962 and FY 1963.

	Number	
	<u>FY 1965</u>	<u>FY 1966</u>
a. Full academic year	40	150
b. Short-term (1-6 months)	20	50

Section 6.

AGENCY FOR INTERNATIONAL DEVELOPMENT

HEALTH AND SANITATION PROGRAMS

OFFICE OF TECHNICAL COOPERATION AND RESEARCH (TCR)

- I. Introduction
- II. Summary of Financial Assistance for Health and Sanitation Activities,  
Office of Technical Cooperation and Research, as proposed for FY 1965
- III. AID/Washington Health Positions in Health Service, TCR, 1964.
- IV. Description of Health and Sanitation Projects funded by TCR as  
proposed for Fiscal Year 1965
- V. Estimate of Possible Needs for U.S. Public Health Service (PHS)  
assistance in Health and Sanitation Programs in Office of Technical  
Cooperation and Research (TCR)

OFFICE OF TECHNICAL COOPERATION AND RESEARCH

I. INTRODUCTION

The Office of Technical Cooperation and Research is a central staff office that provides direct staff services to the Administrator of A.I.D. on policy matters in technical cooperation. It administers the research and analysis program for the Agency, it administers the American Schools and Hospitals abroad program, and it carries out a series of projects of an inter-regional or non-regional character under the title of general technical services. Within the Office of Technical Cooperation and Research are various service staffs including Health. The Health Service has three branches -- Malaria Eradication, Community Water Supply, and Population Reference and Research. There is a close working relationship between the Health Service and the Office of International Health, U.S. Public Health Service (PHS). The PHS provides a spectrum of technical backstopping services to the Health Service and the whole of A.I.D. through the mechanism of inter-agency agreements.

II. SUMMARY OF FINANCIAL ASSISTANCE FOR HEALTH AND SANITATION ACTIVITIES, OFFICE OF TECHNICAL COOPERATION AND RESEARCH AS PROPOSED FOR FISCAL YEAR 1965,

<u>Activities</u>	<u>Amount</u> <u>(dollars)</u>
American Schools and Hospitals	\$12,300,000
Health Program Research	1,500,000
Public Health Service (technical backstopping, participant training, demonstration projects, biomedical information center)	610,000
Association of American Medical Colleges	44,000
American Hospital Association	30,000
Special Projects (e.g., population)	700,000
Administrative (TCR/HS)	250,000
	<hr/>
	\$15,434,000

AGENCY FOR INTERNATIONAL DEVELOPMENT

III. AID/WASHINGTON POSITIONS IN HEALTH SERVICE, TCR, 1964

The Health Service, Office of Technical Cooperation and Research, has the following staff funded from non-regional funds:

a. Director

Deputy Director

Administrative/Program Assistant and two secretaries.

The Director and his immediate staff provide over-all direction for the three Branches within the Health Service and serve as a focal point for AID-PHS relationships.

b. Malaria Eradication Branch (MEB)

Chief, Deputy, Public Health Administrator, Program Analyst and two secretaries.

The MEB has direct coordinating and technical backstopping responsibilities in the world-wide malaria eradication program. In addition, it is responsible for response to or reference of requests in the field of communicable disease control.

c. Community Water Supply Branch (CWSB)

Chief, Deputy, Sanitary Engineer, and two secretaries.

Like MEB, the CWSB has direct responsibilities in the development of special training programs for participants and it provides a focal point for Agency backstopping or referral of requests in problems of environmental sanitation.

d. Population Reference and Research Branch (PRRB)

Chief.

This newly-created Branch will serve as the Agency focal point for technical backstopping related to population problems.

e. Consultants

The consultants that serve TCR/HS are also available to serve as consultants to Regional Bureaus and USAID's.

The list of present TCR/HS staff and consultants is attached.

This also includes the Regional Health personnel in Washington (Appendix 3).

IV. DESCRIPTION OF HEALTH AND SANITATION PROJECTS FUNDED BY OFFICE OF TECHNICAL COOPERATION AND RESEARCH AS PROPOSED FOR FISCAL YEAR 1965

1. American Schools and Hospitals Abroad

This program was initiated as a specific item in the Foreign Assistance Act of FY 1964 (Section 214). Various institutions had been supported prior to that time from development grants, the President's contingency fund, and special local currency appropriations. The medical institutions which have been supported under this program include: Children's Hospital of Krakow, Poland; Project Hope, and the American University of Beirut's Medical Center.

The following requests have been made for FY 1965:

Project Hope	\$ 1,500,000
American University of Beirut Medical Center	10,500,000
Admiral Bristol Hospital and Nursing School	<u>300,000</u>
TOTAL	\$12,300,000

2. Research

Research in the health sector has been concentrated in several areas: communicable disease, particularly malaria eradication; health manpower; effects of investment in health on economic development and nutrition. Future research will undoubtedly focus on problems related to population growth. Because of a \$6 million ceiling on research in FY 1964, it was possible to fund only the following projects: malaria eradication (CDC) \$285,000; malaria insecticide studies (CDC) \$70,000; effects of investment in health on economic development (Harvard) \$9,250; study of methods of improving training and use of middle level manpower (Medical College of Virginia) \$150,200. Projects approved, funding in FY 1964 or 1965: Functional analysis of health centers

(Johns Hopkins) \$200,000; child feeding (ICNND) \$73,000. If the 15 million dollars requested is appropriated, we should fund about \$1,500,000 for health research in FY 1965.

3. General Technical Services

A. Nutrition Surveys - Many highly successful nutrition surveys have been carried out during the past nine years by the ICNND. During recent years A.I.D. has supported selected surveys and the projected program for FY 1965 is principally for follow-up activities. This mainly consists of short-term consultative visits; preparing, receiving and clearing with country counterparts materials for final reports; investigating and analyzing past programs as a basis for future activities. The proposed funding from non-regional funds is \$125,000. It is likely that USAID/Korea will request a special survey in FY 1965 which will be funded by country program funds (FE Region) and there will probably be several (up to 6) ARPA funded surveys.

B. Technical Consultation and Support - This includes the agreement with PHS to provide general technical services in support of A.I.D. programs. (See appendix to this section for A.I.D. Summary of PHS support of A.I.D. programs.) In addition to the services described in the attached report, A.I.D. has requested PHS to provide the services of a PHS officer for full-time backstopping in health education; continued backstopping of the A.I.D. nursing program; the services of a senior public health physician to review A.I.D. and WHO health programs in order to develop better coordination and better program and personnel planning and the services of a senior public health nurse to assist in the development of health manpower studies in conjunction with the Rockefeller Foundation. A special project was initiated with the National Library of Medicine (see E - below).

C. Administrative Support from PHS - This covers the administrative and housekeeping services for the PHS Officers assigned to A.I.D. Budget for FY 1965 is \$42,000.

D. Participant Services, PHS - This activity provides for services to and in support of A.I.D.-sponsored participants during their professional and technical training while in the U.S. In addition to direct A.I.D. activities, funds are available to provide for participation by other Federal Agencies in the planning, development and implementation of training programs for participants. The present budget estimate for FY 1965 is \$276,000.

E. National Library of Medicine, PHS - An agreement was signed in FY 1964 and initial funding provided to develop an expanded international biomedical information exchange program. The program is planned initially for three years with the hope that if successful, this may receive funding through WHO. An initial grant of \$48,000 was made in FY 1964 and if the program develops as planned, funding should be \$100,000 in FY 1965

F. Association of American Medical Colleges (AAMC).- Since 1961 the AAMC has provided world-wide consultative services in medical education through a general contract which is supplemented by specific task orders. A task order has just been signed which initiates a study directed toward identifying and clarifying basic issues related to the role of U.S. medicine, US. medical schools, the AAMC, and other agencies (within the USA) which might be instrumental in the advancement of medical education in the developing countries. Basic funding for the AAMC contract will be \$44,000 in FY 1965 and the special study (funded in FY 1964) will be \$94,000. Field consultations will be funded by USAID's.

G. American Hospital Association (AHA) - The A.I.D. provides basic support for the International Division, AHA. The Division provides continuing consultative services to AID/W and services to USAID's on request. Field consultations are funded by USAID funds. The basic budget for this contract is \$30,000.

H. Special Projects - There is a variety of special projects in support of the community water supply development programs, malaria training, population and other new projects, demonstrations or special projects of world-wide significance. Proposed funding for FY 1965 is \$700,000. This budget may be increased by as much as \$1,000,000 to cover institutional development grants, program evaluations or other special activities in the population field.

V. ESTIMATE OF POSSIBLE NEED FOR U.S. PUBLIC HEALTH SERVICE (PHS) ASSISTANCE  
IN HEALTH AND SANITATION PROGRAMS IN OFFICE OF TECHNICAL COOPERATION  
AND RESEARCH (TCR)

The need for PHS assistance, in addition to that for regional programs, falls into the major categories of programs supported by TCR. The major programs supported by TCR fall into three categories: 1) Americal Schools and Hospitals Abroad, 2) Research, and 3) General Technical Services. The descriptions of the programs and projects in Section IV indicate the extent to which TCR is dependent on PHS for assistance.

a. Long-term Assignments - The Deputy Chief, Health Service, Office of Technical Cooperation and Research, is a Public Health Service Officer, and we will hope this arrangement will continue in effect during FY 1965.

In addition, the Deputy Chief of the Malaria Eradication Branch, Health Service, TCR, is a Public Health Service Officer, and we hope this arrangement will continue in effect in FY 1965.

It is hoped that following the retirement of Mr. Charles Pineo, Chief, Community Water Supply Branch, at least one Public Health Service Officer will be assigned to the Community Water Supply Branch, Health Service, TCR.

b. Short-term Consultation - The present estimates (man months) for consultation are as follows: communicable disease control, 2; public health administration, 4; demography and vital statistics, 3; health education, 1; nursing, 6; sanitary engineering 3; nutrition, 2; and other, 2. These services are in addition to those covered in the regional program estimates and in the specific inter-agency agreements (e.g., National Library of Medicine).

SUMMARY OF HEALTH AND SANITATION PROGRAMS  
PROPOSED FOR FISCAL YEAR 1965

The health and sanitation programs which are proposed for AID support in fiscal year 1965 are a reflection of many factors, particularly the recognition that these programs may play a fundamental role in social and economic development. In the early stages of social and economic development, health and sanitation programs may play a particularly important role. As incomes rise and mortality rates decline rapid rates of population growth are likely to occur and be associated with critical needs for food, particularly for infants and preschool children. In these situations the Food for Peace Program has played a vital role. When countries reach higher levels of economic and human resource development external technical assistance in health is rarely required. In these situations the World Health Organization, private organizations or the U.S. Public Health Service can almost always meet the need.

