9310067-(2)
PO-AAL-523-B1

AID 1025-1 (7-71) (FACE SHEET)

NONCAPITAL PROJECT PAPER (PROP)

I. PROJECT IDENTIFICATION

1. PROJECT TITLE: OIH/RSSA

APPENDIX ATTACHED: [X] YES [ ] NO

2. PROJECT NO. (M.O. 1095.2)

3. RECIPIENT (or city)
[ ] COUNTRY
[ ] REGIONAL [ ] INTERREGIONAL TAB

4. LIFE OF PROJECT
BEGINS FY 76
ENDS FY 79

5. SUBMISSION
[X] ORIGINAL 52p DATE
[ ] REV. NO. DATE
CONTR./PASA NO.

II. FUNDING ($000) AND MAN MONTHS (MM) REQUIREMENTS

A. FUNDING BY FISCAL YEAR	B. TOTAL $	C. PERSONNEL (1) $	C. PERSONNEL (2) MM	D. PARTICIPANTS (1) $	D. PARTICIPANTS (2) MM	E. COMMODITIES $	F. OTHER COSTS $	G. PASA/CONTR. (1) $	G. PASA/CONTR. (2) MM	H. LOCAL EXCHANGE CURRENCY RATE: $ LS (U.S. OWNED) (1) U.S. GRANT LOAN	(2) COOP COUNTRY (A) JOINT	(2) COOP COUNTRY (B) BUDGET
1. PRIOR THRU ACTUAL FY												
2. OPRN FY 76	913	524	314									
3. BUDGET TQ	180	116	78									
4. BUDGET +1 FY 77	880	470	290									
5. BUDGET +2 FY 78	935	489	290									
6. BUDGET +3 FY												
7. ALL SUBQ. FY												
8. GRAND TOTAL	2908	1599	972									

9. OTHER DONOR CONTRIBUTIONS

(A) NAME OF DONOR	(B) KIND OF GOODS SERVICES	(C) AMOUNT

III. ORIGINATING OFFICE CLEARANCE

	TITLE	DATE
1. DRAFTER Ray D. Newman	Chief, Div. Prog. Admin. & Mgmnt	3/4/76
2. CLEARANCE OFFICER Lee M. Howard, M.D.	Director, Office of Health	3/8/76

IV. PROJECT AUTHORIZATION

1. CONDITIONS OF APPROVAL

2. CLEARANCES

BUR/OFF.	SIGNATURE	DATE	BUR/OFF.	SIGNATURE	DATE
TA/PPU	Lohva Wakefield		AFR NENA		
TA/PPU	John Gunning		AA/TA		
LA ASIA					

3. APPROVAL AAs OR OFFICE DIRECTORS

SIGNATURE	DATE

TITLE

4. APPROVAL A.I.D. (See M.O. 1025.1 VI C)

SIGNATURE	DATE

ADMINISTRATOR, AGENCY FOR INTERNATIONAL DEVELOPMENT

Recommendation:

That funding for the OIH/RSSA be approved up to the following amounts for the periods indicated:

	FY 1976	T.Q.	FY 1977	FY 1978
Personnel Services	$524,000	$116,000	$470,000	$489,000
Subcontract personnel	150,000		160,000	174,000
Other costs	239,000	64,000	250,000	272,000
	$913,000	$180,000	$880,000	$935,000

This Project Paper provides continuing funding for a resources agreement with the Office of International Health, Department of Health, Education, and Welfare (OIH). A discussion of the need for services, the purpose served by the personnel resources provided and other information that describes the arrangement between AID and OIH follows as required by TAB program guidance 76-1.

1. Contribution of the proposed extension of the OIH/RSSA in context of the Key Problem Areas identified for Agency health activity.

The Office of International Health, of the Department of Health, Education and Welfare (OIH/DHEW) has provided health consultants to AID for more than two decades. OIH/DHEW has access to personnel with expertise in most basic health disciplines except sanitary engineering. (Appendix A). The current and proposed arrangement concerning funds is for consultant personnel and travel to support project development and project evaluation, particularly health sector assessments and health planning; and for bi-lateral and multi-lateral donor coordination and representation. Since a major need of the Agency for the next three-year period is to support Agency efforts in health sector assessment and planning, this resources agreement is included for funding the TAB Key Problem Area for health planning (KPA 12). The major portion of the funding is for this purpose.