The types of programs and the nature of the assistance provided vary from one region to another because of the history of U.S. assistance and the nature of current needs and resources. Although the needs in Africa are almost unlimited, the major responsibility for assistance in the health sector rests with the countries of Western Europe and the United Nations and its specialized agencies. In Latin America the U.S. has provided technical assistance and grant funds to support health and sanitation projects for more than twenty years. Because of the progress which has been made in such fields as community water supply development, it has been possible for the Latin American countries to obtain more than \$200 million in loan funds from AID

the Export-Import Bank and the World Bank to support projects in this field.

The Far East countries have not only suffered from the ravages of World War II but mutual security interests have necessitated major military assistance programs in Korea, the Philippines, Taiwan, South Vietnam and Thailand.

Malaria was a major problem and large scale eradication efforts have been supported in this region. Medical education has also received more support from the AID in the Far East than in any other region. In the Near East, South Asia (NESAs) Region, there has been a major shift from development grants to loans to support commodity costs of such technical cooperation programs as malaria eradication. Rural health, health education and health manpower development in the NESAs region have also received support from 10 to 15 non-U.S. Government organizations.

The Food for Peace Program has been particularly important in Turkey, Pakistan and India. In the future, more and more attention will be given to the problems associated with rapid rates of population growth.

The funding proposed to support health and sanitation projects in each of the regions and for non-regional projects is summarized in Table 1.

Table 1

Funding Estimates for Health and Sanitation Programs in FY 1965

<u>Regional</u>	<u>Dollars</u>
Far East	\$ 12,076,000
Africa	5,299,000
Near East South Asia	4,692,000
Latin America	21,179,000

(continued over)

Funding Estimates for Health and Sanitation Programs in FY 1965 (cont'd.)

Non-Regional

American Schools and Hospitals Abroad	\$ 12,300,000
Health Program Research	1,500,000
Public Health Service	610,000
American Hospital Association	30,000
Association of American Medical Colleges	44,000
Special Projects (e.g. Population, Malaria Training	700,000
Administrative	250,000
	<hr/>
TOTAL	\$ 58,680,000*

Although these programs are in 53 countries, major emphasis in health and sanitation funded by technical cooperation and development grants as well as development loans has been concentrated in Ethiopia, Indonesia, Laos, Thailand, Vietnam, India, Pakistan and Brazil. The largest single grant will be \$10.5 million to the American University of Beirut for construction of a teaching hospital as part of the new medical center which will serve the whole of the Middle East as well as Ethiopia, Sudan and Pakistan.

The types of programs supported followed very much the world-wide priorities defined in the Health Sector Guidelines (Appendix 3). These are summarized in Table 2.

\* Do not include loan funds obligated in FY 1964 for use in FY 1965 as follows: India, \$3,150,000; Pakistan, \$5,300,000; Brazil, \$3,400,000.

Table 2

Health and Sanitation Projects Programmed for Support in FY 1965

<u>Type of Program</u>	<u>Number Supported</u>
Community Water Supply	23
Rural Health Services	18
Malaria Eradication	14
Medical Education	10
Nursing	9
Public Health Administration	7
Health Education and Communicable Disease Control	6 (each)
Auxiliary Training and Sanitary Engineering	5 (each)
Other	5 (each)

The present AID health and sanitation personnel are summarized in Tables 3 and 4. At present there are 279 positions with 43 vacancies and 236 direct hire employees or personnel assigned to AID by the U.S. Public Health Service. There are, in addition, personnel employed under seven university contracts that are not included in this summary. There will probably be an additional fifty positions added to the health and sanitation program in Vietnam during the coming year.

Table 3 page a

## CATEGORY SUMMARY HEALTH PERSONNEL 5/25/64

COUNTRY	Hlth Adm			Adv/Hlth Educ			Malaria Adv&Spec			/ Nurses			/Physicians/ Public Hlth Adv.			/Sanitarian/Sanitary Engr.			/Well Driller			/ Miscellaneous	/ Total					
	Po	PHS	Va	Po	PHS	Va	Po	PHS	Va	Po	PHS	Va	Po	PHS	Va	Po	PHS	Va	Po	PHS	Va		Po	PHS	Va			
AFRICA																												
Ghana	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		1	-	-
Cameroun	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-		1	-	-
Ethiopia	1	1	-	1	-	-	5	-	-	11	2	-	6	1	2	-	-	-	2	-	-	-	-	-	Sociologist Po-1 1 Vacancy	27	4	3
Liberia	-	-	-	-	-	-	-	-	-	1	-	-	1	-	-	-	-	-	1	-	-	-	-	-	Med. Clinician Po-1, Dir. Hire	4	-	-
Malagasy Rep.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	1	-	-		2	-	-
Sierra Leone	-	-	-	-	-	-	-	-	-	-	-	-	1	1	-	-	-	-	1	-	-	1	-	-		3	1	-
Somali Rep.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-		1	-	-
Rep. of Ghad	-	-	-	-	-	-	-	-	-	1	1	-	1	-	-	-	-	-	-	-	-	-	-	-	Med. Clinician Po-1, Dir. Hire	3	1	-
Upper Volta	-	-	-	1	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-		2	-	-
FAR EAST																												
Burma	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-		1	-	-
Indonesia	-	-	-	1	-	-	16	1	10	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-	Equip Opn Mntn Spec Po-1, Dir. Hire Med Supply Adv Po-1, Dir. Hire	21	1	10
Korea	-	-	-	-	-	-	-	-	-	-	-	-	1	1	-	-	-	-	-	-	-	-	-	-		1	-	-
Laos	1	-	-	-	-	-	-	-	-	-	-	-	2	-	1	-	-	-	-	-	-	1	-	-	Med. Technologist Po-2, Dir. Hire	6	-	1
Philippines	1	-	-	-	-	-	7	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Med. Educator Po-1, Dir. Hire	9	1	2
Thailand	-	-	-	1	-	-	6	-	-	1	1	-	1	1	-	1	-	-	5	-	2	-	-	-		15	2	2
Viet Nam	1	-	-	2	1	-	12	-	2	14	11	1	11	6	4	-	-	-	1	-	-	1	1	-	Anaesthetist Po-4, PHS-4 Equip Opn Mntn Spec Po-1, Dir. Hire Hospitl Equip Engr Po-1, Dir. Hire Med. Education Po-8, 3 Dir. Hire 5 Vacancies Hosp Admn Adv Po-1, Dir. Hire Med. Supply Off Po-1, Vacant Med. Technologist Po-3, PHS-3	63	26	13



Table 3 page c.

	Hlth Adm Adv		Hlth Educ		Malaria Adv&Spec		Nurses		Physicians		Public Hlth Adv.		Sanitarian		Sanitary Engr		Well Driller		Miscellaneous		Total		
	Po	PHS Va	Po	PHS Va	Po	PHS Va	Po	PHS Va	Po	PHS Va	Po	PHS Va	Po	PHS Va	Po	PHS Va	Po	PHS Va		Po	PHS Va		
LATIN AMERICA																							
Bolivia	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	-	1	-	-	Industrial Hygn Adv Po-1, Dir. Hire	3	-	1
Brazil	-	-	1	-	4	1	-	-	-	-	-	-	-	-	5	-	-	-	-	Comm Wtr Spl Adv Po-1, Dir. Hire Mech Engr. Po-1, Dir. Hire	12	1	-
Colombia	-	-	-	-	-	-	1	-	-	-	1	-	-	-	-	1	1	-	-		2	-	-
Costa Rica	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-		1	1	-
El Salvador	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-		1	-	-
Guatemala	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-		3	-	-
Haiti	-	-	-	-	3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Voice Rehabiltn Spec Po-1, Dir. Hire	2	-	-
Mexico	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-		2	1	1
Nicaragua	-	-	1	1	-	-	-	1	-	1	-	1	-	-	-	1	-	-	-		4	-	1
Paraguay	-	-	-	-	-	-	1	-	-	1	-	1	-	-	1	-	-	-	-		1	-	-
Peru	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-		2	-	-
Ecuador	-	-	-	-	1	-	-	-	-	-	-	-	-	-	3	-	-	-	-		3	-	-
Jamaica	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-		1	-	-
West Indies & East Carrib. Rgnl Cent Am & Panama	-	-	1	-	-	-	1	-	-	-	1	-	1	-	-	1	-	-	-		4	-	1
TOTAL	8	1	16	4	70	6	54	20	3	34	12	12	-	10	-	31	2	2	5	Po-39, PHS-7, Va-8 24 Dir. Hire	279	52	43

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Table 4

## Category Summary Health Personnel 5/25/64

	Africa-Europe			Far East			NESA			Latin America			Totals		
	Pos.	PHS	Vac.	Pos.	PHS	Vac.	Pos.	PHS	Vac.	Pos.	PHS	Vac.	Pos.	PHS	Vac.
Anaesthetist	-	-	-	4	4	-	-	-	-	-	-	-	4	4	-
Community Water Adv	-	-	-	-	-	-	1	-	-	1	-	-	2	-	-
Construction Supr.	-	-	-	-	-	-	1	-	-	-	-	-	1	-	-
Engr Draftsman Design.	-	-	-	-	-	-	1	-	-	-	-	-	1	-	-
Equip. Op. Mntn.	-	-	-	2	-	-	1	-	-	-	-	-	3	-	-
Health Admin. Adv.	1	1	-	3	-	-	4	-	-	-	-	-	8	1	-
Health Educator	3	-	-	4	1	-	6	2	1	3	1	-	16	4	1
Hospital Admin.	-	-	-	1	-	-	2	-	-	-	-	-	3	-	-
Hospital Equip. Engr.	-	-	-	1	-	-	-	-	-	-	-	-	1	-	-
Industrial Hygn. Adv.	-	-	-	-	-	-	-	-	-	1	-	-	1	-	-
Malaria Adv./Spec.	5	-	-	41	2	13	14	3	1	10	1	-	70	6	14
Med. Clinician	2	-	-	-	-	-	-	-	-	-	-	-	2	-	-
Med. Education	-	-	-	9	-	6	1	-	-	-	-	-	10	-	6
Med. Supply Adv.	-	-	-	2	-	1	1	-	-	-	-	-	3	-	1
Med. Technologist	-	-	-	5	3	-	-	-	-	-	-	-	5	3	-
Mechanical Engr.	-	-	-	-	-	-	-	-	-	1	-	-	1	-	-
Nurses	13	3	-	15	12	1	23	5	2	3	-	-	54	20	3
Physicians	10	2	2	15	8	5	6	2	0	3	-	2	34	12	9
Public Health Adv.	-	-	-	4	-	-	3	-	3	5	-	1	12	-	4
Sanitarian	1	-	-	6	-	2	3	-	-	-	-	-	10	-	2
Sanitary Engr.	6	-	-	2	1	-	9	-	1	14	1	1	31	2	2
Sociologist	1	-	1	-	-	-	-	-	-	-	-	-	1	-	1
Voice Rehabilitation	-	-	-	-	-	-	-	-	-	1	-	-	1	-	-
Well Driller	2	-	-	1	-	-	1	-	-	1	-	-	5	-	-
TOTAL	44	6	3	115	31	28	76	12	7	43	3	4	279	52	43

Positions 279  
 Vacancies 43  
 Personnel 236

KEY: Pos.= Positions  
 PHS = Public Health Service Personnel  
 Vac.= Vacancies

TCR/HS:DSteussy 6/30/64

The requirement for Public Health Service personnel is likely to show a gradual increase in the next few years due to the improved climate in AID-PHS relationship. An increase of about 80 may occur if the malaria eradication program is transferred to the Public Health Service. The requirements at present are as follows: Far East - 35; Africa - 15; Near East South Asia - 15; Latin America - 3, and Office of Technical Cooperation and Research - 5.

The needs for short term consultant for USAIDs and AID/W is summarized in Table 5.

Table 5

Estimated Short Term Consultation Requirements

Field of Activity	AID Requirement (Man Months)				
	TCR	AFR	FE	NESA	LA
Communicable Disease Control	2	3	8	10	5
Public Health Administration	4	1	0	3	3
Demography and Vital Statistics	3	0	2	3	4
Health Education	1	4	4	17	6
Nursing	6	0	3	4	3
Sanitary Engineering	3	3	2	12	2
Nutrition	2	6	3	1	3
Other	2	0	4	2	8

These requirements cannot be estimated exactly, but are based on the experience of recent years plus present program activities.

The number of health participants has been declining in recent years and with the phase out of programs in Latin America may take a sharp drop.

Present estimates do not include any appreciable increase of participants in fields related to population problems. Estimates for the total number of participants by region are as follows: AFR - 70; FE - 100; NESA - 128; and LA - 60.

This report briefly summarizes the present estimates of the programs in health and sanitation for fiscal year 1965. As was stated at the outset of this report, we have yet to achieve, within AID, wholehearted acceptance of Disraeli's famous statement: "The health of the people is really the foundation upon which all their happiness and their powers as a State depends."

APPENDIX I

MEMORANDUM

TO : Leona Baumgartner, M.D., AA/HRSD                      DATE: November 20, 1963  
FROM : Philip R. Lee, M.D., HRSD/HS  
SUBJECT: Summary of AID Agreement with PHS

I. Assignment of Public Health Service Personnel

The Public Health Service presently has on loan to AID in both AID/W and in the field a total of 63 people. These are divided into two groups, as follows:

A. AID/W Public Health Service officers on reimbursable detail to AID/W, occupying AID/W positions. These include:

Dr. Edward O'Rourke, Deputy Director, Health Service/HRSD  
Dr. Arthur G. Curtis, Chief, Office of Institutional Development, Bureau of Africa and Europe  
Miss Mary Jo Kraft, Health Educator, Bureau for Near East and South Asia  
Mr. Donald R. Johnson, Acting Chief, Malaria Eradication Branch, HRSD

Total cost per year - \$68,823\*

B. USAID General PHS personnel assigned to AID field missions as of July 1, 1963, amount to 59, (not including surgical teams in Vietnam) AID advances funds to PHS to pay for these personnel, and PHS in turn pays them directly. Breakdown is as follows:

Medical Officers	13
Nurses	18
Sanitary Engineers	7
Sanitarians	7
Health Educators	5
Malariologists	7
Health Admin Adv	1
Pharmacist	1
Total	<u>59</u>

These people occupy US AID Mission positions and are chargeable to Mission funds.

The total spent for field technicians in FY 1963 was \$887,924.

\*This figure includes charges for reimbursable details summarized in section II.D below (Indonesia malaria eradication evaluation team).

C. USAID Special

Surgical Teams - Vietnam - This is a program to furnish surgical teams (up to 24 persons) to work in the hospitals in certain provincial capitals in Vietnam as part of the present emergency situation. In this case, a separate agreement was not signed, but a project implementation order for technical services (PIO/T) was issued, with PHS concurrence, to cover the necessary expenses. \$350,000 was budgeted for FY 1963, this amount being used for professional services, administrative support, travel and transportation of persons and things, and miscellaneous costs. Currently 20 people are assigned to the project, including 5 surgeons, 4 anesthetists, 7 nurses, 4 medical technologists. A PIO/T for \$375,000 was issued for FY 1964 for the continuation of services in connection with the surgical teams. Under the terms of this arrangement, AID pays for one professional and one clerical person in the Bureau of Medical Services to compensate the PHS for professional support and related administrative services to these groups in the field. It is contemplated that this agreement will continue for two to four years.

II. Training Services

Funding FY 1963	\$273,146
Funding FY 1964	326,200
Funding FY 1965	333,000

32 positions are programmed, but AID pays for 27 man-years. Staffing includes 1 chief (O-6), 2 director-grade officers (O-6), 2 senior-grade officers (O-5), 7 program specialists, 2 traffic officers, 16 clerks, 2 other.

Purpose - To program and administer the participant training program in health for AID and to assist in part for the programming of WHO and UN health participants. These include both long-term and short-term participants, short-term being defined as less than 6 months and including those for whom there is both primary and secondary responsibility. Primary responsibility denotes full responsibility for the group, and secondary indicates that there is assistance by some other organization in part of the training program.

AID estimates an average cost per participant (all categories except agriculture) as \$5,000 a year; this figure includes subsistence, international travel, and tuition. For agriculture the estimate is \$4240 which does not include international travel or tuition; some participants go to land-grant colleges for training, and such costs and international travel are funded from an over-all budget. In practice, total costs for health participants averages around \$4600.

PHS Participant Workload Data

	<u>Actual FY 62.</u>	<u>Actual FY 63</u>	<u>Estimated FY 64</u>
<u>AID Participants (Primary &amp; Secondary)</u>			
Left over from last year	269	259	325
New Participants	<u>378</u>	<u>354</u>	<u>354</u>
Total AID	647	613	679
<u>U.N. Fellows</u>			
Left over from last year	?	34	8
New Participants	<u>?</u>	<u>118</u>	<u>118</u>
	169	152	126
Grand Total	816	765	805

III. Research

Numerous special agreements have been signed with various parts of the Public Health Service to undertake specific projects or programs at the request of AID. Each of these has been handled on an individual basis and has been negotiated under the terms of the General Agreement, but with various parts of PHS.

A. SEATO Cholera Research Laboratory - This is an agreement with the NIH for the purpose of developing a SEATO cholera research program, the principal part of which is the SEATO-Pakistan Cholera Research Laboratory in Dacca, East Pakistan. It was originally funded from \$400,000 of FY 1957 funds, with additional grants of \$150,000 in FY 1962, and \$200,000 in FY 1963 with \$200,000 proposed in 1964. NIH has assumed the operating responsibility for this laboratory, and has assigned the technical personnel to work in the laboratory. This personnel consists of one Director, 3 Medical Officers, and an Administrator. Major contributions to this project have been made by the Government of Pakistan and the US AID Mission in Pakistan, and the NIH through the use of its own P.L. 480 funds. Also, payment of most of the U.S. personnel noted above has been from the National Heart Institute or the Office of International Research. In addition to this, outside contributions have also been received from the United Kingdom, Pakistan, and Australia.

This program has had difficulties in getting itself organized as an international laboratory, but is presently staffed and organized in such a manner that it is expected that basic medical research, epidemiological investigations, and vaccine studies can be undertaken in the hope of finding a solution to the total cholera problem in Asia. As a SEATO

program, most of its basic work is done in either Pakistan, Thailand, or the Philippines.

B. Interdepartmental Committee on Nutrition for National Defense (ICNND). - All research proposals in AID countries will be funded out of AID research funds, under the Health Section/HRSD. (Any program activities resulting from ICNND research will be funded by the Country Missions involved.) It is proposed that the basic funding of ICNND be delegated to DHEW. Research on malnutrition and parasitic infections in the Near East with Vanderbilt University and NAMRU-3 was under way in FY 1963 and will continue in FY 1964.

C. Upper Volta Measles Study - There is no formal agreement covering this project, which covered a mass immunization program in Upper Volta, utilizing 731,000 doses of measles vaccine on an experimental basis, in conjunction with yellow fever vaccine and smallpox vaccine. The NIH has furnished the technical personnel and obtained the necessary vaccine, and AID has furnished the necessary vehicles, jet injectors, and additional supplies required. The Government of Upper Volta furnished personnel and other logistic support.

D. AFC Regional Measles Control Project - Training and Demonstration - Because of the widespread importance of measles as a cause of death and disability in many African countries, two NIH virologists participated in an OCCGE meeting in Paris in May 1963 at AID expense to discuss further protective activity. In July 1963 AID made a grant not to exceed \$25,000 to the OCCGE to assist a program for training member-country personnel in the technique of measles immunization campaigns, plus \$230,000 worth of commodities for pilot demonstrations. The Division of Biological Standards of NIH donated 90 days TDY for two technical consultants. One AID Public Health Physician in Upper Volta participated in the activity. A three-weeks' Training-Demonstration Program was held in Upper Volta in October 1963, with faculty from the OCCGE plus the two NIH virologists and the AID physician. Individual countries are subsequently conducting field demonstrations.

E. Hemorrhagic Fever - Bolivia. This was a cooperative program, AID/NIH/Bolivian Government, under which six consultants from the Middle Atlantic Research Unit of NIH (MARU) at Panama went to Bolivia in May-June 1963 because of an outbreak of the fever with high mortality. Through their research they apparently isolated the casual virus for the first time. Now the team is undertaking a study to determine the vector and the reservoir; bats and field mice are suspect. NIH and the Bolivian Government are contributing funds; AID has contributed \$32,000 each year for two years.

F. International Center for Medical Research and Training (ICMRT).

At the request of the University of Maryland, and with the concurrence of NIH, an agreement was negotiated between the Government of Pakistan, The University of Maryland and AID to provide elements of administrative and logistic support to U.S. members of the ICMRT at Lahore, West Pakistan. This assistance was requested by the University of Maryland because the University learned that without the administrative organization and relationships with the Government of Pakistan which AID possessed they were unable to support administratively the ICMRT without heavy additional expenses and duplication of effort.