The arrangement with OIH has increased the flexibility of direct hire AID personnel resource utilization as changes in priorities and initiatives in health have occurred over the years. For instance, current Agency efforts in health sector planning were started with assistance of OIH staff.

A. Assistance in health planning and health sector assessment

1) Health sector assessment is relatively new in LDCs and criteria are in various stages of refinement and development. A set of guidelines has been developed by the OIH staff and a copy of these guidelines is attached (Appendix B). It is not anticipated, however,

that written guidelines can replace the necessity for competent consultant staff who have experience and continuing involvement in AID health sector assessment and health planning. This competency is required to: a) develop plans with host government, mission and regional bureau personnel for health sector assessments; b) identify and train nationals to be involved in assessments; c) assist in the sector assessment and/or periodically monitor progress on assessments; d) monitor the quality of assessment activity; e) assist in the identification of expert consultants for analysis activities; f) assist in preparation of DAPs and design of field projects; g) assist in the review of project documents; h) assist in development of project evaluation formats and provide technical assistance in project evaluations. Under the terms of the RSSA it is not intended that OIH will be able to meet all the Agency needs for the above activities. They will be, however, the major source of expertise for the Agency in this regard.

Specifically, planning efforts will have as an aim the development of interventions that will result in the provision of health services to a majority of the population of the LDC. For instance, a possible outcome of a health sector assessment may be a pilot project designed to reach a majority of the population. This was a result of the sector assessment in Bolivia. Additionally, sector assessments may result in the discovery of innovative techniques already developed in an LDC that should be used more extensively in that LDC or that will have applicability to LDCs with similar problems.

2) Preparation of briefing documents and other published data on less developed countries for use by the Agency:

OIH will prepare, publish and distribute health profiles as required and requested by AID. These health profiles or Syncrisis (title given to the published documents) studies are the compilation of data and other information available from current literature on the health status of a specific country prepared by trained staff experts. These studies are normally prepared to assist in DAP preparation, the development of health sector assesments and in planning for health projects development. In addition to the preparation of health profiles, OIH also prepares less formal and detailed briefing documents on specific areas and countries as requested by the Agency.

B. Assistance in Key Problem Areas of Integrated Health Delivery Systems (KPA 11) and Environmental Health (KPA 13).

Upon request OIH will work with other TA/H professional staff concerned with integrated health delivery systems and environmental health to assist missions and regional bureaus in the development of new projects and the development of cost effectiveness information on various kinds of health interventions. With the assistance of the OIH staff, AID may undertake studies designed to develop information on the relative advantage or disadvantage of interventions for control of specific diseases such as malaria. The result of these studies may have applicability to

current and future programming. OIH personnel will also assist in the development of research activities.

C. Assistance and collaboration in other health activities: The OIH assists in collaborative efforts with other bilateral donors and international agencies such as WHO that have common program priorities with AID. The AID health staff in TAB, PHA, and regional bureaus is not adequate in size to permit liaison directly in all cases nor to provide representation at all meetings where international health issues are discussed. Historically, OIH has played a collaborative role with AID in this area and funding has been provided for this purpose. RSSA Service also includes a part-time Public Health Analyst who provides the Agency with current program information. Reports to AID on RSSA and PASA activities of the Public Health Service agencies are prepared regularly by this analyst. Background information on all U.S. assisted programs in international health, including historical summaries and current data, staffing, budget, and political or economic data related to such activities is maintained for professional use and general reference.

The manpower proposed for the next three years make provision for minimum requirements for support of Agency activities in health sector assessment and national health planning as well as the necessary collaborative efforts required for a worldwide assistance program in health.

While the RSSA funds specific positions at OIH, the arrangement allows for a broader array of DHEW professional talent than could be provided by listed personnel. For instance, the Director, his Deputy, or other staff members in OIH may provide consultation and representations without direct AID compensation. In addition, the Agency has often been able to obtain HEW talent outside OIH without a separate funding.

2. Services to date:

Attached is a table that reflects services provided during FY 1973, 1974 and 1975 with some projection of future outputs. These lists are illustrative of the services AID has received through the resources agreement.