Parke-Davis developed a new drug CI-501, a long-acting drug against malaria. It is injected and lasts for six months at a time. The drug is under investigation by Dr. Coatney at NIH who has been carrying out studies at Atlanta on prisoners. In order to conduct field trials, Dr. Coatney made arrangements through NIH with the University of Maryland, ICMRT at Lahore, to carry out field studies in Pakistan. AID is contributing to the ICMRT program about \$50,000 a year in local currency derived from the Pakistan Trust Fund and used for administrative support costs.

Malaria Eradication Research Contract  
with the Communicable Disease Center

Funding FY 1962	\$235,000
Funding FY 1963	235,000
Funding FY 1964	285,000

Project Personnel - 12 chemists, 24 research assistants, 8 biologists, 2 engineers, 1 sub-professional.

Supporting Personnel - 2 professionals, 4 sub-professional supervisors, 6 administrative personnel, 3 laborers.

Purpose: Research and development relating to all aspects of malaria insecticides, with particular emphasis on chemical formulations, packaging, insecticide resistance studies, and development and improvement of application equipment.

H. DDVP Studies in Haiti and the United States

Funding FY 1962	\$30,000 first
Funding FY 1963	100,000
Funding FY 1964	<u>70,000</u> last
Total	\$200,000

Part-time services of one professional plus the services of five Haitians. One AID technician in Haiti also works part-time on this program. At the Savannah laboratories, development research on formulations and dispensing devices is continuing as a part of the total activities in these areas.

Purpose: Under the general research agreement with the CDC a new organophosphorous insecticide, DDVP, was developed, and it is the purpose of this agreement to carry out field studies on the usage of DDVP and to determine its effectiveness and its potential utilization in the world-wide malaria eradication program.

IV.

A. Technical Consultation and Support

Funding FY 1963	\$61,305
Funding FY 1964	69,800
Funding FY 1965	72,300

Funding includes salaries for a total of six persons - two public health physicians, one sanitarian, and three secretaries--and financial support for travel and other administrative expenses supporting this group.

Purpose: Primarily to make available to the AID the organizational capability of the PHS, including advisory services by professional personnel, backstopping administrative activities, furnishing technical information, review of special proposals, assistance in procurement of technical reports and literature.

In addition, special PHS technical support is summarized as follows:

PHS and AID/W personnel: Multiple consultation, both by personal visit and by telephone, is on a daily basis; in Health Service, the personnel attend an average of four meetings a week in PHS. PHS personnel attend regular HRSD/HS meetings twice a month.

Individual consultation: Services of two retired sanitary engineering officers, Dr. Arthur Miller and Mr. Alfred Wieters, on intermittent basis; part-time services of two medical directors, Dr. Spence and Dr. Donovan, working in PHS on recruitment and staffing.

To USAID's, FY 1963: 64 special consultants were made available for 67 overseas trips for AID, a total of 2657 days. Travel funding was primarily by country programs, but all consultation for less than 30 days was on non-reimbursable basis for salary.

To USAID's, Estimated for FY 1964: Research projects consultant to Iran, Pakistan, India, 45 days; nutrition consultants for overseas trips, 93 days; nursing advisors for overseas trips, 160 days; at least three man-years for evaluating surveys in Brazil and Ethiopia, drawn from panel of about 18 malaria experts PHS has agreed to set up to be available for field teams as needed.

PHS and A/CRD: Upon request by Missions and by HRSD/HS, the Communications Resources Division transmits inquiries for technical information and PHS publications to the PHS at the rate of about three per week. A/CRD also makes arrangements on a very limited basis for the loan of films to AID overseas Missions; most of the requests go directly to CDC/PHS/Atlanta. Special types of consultant services in the area of communications have been furnished by CDC to AID/W and in medical education to Colombia.

B. Interdepartmental Committee on Nutrition for National Defense

A total of \$314,000 was expended in FY 1963 from Washington funds; \$174,000 was expended in Development Grants and \$140,000 from the Alliance for Progress. Principal assessments were new ones in Venezuela, Brazil and Malaya, completion of survey in Bolivia, carry-overs from FY 1962 in Burma, Uruguay, and Jordan, and follow-up in 14 other countries. Estimates for FY 1964 are \$125,000 Development Grants and \$175,000 Alliance for Progress, to include completion of survey reports for Bolivia, Malaya, Brazil, and Venezuela, regional projects in NESAs and LA, and studies of proteins and other food supplements for school feeding and child and maternal centers in Colombia, Chile, and Peru, as well as follow-up in other countries previously surveyed by ICNND.

C. Communicable Disease Center.

(1) Polio Immunization Program - British Guiana. A team of four persons from CDC/Atlanta went to British Guiana in December 1962 on non-reimbursable detail for one month, to assist the Government in setting up an immunization program for administering trivalent vaccine. They conducted epidemiological studies, and were responsible for controlling the epidemic which has crippled more than 400 persons, almost all under 5 years of age.

(2) Polio Immunization Program - Dominican Republic. A team of three persons from CDC/Atlanta went to the Dominion Republic in Spring 1963 on non-reimbursable detail for two weeks, to assist the Government in setting up an immunization program for administering trivalent vaccine.

(3) Polio Immunization Program - Jordan. CDC is assisting in development of plans for poliomyelitis immunization program in Jordan in view of a continuing polio problem there. Over the past several years, data from a MEDICO orthopedic team revealed that 20-40 percent of the problems appeared to be post-polio residual paralysis. A mass immunization campaign is planned for children five years of age and under, employing trivalent vaccine from England. An epidemiologist from CDC, Dr. John Witte, is assisting with the program.

(4) Central America Malaria Eradication Evaluation Team.

Discussions have been held with CDC, and it is expected that they will furnish an Evaluation Team, on a Participating Agency Service Agreement, to survey Central American malaria eradication programs starting in January 1964. The Team would be composed of four members, and it is anticipated that approximately sixty days would be required for the evaluation. It is hoped that this will form the basis for additional malaria eradication program evaluations to be performed by CDC.

(5) Other Malaria Eradication Evaluation Teams.

In addition to the above, CDC has agreed to the detail of Dr. John W. McDowell on a reimbursable basis to assist in an evaluation of the Iran Malaria Eradication Program, scheduled to begin on November 18 and last approximately one month. Also Dr. Alan Donaldson, Deputy Chief, CDC, spent 2 weeks in the Philippines recently to study the training facilities and curriculum of the Malaria Eradication Training Center there. Discussions have also been held with CDC regarding the possibility of their preparing training manuals for use in connection with courses given at Malaria Eradication Training Center.

In December 1962 PHS assembled a three-man team on reimbursable detail under Participating Agency Agreement to perform an evaluation of the Indonesia malaria eradication program. This evaluation lasted approximately one month.

(6) Audiovisual Aids in Medical and Health Education.

The CDC has made available advisory services for consultation in the field of audiovisual aids. Dr. James Lieberman visited Bogota, Colombia in June 1963 at the invitation of the Colombian Association of Medical Colleges to advise on new methods for using audiovisual aids in medical education and to explore whether opportunities exist for utilizing new techniques in Colombia. Dr. Lieberman is also available to discuss with U.S. universities the possibility of establishing a participant training program in the use of audiovisual materials in health education, for application in overseas medical and health programs.

D. National Library of Medicine

Approximately 10 percent of interlibrary loans are made, through photoduplication, without charge to the libraries throughout the world in lieu of the lending of original materials. Foreign distribution of the Index Medicus, published monthly by the library with annual accumulations published by the American Medical Association, constitutes 45 percent of the total distribution of the Index. In addition, the library turns over to the U.S. Book Exchange, Inc., a contracting agency for AID, the large volume of duplicate materials which it receives from all sources. The library has no formal agreements to support AID programs, but as individual Missions make demands upon its services it responds to them. In the past the library has provided technical consultation to individuals preparing for foreign AID missions.

V. Administration

Funding FY 1963	\$35,597
Funding FY 1964	38,871
Funding FY 1965	39,618

Staffing: a total of 6 positions, including 2 administrative officers, 3 clerks, and a clerical assistant.

Purpose - Administrative and housekeeping services for the 59 Public Health Service officers on loan to the AID program.

Collated by  
LEWillier

August 26, 1964

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June 15, 1964

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June 12 to Mr. Fordham)

\*On travel basis only, at request of AID/W

### III. Definitions

A few definitions of quasi-professional colloquialisms are given here.

1. Demography - The science of population.
2. Disease - The alteration of cells or tissues that jeopardizes survival in a given environment; this implies that the disease state is a maladjustment to the environment, that is - to climatic conditions, biologic conditions (parasites) (food), social and cultural conditions.
3. Diseases (communicable) - Diseases whose cause can be transmitted from man-to-man or animal to man.
4. Drugs - Any chemical substance used in the protection of health or the treatment of disease.
5. Enteric infections - Infections that cause disease through the intestinal canal.
6. Family planning - The study of techniques that permits spacing birth in accordance with wishes and resources without resulting in any harmful effects to parents.
7. Health - Adjustment to the environment.
8. Health manpower - The human resources that can be mobilized in a given environment to carry out health plans.
9. Health plans - The plans that aim at modifying the environment to facilitate adjustment (malaria eradication, community water supply, etc.) and: The plans that aim at modifying the host to facilitate adjustment (vaccination programs, school lunch programs, curative medicine, etc.).
10. Health services - The services that administer health plans (Ministries of Health and their administrative subdivisions, private enterprise medical care, mission medical care, etc.).
11. Immunization - The creation in living things of a state of protection against an infective agent by challenging their own defense mechanisms!

APPENDIX 3. (Summary of Health and Sanitation Programs  
Proposed for Fiscal Year 1965)

Final Draft, May 11, 1964

HEALTH AND SANITATION

1612.50 Introduction

(a) These guidelines attempt to define in concise terms the general philosophy of health sector programs; the over-all A.I.D. policies and program priorities in the health sector; the methods of planning, implementing and evaluating health programs and projects; and they describe in some detail the two major health sector activities, namely, malaria eradication and community water supply development.

(b) The goals and strategy of A.I.D. have been clearly stated: "To help countries that are striving for freedom, security, and economic and social progress." Our efforts to achieve a free and secure world flow both from the national interest and "from a proud humanitarian tradition."

(c) In view of A.I.D. goals it is not difficult to justify interest in health sector programs or projects. It is clear that health and food are at the very top of human preoccupations, hence programs in this sector can have a unique impact on people the world over (e.g., measles immunization in West Africa, malaria eradication in India). In addition, the achievement of reasonable standards of health is both a prerequisite for and an objective of national development. The high incidence of preventable infectious disease, widespread malnutrition and high rates of population growth constitute serious obstacles to development. The implications of the high rates of population growth in terms of economic and social development are receiving increasing attention throughout the world. The diseases which cause premature death of large numbers of people result in loss of human capital. These diseases which produce recurrent or chronic illness and disability may cause absenteeism, diminished productivity, lowered school attendance and performance, decreased initiative and energy as well as stunted physical growth and mental retardation.

(d) The problem of which comes first, health or economic development, is behind many uncertainties in planning. The fact that health is purchasable, hence funds must be produced to buy it, is complicated by the knowledge that healthy human resources are needed to spur economic and social development.

(e) The basic objective, in terms of the health sector, should be the elimination or effective reduction of those diseases which represent deterrents to social and economic development. There are, broadly speaking, two methods of achieving this objective: 1) To assist the less developed countries meet their most immediate health problems, and 2) to assist in the development of the trained manpower and institutions that will be able to cope with the health problems on a continuing basis.

(f) The A.I.D. intervention in health programs will ordinarily be determined by the degree to which preventable infectious diseases, malnutrition or rapid rates of population growth prevent or seriously inhibit economic and social development; by the stage of human resource development within the country; by the priority assigned to health programs by the host government; by the attitudes and knowledge of the Mission Director, Program Personnel, as well as Health Personnel in the USAID and AID/W; by the need for impact social benefit programs in situations of political insurgency, unrest, or national disasters; by the economic resources that can be invested in the health sector; and by general considerations.

(g) Good health may be valued as a component of a higher standard of living. The creation of the means of good health, such as the building of social overhead capital; the provision of environmental health or sanitation services (see M.O. 1612.52, Environmental Sanitation); progress of personal, but intermittent public health services, such as immunization campaigns; and the provision of personal health services (medical care) on a continuing basis, must be weighed against other elements contributing to an improved standard of living as meriting A.I.D. support.

(h) In considering health programs, as well as those in other sectors, attention must be given to their effects on population growth rates as well as their contributions to the health of the people and to economic growth and social development.

(i) One of the major objectives of A.I.D. health programs is to improve the capability of the multilateral agencies, particularly WHO, PAHO and UNICEF. In order to accomplish this objective, close cooperation and coordination are required in the field and at the headquarters level. This latter requires close working relationships between AID/W (Office of Technical Cooperation and Research, as well as Regional Bureaus), IO/State, U.S. Public Health Service (Office of International Health) and the Childrens Bureau with the multilateral agencies. In the field, close working relationships should be established between USAID health personnel and those of multilateral agencies.

## II. Statutory Authority

(a) The statutory authority for health and sanitation program support is based on the general authority in the Foreign Assistance Act of 1961, as Amended, which authorizes technical cooperation and development grants. In addition to health and sanitation programs which contribute to economic development and the development of human resources specific authority is given for assistances to American schools and hospitals abroad (Section 214) and to Voluntary Agencies (Section 216). Both of these programs make significant contributions to health and sanitation sector goals.

(b) Development Research (Title V, Section 241) funds are utilized to support health related research. In this section it states: "Funds made available to carry out this section may be used to conduct research into the problems of population growth" (Section 241(b)).

(c) Health and sanitation projects are supported under Section 401 (Supporting Assistance) which authorizes the furnishing of assistance to friendly countries, organizations and bodies eligible to receive assistance under Part I (Foreign Assistance Act of 1961, as Amended) on such terms and conditions as the President may determine in order to support or promote economic or political stability. Examples include malaria eradication in Haiti, community water supply and environmental sanitation in Yemen.

(d) The contingency fund (Section 451) has been used to support health projects authorized by Part I in accordance with the provisions applicable to the furnishing of such assistance, when the President has determined such use to be important to the national interest. Examples include disaster relief and Project Hope.

(e) The last four Presidents have strongly emphasized the importance of attacking hunger, disease, poverty and ignorance in less developed countries. President Johnson in his health message for FY 1965 specifically identified the bilateral malaria eradication programs as ones requiring continued U.S. support.

(f) Although not specifically noted in authorizing legislation since 1961, there have been repeated expressions of Congressional intent of support for health programs, particularly the malaria eradication program.

### III. Definitions

A few definitions of quasi-professional colloquialisms are given here.

1. Demography - The science of population.
2. Disease - The alteration of cells or tissues that jeopardizes survival in a given environment; this implies that the disease state is a maladjustment to the environment, that is - to climatic conditions, biologic conditions (parasites) (food), social and cultural conditions.
3. Diseases (communicable) - Diseases whose cause can be transmitted from man-to-man or animal to man.
4. Drugs - Any chemical substance used in the protection of health or the treatment of disease.
5. Enteric infections - Infections that cause disease through the intestinal canal.
6. Family planning - The study of techniques that permits spacing birth in accordance with wishes and resources without resulting in any harmful effects to parents.
7. Health - Adjustment to the environment.
8. Health manpower - The human resources that can be mobilized in a given environment to carry out health plans.
9. Health plans - The plans that aim at modifying the environment to facilitate adjustment (malaria eradication, community water supply, etc.) and: The plans that aim at modifying the host to facilitate adjustment (vaccination programs, school lunch programs, curative medicine, etc.).
10. Health services - The services that administer health plans (Ministries of Health and their administrative subdivisions, private enterprise medical care, mission medical care, etc.).
11. Immunization - The creation in living things of a state of protection against an infective agent by challenging their own defense mechanisms.

12. Malaria eradication - Techniques that allow total interruption of malaria transmission.
13. Malnutrition - A condition of the living thing caused by deficiencies in the diets.
14. Medical care - The sum total of the techniques used to help a patient overcome his disease.
15. Medical ecology - The study of the relationship between environment and the human host when striving to adjust.
16. Nutrition - The science of the utilization of food by the human body.
17. Occupational hygiene - The measures that facilitate adjustment between worker and environment in the context of gainful employment.
18. Patterns of disease - The multiple aspects of human maladjustments in a geographically defined environment.
19. Potable water - Harmless, drinkable water.
20. Preventive medicine - The sciences of the multiple factors that combine to create the disease state and the techniques that protect man and population against their action.
21. Public health - The sum of health plans and measures that can be implemented by governmental agencies at state, provincial, or township levels.
22. Sanitation - The health plans that directly address themselves to the cleansing of the environment (sewage, garbage disposal, anti-pollution projects of all kinds).
23. Vocational rehabilitation - Measures intended to restore an individual or a group to a satisfactory adjustment to the environment of a given profession or skill

IV. Health Factors Involved in the Section of Activities to Achieve Economic, Political and Social Goals

(a) Some system of priorities in health sector technical assistance and in loan funded health projects, is essential since health needs are so vast and the resources available in funds and trained personnel are so limited. In considering possible programs it must be kept in mind that the U.S. will be working in these countries for only a limited period of time; that our basic purpose is to assist other countries in learning how best they can solve their own problems rather than our doing a job for them; that for many reasons we should often favor activities that could affect the welfare of a large number of people within a relatively short period of time (e.g. malaria eradication, community water supply); and, that while a great many health activities are theoretically or actually desirable, certain of them are impractical for technical or scientific reasons and others because of administrative or cultural difficulties.

(b) The nature and scope of health measures to be employed will be determined in the light of the ascertained political, social and economic needs. In some instances social and welfare benefits (e.g. medical care) must be provided to people before economic development programs can be initiated because of political instability, the need to forestall insurgency, or to demonstrate the good faith of the U.S. and the host government. Under these circumstances, the most appropriate activities will usually be (1) those that reach large numbers of people rapidly, or (2) those which reach an important or select group within the population rapidly. Although preventive health measures ordinarily are of primary importance, in special situations, medical care is more immediately effective. Medical care may include the spectrum of diagnostic, therapeutic and rehabilitation services, all politically effective, but not striking at the cause of disease or disability through long-term programs of preventive medicine. (3) In such politically or socially motivated programs, AID may or may not elect to assist in providing a health-services infra-structure which will eventually maintain the health programs unaided.

(c) In other situations, health assistance will be programmed like other technical assistance efforts. Under these circumstances certain data, even if not precise, will provide a basis for action: (1) The existing patterns of disease, particularly malnutrition, enteric infection and other preventable diseases; (2) environmental conditions adversely affecting health; (3) the size of the population, composition, number in work force, school age, etc., as well as rate of population growth; (4) available health manpower, from professionals to lowest levels of auxiliary workers; (5) organization of existing health services, including the emphasis on preventive or curative services; (6) administration of health services; (7) the legal basis for the health services; (8) existing institutions for provision of health services and training of manpower; (9) economic base to support health services and present methods and kinds of financing; (10) likelihood, considering human and economic resources,

of self-sustaining health services; (11) the potential effect of failure of U.S. support for a particular program; (12) overall technical and administrative feasibility; (13) anticipated cost in terms of local currency and foreign exchange; (14) duration of U.S. participation; and (15) likely results of the program or project.

(d) Elements in priority determination of health activities directed toward reducing or eliminating specific diseases relate to whether or not a specific, effective and relatively economical control measure is available (malaria, yaws, smallpox, etc.); whether there are international reasons for concentrating effort in a particular direction (world-wide malaria eradication); what the costs of control may be in relation to the direct and indirect costs of no control; what public knowledge exists concerning a particular health problem and what the public wishes to have done about it; whether necessary personnel, facilities, supplies and transportation may be available, and the degree of international support required; length of time required to produce a significant change in the situation, and how likely the change is to be lasting; whether work begun in a pilot phase can be broadly reproducible throughout a large geographic area; whether control of one health problem may contribute to control of others, or whether new problems may be created; and whether the control program may be evaluated satisfactorily.

(e) Priorities should be based on demonstrated ability of the health programs to do the following: (1) strengthen the economy by improving the physical strength, energy, learning ability, morale or motivation of a significant number of people; (2) improve the environmental conditions and thus eliminate health hazards and improve the potential for the development of agriculture, water and other natural resources; (3) contribute to political objectives by reaching large numbers of people or groups in particular need (e.g. civilian casualties); and (4) demonstrate our humanitarian interests.