	FY 1973	Actual 1973 - 1975 FY 1974	FY 1975	FY 1976
KPA 11 Health Delivery Services				
1. Health Project Development Total			1.MEDEX Cont. - Admin. & Management	
	CENTO countries East Asia			
2. Consultations to AID Reg.Bureaus and USAIDs	Services of PH Physician Nurse Advisor Sanitary Engineer 3 Health Educators			
3. Project Review, Monitoring & Evaluation			Cali College (1)	
KPA 12 Health Planning				
1. Country Health Profiles Total	(5) Honduras El Salvador Haiti Philippines Panama	(6) Liberia Ethiopia Dom. Republic Ghana Thailand Nicaragua	(5) Botswana Lesotho Swaziland Zaire Tunisia	(13) Egypt Haiti (Rev.) Korea Jamaica Senegal Morocco Bangladesh Guatemala Mozambique Guinia Bisson West Bank (Gaza) Syria Abu Dhabi
2. Briefing Documents Total		(1) Nigeria	(5) Afghanistan Algeria Portugal Saudi Arabia Pakistan	

	FY 1973	FY 1974	FY 1975	FY 1976
Health Sector Assessments Total	(1) Colombia	(1) Colombia Honduras (Incomplete)	(5) Bolivia Dom. Republic Haiti Colombia Chile (Nutrition) Pakistan (Incomplete)	(6) Panama Nicaragua Guatemala Chad Tunisia Colombia
DAP Preparation (Health Section)Total		(1) Dom. Republic	(6) Botswana Lesotho Swaziland Tunisia Liberia Zaire	(2) El Salvador Paraguay
Health Project Development Total (Loan & Grant)		(2) Research-Cost Loans Effect. of Alterna- Health Systems Research on Nutrition in Central America & Panama	(7) Dom. Republic Bolivia Haiti Indonesia Pakistan PL 480 funded health Planning in Egypt Research-support to LDC health economics	(9) Panama Nicaragua Guatemala Egypt Syria Haiti 3 - Health Planning Res.
Guidelines and Health Strategy Papers Total	(1) a)Syncrisis Guidelines b)EPA Action Plan for TA/H	(2) a)Health Sector Assessment Guidelines b)World Bank Health Strategy	(3) a)Assist to TA/H for Health Strategy b)Revision of Health Sector Assess.Guide- lines c)Malaria Planning Model	(?) How-to-Sector Analysis Mode

3. Evaluation of Services

The TAB Office of Health has been charged with the funding and management of OIH/RSSA for the two preceding fiscal years. In September 1974, RSSA services were reviewed with the Deputy Directors of the two respective offices in attendance. On April 30, 1975, a formal review of the performance was made with representatives from the Regional Bureaus, TA/PPU, PPC/DPRE, OIH and TA/H. A copy of the resultive PAR is appended (Appendix C).

The technical competence of the OIH staff was not questioned, nor their performance. Staff size and responsive capability were discussed. The only two major issues that surfaced were: publication of the Health Profiles (Syncrisis studies) and the provision of funds for additional short-term consultants.

Syncrisis studies are utilized by a wide audience involved in the development and planning of project activities in LDCs and others utilizing the information as a basis for study of international health issues and problems. The Agency has continued the publication of these documents for this year and plans to assess the need for continuation again in the April 1976 review of the project. Provision has not been made for additional unspecified short-term consultants, although this was an expressed need by some regional bureau representatives. There are multiple sources of special consultants for a variety of purposes through other AID contract arrangements, e.g., IQCs. It is clearly recognized that U.S. universities and other private institutions constitute a major professional resource outside the federal government. The intent of the DHEW resource is to provide

timely, professional consultation for fairly specific purposes that can be reasonably identified and monitored. Technical personnel under the RSSA primarily provide support in areas where AID is lacking in professional talent rather than to perform tasks that would be competitive with the private sector or other already approved agreements. Through this arrangement, the Agency is provided with considerable supplementary professional talent, although there is no intention that total Agency needs for any purpose can be met by use of this single resource.

4. Expected Trends

Listed below are program funding figures for FY 1975, 1976, TQ and 1977.

AID submission to OMB October 1975 (in millions)

	FY 1975	FY 1976	TQ	FY 1976
Health-less-POP	71.8	69.1	20	124.8

A major part of health activity over this three-year period is directed to new initiatives mandated by Congress. These new initiatives require unprecedented support to the health sector. Planning for health must be comprehensive, with efforts to integrate basic elements of health, including family planning and nutrition. This broadened scope requires a continuing personnel resource able to support Agency initiative. The desire of LDCs to reach a majority of their populations with health services also necessitates the choice of interventions based on data applicable to specific local or country situations. The gathering and interpretation of applicable data and the use of such data in decision-making is a relatively new experience for many LDCs. The provision of assistance to LDCs for the development of health activities in the near future will require considerable

technical expertise in agreed priorities such as health delivery systems, planning, and environmental health. In each area, there is the need to develop data for the assessment of problems and definition of potential interventions. This process must be tied to the development of potential projects to follow after assessment. In addition, evaluation also requires considerable expertise in assessment and planning. These efforts require sophistication of data development and use of such data for project activities that have the potential of reaching the poor majority. Collectively, these requirements are beyond the scope of the proposed OIH resource or any other single resource. The primary purpose for OIH will be to provide timely assistance directly to the AID health programming process, and further, to play a role in the assessment of the quality of the performance of health planning activities of the Agency.

Based on current use being made of OIH staff, the FY 1975 level of support is being used as the approximate estimate of staff needs for the three years following.

5. Alternate Sources

The DHEW and OIH have been the major federal resource for health manpower consultation to AID for more than twenty years. The use of this resource has allowed the Agency to mount programs, assess priorities and develop new initiatives with a relatively small in-house career staff. While the most effective use of personnel for a defined AID activity over an extended period is through direct-hire, AID personnel, in terms of both cost and ability to act, the second best alternative for immediately available staff consultation is the use of internationally-oriented professional staff in DHEW.

While use of a personnel resource such as OIH has some of the characteristics of contract, the costs are below that for non-federal contract personnel. DHEW, because of its extended relationship with AID and its predecessor agencies, has a significant number of professional staff with international health experience from prior assignment with AID and from DHEW in-house international activities (e.g. quarantine, research, UN-relations.)

The assumption made on cost is based on the following reasoning: If one starts with the presumption that base salaries are comparable between private industry and the government, a contractor would require reimbursement for other costs which, again, can be presumed equivalent. The additional cost factor required for a non-federal contractor would be charged as overhead or a profit margin. Overhead is most frequently based on a percent of salaries and fringe benefits. In the Agency's experience, non-federal overhead has varied between 20% and 100% and usually represents an additional cost above that which would accrue from the use of direct-hire or other government agency staff support. In the case of the DHEW/RSSA, payment is made for administrative staff and other costs, but there is no charge equivalent to overhead.

As noted in Section 4 above, this resource is not designed to provide all the assistance the Agency requires. Personnel provided through these resources will only meet minimum AID requirements for some of the sector assessments, to monitor progress on other assessment activity and to assist in research.

6. Management of Resources

In the past, OIH has submitted quarterly or semi-annual reports to AID

on activities undertaken on behalf of AID or activities that are of particular interest to AID. During initial reviews of the first draft of this document, there was an expressed need for detail regarding the day to day work of personnel funded through the RSSA. To provide the detail that will be required for future decision-making on funding and personnel levels and to meet the needs expressed above, the past pattern of narrative report will be discontinued and a monthly or quarterly report will be submitted to TA/H reflecting job assignments and work accomplished in these job assignments.

The following procedures will be used to assign or determine assignment of OIH/RSSA funded personnel to AID activities such as project design, development, and evaluation; attendance at meetings and conferences; development of special studies; preparation of health profiles and briefing documents and for other purposes authorized under the RSSA agreement:

a. Work plans for personnel will be developed by OIH and approved by TA/H covering an initial period of two months and maintained at least one month in advance. The work plan will include a concise definition of the work to be performed, e.g., Syncrisis-Korea, Sector Assessment-Colombia, etc.

b. Alterations of these work plans may be proposed by TA/H or OIH and will be considered approved when accepted by both parties.

c. Service to be provided by OIH to Missions and Bureaus should be requested in writing through TA/H.

d. Staff meetings of TA/H and OIH will be held on the first Thursday after the first Monday of each month to approve work plans and discuss problems that have arisen in the utilization of personnel,

development and implementation of work plans.

e. Reports on personnel utilization will be forwarded to TA/H for the joint staff meeting. The monthly report will be designed to show time worked during the current month on each activity using the same description as agreed for the work plan and will also reflect cumulative time worked on each activity.