(f) When immediate social or welfare objectives are required concurrently with economic development activities, improvements in housing, community water supply facilities (see M.O. 1612.52, Environmental Sanitation, Part I), nutrition, education, medical care, community development, and preventive medical programs have been shown to be feasible programs for AID support. A relationship undoubtedly exists between a reasonable or adequate level of health and economic and social development. Accurate data on the relationship are, however, lacking. Although some data are available on the economic and social benefits of malaria eradication, it is difficult to apply these under different conditions. Also it is a generally accepted fact that community water supply facilities are essential for social and economic development. The availability of adequate quantities of sanitary potable water is a major deterrent to the spread of enteric diseases. It is even more difficult, however, to evaluate the possible long-term economic and social consequences of protein malnutrition in the pre-school child (age 1-5). It is known that this condition contributes to the high morbidity and mortality in these children from preventable infectious disease and it also results in physical and mental

retardation. The ultimate consequences in terms of educational attainments, energy potential, emotional stability and other aspects of adult behavior are impossible to predict accurately with current knowledge.

(g) Careful inter-disciplinary study of an entire development program is necessary to determine how the economic and technical assistance elements can best augment each other, to insure that economic assistance or projects in various sectors do not cancel out achievements in others or create new problems. (See M.O. 1621.1, Multisector Guidance, General)

## V. Planning Health Activities

(a) When the country goals are directed toward economic and social development, the emphasis should be on long-range goals, the consideration of problems related to population growth, the development of permanent institutions, the elimination of malnutrition and preventable diseases, the education and training of health manpower, and cooperation with other assisting governments, multilateral agencies and private organizations. Health program activities to meet these goals may include:

1. The development of a long-range plan for the development of health services if one does not exist.
2. Measures to assure adequate financing for health programs.
3. Emphasis on the organization of health services and the development of appropriate administrative relationships to provide adequate distribution and efficient utilization of personnel and facilities.
4. Assistance in the development of institutions which will educate and train the required professional, subprofessional and auxiliary health manpower. Provision should be made for undergraduate, graduate, and post-graduate training. Consideration should also be given to utilization of audiovisual methods and other modern biomedical communications techniques in these programs.
5. Development of research programs, projects and institutions in demography, problems related specifically to population growth; nutrition; sciences basic to medicine (including behavioral sciences); health manpower development; the economic costs and effects of health services; environmental health (particularly related to water supply and waste disposal); the control of communicable disease; and the relationship of animal diseases to man.
6. Measures to promote the development of a healthful environment such as the installation of water and sewerage systems and malaria eradication programs (see M.O. 1612.51, Control of Specific Diseases, Part I). These are the largest AID-supported health programs and they achieve

one of the highest level of return, in terms of health, per dollar invested. For example, U.S. support for the malaria eradication program has averaged almost \$30 million annually for the past six years while approximately \$330 million has been made available by the U.S. and international lending agencies for the development of community water supplies in recent years. Environmental health or sanitation measures include development of sanitary potable water supplies, safe excreta disposal, sanitary and storm drainage, insect and rodent control, food and milk control, garbage and refuse disposal, industrial hygiene, water and air pollution control and other measures needed to produce an environment with the minimum of preventable health hazards.

7. Immunization programs to protect large populations, or segments of the population, against major disease problems such as smallpox, typhoid, cholera, tetanus, poliomyelitis, diphtheria, and tuberculosis.

8. Programs designed to improve the health levels of specific groups such as school children, the military, miners, industrial workers, civil servants, mothers and infants.

9. In nutrition programs, close cooperation with the agricultural, industrial and other sectors is essential in improving food production, supply, distribution, marketing and consumption in order to improve the nutritional status of the people and prevent food-borne diseases. The programs should take cognizance of information on specific nutritional deficiencies obtained by nutrition surveys and other studies in order that appropriate foods be consumed.

10. Measures to prevent the reinfection of protected populations such as periodic immunization, quarantine and surveillance programs.

11. Programs of health education for the public or selected groups such as teachers, mothers, community leaders, military personnel or school children.

12. Coordination of health sector programs with those of other sectors. Particular attention should be given to making optimal use of the Food for Peace Programs to meet nutritional needs. Environmental sanitation, particularly community water supply, may be essential in community development programs. Occupational hygiene or industrial medicine may fit into an industrial development program while a vocational rehabilitation program may be very suitably developed as part of a small or light industrial development project (see M.O. 1611.1, Introduction to Sectoral Guidelines, Part II, B, 4).

13. Programs whose first objective is the improvement of animal health by the eradication or significant reduction of such diseases as foot and mouth disease, rinderpest, and trypanosomiasis. The improvement in animal health not only may have a direct effect on human nutrition but it may have profound effects on capital formation and economic development.

14. Cooperation with programs of multilateral agencies, particularly the malaria eradication and community water supply programs of WHO, the nutrition programs of FAO, and the maternal and child health programs of UNICEF.

15. Provision of such commodities as DDT, vehicles, books, films, and occasionally drugs or vaccines in association with other health programs.

16. Medical care programs, including the provision of specialized medical teams (i.e., surgical teams), in disaster relief.

(b) There are three broad categories of priority grouping for health programs on a world-wide basis. In applying the priorities, the mission should take into account local economic, political, and cultural factors and the relationship of each project to the current administration and the long-range health program of the country. In addition, the availability of other external assistance from multilateral agencies (e.g., WHO, PAHO, UNICEF, FAO), other developed countries, and private resources must be carefully evaluated.

(c) Within each of the three priority groups which follow, the numerical order is not intended to indicate priority within the group.

1. First priority programs

(a) Malaria eradication programs, particularly those in countries where the U.S. has bilateral agreements or when failure to achieve eradication within a country will jeopardize a regional program.

(b) Community water supply development. This includes major urban water supply systems as well as those in rural areas. U.S. assistance can be in the form of technical assistance, development grants, or loans.

(c) Mass campaign against diseases of major importance; e.g., measles, trachoma, smallpox, tuberculosis, typhus, yaws, leprosy, tetanus, and poliomyelitis. The U.S. Public Health Service is often uniquely qualified to provide the technical backstopping and personnel for such programs.

(d) Health manpower development. This may be at the professional or subprofessional level, and it may include development of indigenous training facilities and programs, as well as fellowships for participant training in the United States or in third country institutions (e.g., American University of Beirut). In certain circumstances, the development of a particular professional group should receive emphasis (e.g., nursing), while in others, it may be the health team (public health officer, community nurse, and sanitarian). The participant training program need not be project-related, but there should continue to be careful selection of the participants for academic ability as well as leadership potential. More emphasis should be given to quality as opposed to quantity and to the selection of young, potential leaders.

The programs of participant training should emphasize fields of high priority need within the country (e.g., biostatistics, nutrition, public health administration, family planning, malaria eradication, sanitary engineering, and basic science). The programs of health manpower development should also include the application of new approaches in biomedical communications, such as audiovisual techniques and programmed instruction when appropriate.

(e) Programs related to population problems in those countries where rates of population growth present problems. Such programs might include vital statistics; health services, including family planning; demography; midwifery training; program evaluation; etc.

(f) Nutrition programs. These should be based on sound knowledge of the nutrition problems and priority requirements, and related to the Food for Peace programs whenever possible. They should be developed in close cooperation with UNICEF and FAO.

(g) The organization and administration of health services. This should include long-range planning and measures to assure adequate financing for health programs. Programs of training health personnel are often wasteful because of maladministration or lack of financing.

## 2.. Second priority programs

(a) Demonstration through health centers of services on a community-wide basis including sanitation, communicable disease control, health records, vital statistics, nutrition, family planning, maternal and child health, home visiting, health education, laboratory, and general clinical services when required to gain acceptance by the people in the community. Health centers should be used for sub-professional training and for field experience for professionals and should be limited in scope and number to the national capacity to construct and operate them.

(b) Advice and assistance in planning, designing, and supervision of construction of health centers, laboratories, hospitals (teaching) and other health facilities - always keeping in mind the human and financial resources available for long term maintenance.

(c) Programs designed to improve the health levels of specific groups such as school children, the military, miners, industrial workers, civil servants, mothers and infants.

(d) Excreta disposal projects other than as a part of a community sanitation program.

(e) Refuse disposal, fly control and food protective projects.

(f) Equipment and supplies for health facilities such as hospitals and health centers.

(g) Programs of health education for the public or selected groups such as teachers or community leaders.

(h) Programs of veterinary public health.

3. Third priority programs

(a) Programs of medical care. There are, of course, exceptions such as the treatment of civilian casualties in counter-insurgency programs, the use of medical care as an integral part of a generalized health service or in a disaster.

(b) Mobile clinics requiring specialized motor equipment except when an integral part of a community development effort.

(c) Construction of hospitals, except in rare instances when these are major American schools or hospitals abroad or when part of an effort to upgrade health manpower development. The capacity of the country to finance operation of the hospital must be assured.

(d) Training of clinical specialists.

(e) Dental health projects.

(f) Mental health projects.

(g) Medical rehabilitation projects.

(h) Establishing, equipping or operation of a blood bank.

(i) Medical social service.

(j) Purchase of supplies and equipment unless directly related to U.S. supported programs.

(c) The purchase of commodities such as DDT, other supplies and equipment is justified only when it is necessary: 1) to the effectiveness of a program receiving U.S. technical (personnel) assistance; 2) to make an important demonstration complete and convincing; 3) to initiate a major control project by measles immunization; 4) to reach many people through use in training or continuing education, or 5) to aid in major disasters. Many of the present health programs have a significant commodity component. In addition, some drugs and other health related commodities are provided under general support programs. These should be carefully reviewed by qualified health personnel. The handling of commodity purchase in disaster relief programs must also receive careful analysis by the appropriate health personnel. Details of these programs are provided elsewhere in the manual orders (M.O.

(d) Usually A.I.D. participates in such efforts by assisting the host country in the execution of indigenous programs, but if the country lacks adequate planning, administrative, technical or financial resources, A.I.D. may supply or supplement these from U.S. sources or with the cooperation of other assisting governments and multilateral agencies.

(e) The decision as to the need for health measures, their nature and scope will rest on appropriate technical evaluation of individual country situations by qualified professionals, on total program needs and priorities and on the availability of U.S. domestic resources to provide the needed assistance. In view of the world-wide shortages of health personnel, particularly physicians, nurses, and midwives in U.S., many high-priority programs cannot be implemented through U.S. technical assistance because of the shortage of qualified U.S. personnel.

## VI. Implementing Health Plans

(a) The most important factors in the implementation of any agreed upon health program within a country are the availability of indigenous resources, the caliber of professional or technical personnel providing advisory services and the availability of financial assistance when required.