Trials on the above procedure will be initiated in March and April at which time the final procedure to be followed will be approved by OIH and TA/H.

7. Budget by projected inputs

The budget for the next three years is estimated at approximate current levels. Detail as to types of personnel is included. The illustrative outputs expected in FY 1976 are included in part two of this paper.

BUDGET FOR PERSONNEL

	FY 1976	TQ	FY 1977	FY 1978
Personnel				
Health Sector Assessment and Planning:				
Director	$ 37,692	$ 15,077	$ 39,577	$ 41,555
Public Health Advisor	31,892	7,966	33,455	35,128
Public Health Analyst	18,975	4,744	19,924	20,920
Public Health Advisor	29,077	7,269	30,531	32,057
Public Health Analyst	23,998	6,000	25,198	26,457
Public Health Advisor	28,139	7,035	28,139	31,023
Research Assistant	17,421	4,355	18,292	19,207
Research Assistant	14,125	3,531	14,831	15,573
Student Intern	10,420	2,605	10,941	11,498
Student Intern	10,420	2,605	10,941	11,498
Clerk Typist	9,350	2,338	9,818	10,308
Secretary	10,420	2,605	10,941	11,498
Clerk-Typist	7,440	1,860	7,812	8,203
Clerk-Typist	7,440	1,860	7,812	8,203
Temporary (Clerk Typists)	4,482	1,121	4,706	4,941
TOTAL Sector Analysis and Planning	$261,291	$ 70,971	$272,918	$288,069
Professional Services				
Physician	$ 45,107	$ -0-	$ -0-	$ -0-
Program Analyst	14,083	4,200	18,000	18,900
Secretary	15,047	3,762	15,799	16,589
Secretary	12,370	3,093	12,989	13,638
Public Health Advisor	30,414	7,604	31,935	33,532
Secretary	11,463	2,866	12,036	12,638
Public Health Advisor	34,987	8,747	36,736	38,573
Physician (MEDEX)	38,000	-0-	-0-	-0-
	$201,471	$ 30,272	$127,495	$133,870
Administration:				
Deputy Administrative Officer	$ 14,596	$ 3,649	$ 15,326	$ 16,092
Accounts Maintenance Clerk	8,356	2,089	8,774	9,212
Office Services Supervisors	12,730	3,183	13,365	14,035
Clerk	9,438	2,360	9,910	10,405
Clerk Typist	9,350	2,338	9,818	10,308
Messenger	6,596	1,649	6,925	7,272
TOTAL Administration	$ 61,066	$ 15,268	$ 64,118	$ 67,324

SUMMARY BUDGET

	FY 1976	TQ	FY 1977	FY 1978
Summary Budget				
Health Sector Assessment and Planning				
HEW Employees	$261,291	$ 70,971	$272,918	$288,069
Contract Services	150,000	-0-	160,000	174,000
TOTAL Cost Health Sector Assessment and Planning	$411,291	$ 70,971	$432,918	$462,069
Professional Services	$201,471	$ 30,272	$127,495	$133,870
Administration	61,066	15,268	64,118	67,324
	$673,828	$116,511	$624,531	$663,263
Services	$ 50,000	$ 12,500	$ 55,000	$ 61,000
Travel	98,000	24,500	103,000	108,000
Rent, Communication and Utilities	20,000	5,000	21,000	22,000
Printing and Reproduction	61,000	15,000	64,000	67,000
Furniture and Equipment	5,000	-0-	5,000	5,000
Supplies and Material	3,000	1,000	3,000	3,500
Miscellaneous Costs	2,000	500	3,000	3,500
	$912,828	$175,011	$878,531	$933,263

APPENDIX A

Personnel available from OIH include the following disciplines:

1. Public Health Physicians
2. Physician - Economist
3. Economists
4. Health Planner - Economist
5. Health Educators
6. Public Health Advisors - MPH level
7. Program Analyst
8. Research Assistants

In addition to the above types of personnel available on OIH staff, personnel are available in a substantial range of physician specialities, health management personnel, nurses, sanitarians, epidemiologists and statisticians. An actual list of potential personnel is available but too long for inclusion in this paper.