(b) It is extremely important that health programs not be separated from other A.I.D. goals and activities. The job of the Chief Public Health Advisor in the A.I.D. Mission should be to make a choice between all possible health activities that will enhance A.I.D. goals and are compatible with human and economic resources and recommend his choice to the Program Officer. This implies, on the part of the Public Health Advisor, a clear concept of A.I.D. goals and a thorough knowledge of the country and the people. This also requires close working relationships with the Program Officer and the Mission Director and his Deputy Director.

(c) The plan for the implementation of any health project or program should clearly define the program objectives and establish criteria for program evaluation. The kind of precise documentation required to permit evaluation of a program within the context of a particular country's human and economic resources does not lend itself to generalizations but it is one of the most valuable exercises that can be conducted by a USAID in order to improve the quality of programs.

It is of the utmost importance to remember that full cooperation of the recipient country is a "must" for the success of any program or project; that reluctant cooperation leads unavoidably to a waste of taxpayers' money. Recipient countries do not set priorities on the basis of our preferences but on the basis of their (often obscure) motivations; inertia in the form of long delays in funding and staffing will unavoidably be opposed to the

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exemption of an important project; this will reduce to naught the impact and effectiveness of the best conceived project. To avoid these most damaging pitfalls, program officers and public health chiefs must have a good knowledge of the wishes, personalities and local standing of their counterparts; it must be remembered that all projects must have some prestige components; a package of projects may have a prestige component in the form of a single project to which we would give low priority but which for some reason, may have a high one in the eyes of an official of the recipient administration; this single prestige project may often "buy" cooperation for the other projects in the group; it must be remembered that host country officials centralize far more power in their hands than their U.S. equivalents do on an individual basis in the U.S.; that they view with inborn suspicion any new U.S. employee recently arrived in their country; that it takes months and years to gain their confidence and that frequent changes of personnel are extremely detrimental to the implementation of projects.

(d) Under most circumstances the most valuable USAID assistance in the health sector can be supplied by competent professionals who are assigned full-time in the USAID Mission, but who have the full institutional support of the appropriate U.S. governmental or private health resources. This may be the U.S. Public Health Service, or a subdivision thereof (e.g. Communicable Disease Center, Bureau of Medical Services, Office of International Health, Interdepartmental Committee on Nutrition for National Defense); the Department of Health within a state; a medical school, a nursing school, a school of public health, a division within a school or a consortium of schools; a professional association (e.g., American Hospital Association, Association of American Medical Colleges, American Waterworks Association); other institutions (hospital, medical center) or private industry (e.g., pharmaceutical manufacturers). A.I.D.'s present interagency agreements, granting and contracting procedures provide the mechanism for making these resources available. The new policies adopted by A.I.D. relative to participating agencies should make more available to USAID's the full institutional resources of the U.S. Public Health Service and other domestic health resources, both public and private. (See M.O. Chapter 250 on participating agencies):

(e) In addition to the full-time professional health staff in a USAID, a valuable contribution can be made by short-term (one week to three months) professional consultants in such specialties as public health administration, medical care, sanitary engineering, water supply management, health education, demography, nutrition, nursing, entomology, hospital administration, medical education, family planning, maternal and child health, midwifery and pharmacy.

(d) Training activities for health participants are provided in the U.S. and in third countries (particularly at the American University of Beirut), through local or regional workshops organized and financed with A.I.D. assistance, support of training centers (e.g., Malaria Eradication

(Training Center) and courses developed specifically to meet the requirements of the community water supply program. In the U.S. the health participants are programmed primarily (80-90%) by the U.S. Public Health Service. It is important to exercise care in selecting individuals for this training, have a program for follow-up after they return and be sure they have a specific or clearly-defined job to return to after completion of training. The pitfalls of sending participants to the U.S. are many and well-known -- thus it is better to send fewer well chosen participants than too many unwisely selected. Criteria for the selection of participants are basically: Is the applicant of the leadership type, and will his education with the U.S. have a multiplier effect when he returns? Are his ties with his own country strong enough to guarantee that he will indeed return? Is he sufficiently mature to understand that he will have to undergo frustrations when he returns? That he will not find in his country any of the amenities, research and other than are taken for granted in the U.S.? (See also Section V - Health Manpower Development.)

(g) Technical backstopping of USAID health personnel by AID/W is carried out with the assistance of the U.S. Public Health Service and other appropriate domestic resources. Materials and technical information may be obtained directly from the U.S. Public Health Service or through the Regional Bureau Technical Services, the Communications Resources Division, and the Office of Technical Cooperation and Research. Included in such technical backstopping are educational materials, reference materials, audiovisual aids, the development of correspondence courses to meet specific needs or other information and materials as requested to furnish the newest supplies and information to the USAID's. The National Library of Medicine provides a unique, worldwide service of reference search and interlibrary loans. A new worldwide, biomedical information center will soon be established at the Library to provide information not only on the published literature but unpublished research finds, negative results, reports of expert and advisory committees as well as health conditions, and resources on a worldwide basis. These services will be available for researchers, educators, students, public health administrators as well as practitioners and workers in all branches of the health field.

(h) Through development loans and grants offered by A.I.D. under certain conditions and loans from international lending agencies, such as the Inter-American Development Bank, the International Development Association of the World Bank, and the Export-Import Bank, funds are available for the financing of health programs or projects. In terms of loans this is particularly true for such worldwide programs as malaria eradication and community water supply development.

(i) The technical, financial, administrative and other details related to specific health programs (malaria eradication, community water supply, nutrition, maternal and child health) can be obtained from appropriate A.I.D., U.S. Public Health Service, and other available sources.

(j) The greater and more effective utilization of U.S. domestic resources in the foreign aid program are described in detail in the manual orders in Chapter 250. These manual orders are particularly pertinent in view of the increasing utilization of the U.S. Public Health Service in health and sanitation programs.

Proposed Annex to SECTOR GUIDANCE - HEALTH (M.O. 1612.50)

SUBJECT: Community Water Supply Development

The scope of environmental health may include concern with housing, community water supply, the disposal of human excreta, the prevention of water and air pollution, the sanitary state of factories and other places of employment, the state of unsound or adulterated food, the hygienic conduct of eating and drinking establishments. While all these areas of concern are important, community water supply is the one of highest priority in developing countries. An abundant supply of safe, potable water, satisfactory from standpoints of quality and availability, is essential to both economic and social development.

Although the guidance for community water supply development is included under the Health Sector, the principles involved and the assistance which may be provided is applicable, not only to community water supply activities, but also to those activities which are part of agriculture, community development, education, housing, industry, or other sectors.

Efforts in the community water supply programs are directed generally toward assisting countries to: 1) Develop or strengthen self-sustaining, business-type institutions capable of planning, financing, constructing, managing, operating, and maintaining community water supply systems. Such institutions should be established at a level consistent with sound governmental planning. 2) Strengthen the sanitary engineering department of the Ministry of Public Health or other appropriate agency to fulfill its responsibility for control of water quality and often for stimulating and coordinating the development of water supplies and waste disposal for semi-rural and rural areas. Technical assistance may include such activities as reconnaissance and feasibility studies, training, specialized advisory services, and distribution of technical materials.

The Regional Bureaus and Country Missions may request assistance from the Community Water Supply Branch (CWSE), AID/W, in securing technical services and backstopping for activities in the field of environmental health. Full advantages should be taken of these facilities both in securing qualified personnel for direct-hire positions through PASA arrangements, and in obtaining specialized services of experts which can be arranged either through personal services contracts negotiated by the Mission or by WAE appointments.

Development of technical and administrative personnel for staffs of central water authorities, as well as for positions at the regional and local levels, is essential to the success of the program in any given country. Training of selected personnel abroad can be useful; and the specialized services of short-term consultants are particularly effective in conducting local training courses and seminars.

Training of participants in the United States may be accomplished either by enrollment in established courses, such as post-graduate courses in sanitary engineering at certain universities, or in special courses, such as those sponsored by the CWSB) in Ground Water Development at the University of Minnesota, Water Supply Management at the University of Akron, and Sanitary Engineering Design at the University of North Carolina. These courses are being "exported" and assistance will be given in developing the courses on a regional basis in the language of the area through strategically located universities. Also correspondence courses covering various aspects of water works practice have been made available through a contract negotiated with the Pennsylvania State University.  
(See M.O.

The preparation, distribution, and interchange of technical material is extremely important to the development of technical staffs for community water supply programs. Likewise, regional technical congresses, meetings of professional society groups, symposia and seminars contribute to the exchange of technical information and ideas. Assistance will be given in setting up such meetings when desired. Staff attendance should be encouraged. Working with the Communications Resources Division, CWSB is prepared to assist Missions in securing technical publications, and in order to overcome language problems, arrangements have been made for the translation of selected technical publications into the languages of other areas.

In the past few years, there has been a marked increase in the availability of funds for water supply installations. Sources include development loans and grants arranged by AID and loans from international banking institutions such as the Inter-American Development Bank specifically for the countries of Latin America, the International Development Association of the World Bank and the Export-Import Bank. As CWSB maintains liaison with key personnel in the various international lending agencies, it is in a position to assist Missions in providing advice to officials of other governments relative to feasibility studies and the preparation of loan applications.

Provision of pipe water service and waste water disposal to residents of communities requires structural installations which may be classified either as "capital activities" or "technical assistance activities" depending on the expenditures involved and the methods employed in the development and execution of the projects. (See definitions on M.O.s 1024.2 ). Projects involving simple design and relatively low cost generally can be more satisfactorily accomplished using local forces and technical assistance methods, which permits the development of personnel and institutions. More elaborate projects requiring advanced design measures and greater costs require a more formal professional approach with respect to engineering studies, surveys, design and supervision and more extensive systems of control for cost estimating, selection

of bidders, procurement, and disbursements. Projects such as these fall in the category of "capital activities" and are subject to compliance with established criteria if they are to qualify for AID financing through development grants or loans. However, this does not preclude the need for technical assistance activities.

To be effective, appropriate technical assistance should be available through all stages of a capital project. The usual stages in the development of any water supply project may be listed as follows:

Recognition of Needs	Commodities
Reconnaissance	Construction
Feasibility Studies	Operation and Management
Planning and Design	Research

**Evaluation of Needs:** Generally, needs for water supply facilities are recognized spontaneously, particularly at the community level. Program planning at the Mission level should include the recognition of water supply needs as an integral part of the overall country program with evaluation based on available data. Sanitary engineering advisors on the Mission staff should assist officials of the host governments in developing criteria for evaluating needs.

**Reconnaissance:** Full-time sanitary engineers on the Mission staff can assist engineers of the host government in preliminary surveys of existing conditions and studies of how needs can best be met. Results of such studies will make possible the development of a general plan of what the project should entail.

**Feasibility studies** involve a more critical investigation of all technical and economic aspects of the project essential to a definitive selection of the basic elements of the project. Such studies require trained professional personnel which may be provided by a competent consulting firm, by contract consultant or consultants assisted by local engineers, or by local engineers with technical assistance supplied by engineering advisors on the USAID staff.

**Planning, Design, Commodities, and Construction:** For large installations (capital activities), this work might best be entrusted to a competent consulting engineering firm with the understanding that the services of local engineering and other technical personnel be utilized to the greatest extent possible. In the case of small projects (technical assistance activities), these functions may be carried out by local engineers with the assistance of qualified sanitary engineering advisors.

**Operation and Management:** The quality of water service to the consuming public will depend on efficient functioning and sound management of the completed work, which in turn will depend to a large degree on the

effective execution of earlier stages of project development. Technical assistance properly applied can do a great deal toward making possible coordination of all activities during project development and adequate preparation of the personnel to whom operations and management responsibilities will be assigned. Of primary importance also is the development of an awareness in the consuming public that the water system represents a fundamental facility which requires the support of the entire community.

**Research:** Arrangements need to be made for adapting existing technological knowledge to local conditions. Responsibility for investigations should be assigned either to an experimental institute or selected professional personnel utilizing the facilities of academic institutions. Investigations and development procedures, practices, and standards should be carried out simultaneously with the development of the water program. Establishment of the facilities for practical research and the detailed investigations involved should be the responsibility of national engineers with technical guidance supplied by USAID staff or short-term experts where the research is of sufficient depth.

Maximum utilization of competent advisory services to supplement technical assistance permits water supply projects to provide on-the-job training to the greatest extent possible and thus hasten the preparation of a trained corps of personnel. This type of technical assistance also provides continuity of operations through the various stages of project development and the coordination needed to relate individual projects to the overall water supply development program and water supply projects to those in other sectors having a common goal. Projects carried out wholly or in part as technical assistance activities permit maximum utilization of self-help measures.

There will be close cooperation and coordination of the activities of the Office of Engineering and the CWSB/HealthService/Office of Technical Cooperation and Research in AID/W. Similarly, there should be close coordination in the USAIDs of the engineering advisors whether on a technical assistance project, in the Health, Community Development, or Agriculture and Natural Resource Development Sectors; on a capital public works project; a university contract; or a private engineering firm.

Proposed Annex to SECTOR GUIDANCE - HEALTH (M.O. 1612.50)

Malaria Eradication

1. Objective:

The United States, being a member of the World Health Assembly, has endorsed the continuing priority given by the 124-member Assembly to the eradication of malaria in member countries.

It is the intent of the United States to assist in this effort by contributing to the budget of WHO, PAHO, and by assisting selected national programs which meet AID criteria for participation.

2. Pertinent background:

a. The original population at risk to malaria is 1.5 billion, approximately half the world's population.

b. The 85 national programs which are now in process indicate the comprehensive international demand for the eradication of this disease.

c. The United States, through AID, has assisted 28 countries, but currently assists only 17.

d. The program is the largest international health effort ever undertaken by mankind. With presently available methods, it represents a highly complex campaign requiring a wide range of professional competence and administrative experience.

3. Technical objective

To eradicate the reservoir of malaria parasites within the human population.

4. Basic factors of disease transmission:

Three principal factors are involved: Man, parasite, and mosquito.

a. Man:

The reservoir of the parasite is in man. Illness is primarily the result of infection of the red blood cells, which leads to cell destruction, anemia, and fever. Frequently complications follow; e.g., blackwater fever and death due to clogging of brain blood vessels with infected red cells.

b. The Parasite (Plasmodium):

The four known species of human infections, if untreated, survive in the human body for periods ranging from one to thirty years. However, they are rarely infective to mosquitoes after three years. In nature, infected mosquitoes survive only a few months at the longest. Infection in the

mosquito population does not persist without an associated infected human population upon which to feed.

Malaria in the untreated individual has the characteristic of remaining at low levels for long periods of time without producing symptoms. The asymptomatic disease carrier represents a problem in any malaria program with regard to case-finding activities.

c. The Mosquito:

Malaria is transmitted from infected man to uninfected man by the bite of an anopheline mosquito. The biting, resting, and breeding habits of such mosquitoes vary widely and must be studied in order to understand the correct anti-malaria methodology.

5. Anti-malaria methodology:

The method or methods to be used will vary depending on a study of all local factors. It cannot be assumed that any particular methods will apply without trial evidence.

Experience in 85 countries has shown that the two most effective technical methods are use of residual insecticides and drug administration.

Residual insecticide (an insecticide remaining active on wall surfaces): The purpose is to spray the interiors of all dwellings within a known malarious area in order to prevent mosquitoes from transmitting infection from human parasite carriers to uninfected humans. The insecticide remains effective for a varying number of months. It is not the purpose of spraying to reduce the total number of mosquitoes per se, but only to prevent them from transmitting the disease.

Drugs: Complete cure is possible by the administration of three drugs, singly or in combination; 4- aminoquinelines, 8- aminoquinolines, and (in resistant malaria) quinine. All drugs ordinarily last for short durations and are therefore difficult to effectively administer on a mass scale. Drugs are a valuable and necessary supplement to national campaigns. They are not advocated as a sole measure except in special circumstances where small populations are involved.

Other supplementary measures: A variety of direct anti-mosquito measures are available, such as larviciding, fogging, water management or drainage of breeding areas, screening, repellents, etc.

6. Technical strategy:

In countries where the vector mosquito is susceptible to attack by insecticides, it is the objective of the campaign to spray all houses within the known malarious area with repetition of spraying, depending on the interval of insecticide effectiveness, for a period of three to four years. This is called the period of "attack." Providing the coverage has been complete, undetected infections will die out within this period. In practice, due to the migratory habits of man, it is necessary to carefully observe the population

for a period of several years after spraying has been withdrawn. During this period, referred to as "consolidation," active comprehensive case detection is carried out in order to find and treat all residual cases.

Prior to full scale spraying, a year or more of detailed survey will be necessary to define the disease area, to map all localities, and to study the habits of the vector mosquito.

The strategy requires a high degree of efficiency in technical performance and administrative management due to the necessity for total geographical coverage within a relatively brief period of time. Once the campaign is begun, it cannot be terminated prior to completion without the risk of disease recurrence. The availability of man, money, and materials in the right place, and at the right time is an uncompromising requirement.

In general, recognizing that problems will vary widely from country to country, the duration of the total program should not exceed ten years, providing it is executed with the uncompromising efficiency noted above.

#### 7. Global strategy:

In addition to the factors noted in Para. 6, it is essential that adjacent countries coordinate their efforts where movement of population is a significant problem.

Malaria, as a disease, is not ordinarily confined by political boundaries. It is in the interest of all member nations of the World Health Organization, including the United States, that malaria be viewed as a regional problem rather than the internal concern of single countries.

It is essential to the current world-wide effort that concurrent efforts proceed among adjacent countries irrespective of temporary political differences. It is in the interest of the United States that alternate sources of support be assured in any given U.S.-assisted country in order that the prior U.S. investment in the program may not be wasted.

In this regard, malaria eradication is atypical of most public health programs. Temporary delays subject the malaria program to serious jeopardy because of the dynamic nature of the disease. It is not possible to consolidate a reduction in the disease to a "low level." As long as the vector mosquito remains in unreduced numbers, they can fan a small reservoir of infection into a major epidemic.

#### 8. Control versus eradication

##### a. Control

Control is defined as the reduction of a disease to a level where it no longer constitutes a significant public health hazard. Control methods generally focus on anti-mosquito measures with the purpose of reducing the mosquito population. The economic and technical feasibility of this approach (water control, larviciding, etc.) is not applicable over large areas of the earth (e.g., Southeast Asia, Southwest Pacific) due to the extensive breeding

habits of mosquitoes in areas not amenable to water control. Mosquito source reduction methods are completely practical in other areas and should be explored as supplementary measures.

Control methodology has been attempted over a period of 60 years since the discovery of the cause of malaria. The inability to eradicate the disease by control methodology has necessitated recurrent annual expenditures within the national health budget.

b. Eradication

Neither the World Health Organization nor its supporting members, including the United States, have endorsed or advocated malaria control campaigns. It is recognized that the total annual expenditures for eradication are more expensive than pre-war annual control expenditures. The per capita cost of eradication per year is less than control, the low budgets of the latter reflecting their restricted geographical activities.

The Agency for International Development does not authorize the support of anti-malaria activities which are not directed toward the ultimate eradication of malaria.

9. Minimum conditions required by AID for initiation or continuation of:

a. Assistance to Malaria Eradication Programs

Refer to AIDTO Circular XA-643, 6/6/62.

b. The complexity of a national eradication program requires that a comprehensive Plan of Operations be prepared by the Government. It is strongly recommended that this plan be prepared in joint consultation with the WHO and AID in order to achieve uniformity.

It is further recommended that the Plan of Operations be appended to bilateral agreements between AID and the Government, and between WHO/PAHO and the Government. If WHO/PAHO is providing advisory assistance to a country, AID should not sign a bilateral agreement without prior WHO/PAHO signed approval of the Comprehensive Plan of Operations. By this coordination, AID will avoid participation in programs which function under conditions of continual disagreement due to the existence of two varying Plans of Operations.

The Comprehensive Plan of Operations should be developed along the lines of AIDTO Circular XA-643, 6/6/62, USAID Missions will find WHO/Mem/3, July 1961, "Manual on Preparation of Malaria Eradication Programmes" a most valuable guide, as it is essentially a more detailed expansion of the ref. AIDTO Circular XA-643.

c. USAIDs should determine the priority which local governments give to the support of their own programs. Where national governments fail to provide a substantial proportion of their total health budgets to indicate a high priority for malaria, USAIDs should question where government health priorities lie.

10. U.S. Technical advisory assistance:

The malaria eradication project is one of the most complex public health activities in the entire field of international health operations. Requisite technical and advisory skills include: Clinical malariology, epidemiology, entomology, parasitology, sanitary engineering, statistics, health education, campaign management and administration, supply and transport management.

U.S. advisory assistance must be coordinated with available local and other international (WHO) professional direction. The necessity will vary widely.

However, AID/W in no instance recommends U.S. participation in a malaria program without the presence of at least one qualified malaria representative. Without a minimum of one U.S. staff member, it will not be possible for the local USAID Mission to follow or evaluate project progress on the continuing basis which this program requires.