Guidelines for Health Sector Assessment

I. Introduction

This document attempts to present a general overview of goals, content, priorities for and administrative procedures useful for health sector analysis or assessments. It is not a standard format or model to which all health sector assessments should conform. Many methods and techniques exist to address the specific areas of assessment of analysis presented in this document. Some of these methods are described in the documents attached to these guidelines. Other methods and techniques can be found in the annotated bibliography also attached to this document.

The need to choose the techniques and methods most appropriate to problems of a particular country and to the analytical resources, data and time available for the assessment activity forms one of the three central themes of these guidelines.

The second central theme is that of the importance of carrying out health sector assessments in collaboration with LDC institutions. The aspects of variability and collaboration have been demonstrated to be of critical importance in five countries where assessments are ongoing or have been completed.

The third central theme of these guidelines is the multi-sectoral nature of health sector assessment. Many health problems are caused or conditioned by problems in other sectors and many times health can be

most efficiently influenced by activities in other sectors. These guidelines indicate how such extrasectoral causes and potential interventions can be identified.

Health sector assessment as described in these guidelines should be completed prior to the completion of project papers in health. Obviously if such assessments can be completed earlier and submitted with the DAP, the Mission and the LDC government can devote more attention to the details of project planning. Experience to date indicates that once national enthusiasm is generated for a collaborative assessment the process may continue for some time as new problem areas are defined, etc.

No effort is made in this document to present guidelines for DAP preparation. Ther general DAP guidelines are sufficient for the health sector. Technical assistance can also be provided to Missions for preparation of DAPs. Nor are health project plannign guidelines included. They will be forwarded to the field at a later date.

At this point, it is appropriate to indicate what experience to date has demonstrated as reasonable results to expect from health sector assessments:

1) Health sector assessments should develop new knowledge concerning how national health goals can be accomplished most efficiently. If sensibly planned and administered, the assessment is likely to develop a broader commitment among national and international institutions to national health goals as well as a constituency for AID supported activities.

Sector assessment will study national goals to determine if new of dirrerent sectoral goals would be more appropriate to the health problems and resource constraints of that country. The adoption of new goals, however, will ordinarily require the full use of demonstration and negotiation capacities available to the Agency.

2) Health Sector assessments are likely to identify ways in which feasible programs and mixes of programs can markedly improve sectoral performance through a more explicit understanding of alternative program costs and impacts.

3) Assessments will make explicit the results of various levels of investment in terms of changes expected in health sector, but will not resolve the question of optimal amount of mission support for the health sector.

4) Identification of bottlenecks or likely implementation problems will allow mission and LDC support to address critical administrative problems in the health sector.

5) A significant upgrading of national institutional and personnel skills in applied health planning should result if time and care are taken in development of an appropriate scope of work for the assessment.

The remainder of the guidelines will discuss objectives of assessment in section II, determination of assessment priority in section III, general content of health sector assessment in section IV, and procedures for undertaking health sector assessment in section V.

II. Objectives of Health Sector Assessment

Within the AID context there are several objectives of a health sector assessment. They are:

1) To provide an improved basis for programming LDC investments within the health sector including population and nutrition within the context of development goals for the nation.
2) To provide a more factual basis for programming AID support to the health sector including population and nutrition.
3) To contribute to the improvement of LDC institutional capability in health planning by (a) demonstration of a structured analysis of health sector problems and alternative solutions and (b) assessment of the health planning requirements of the LDC and development of estimates of the manpower and resource requirements to accomplish the health planning activities identified.
4) To establish a basis for evaluation of LDC and AID investments within the health sector.

A basic assumption of these four objectives is that health, population, and nutrition goals are so interrelated that joint analysis is required.

The four objectives are competitive in many instances. Particularly those activities which could establish the most factually complete basis for programming investments may be beyond the capacity of the host country institutional capability to participate.

The health sector assessment process described in the remainder of this document is one designed to address the objectives outlined above within the time available in the AID program cycle. The intent is to take full advantage of the time available to do assessment work while not delaying the initiation of other AID progammatic support to the health sector.

III. Statement of Priorities for Health Sector Assessment Activities

The problem of setting up priorities for the content of a collaborative health sector assessment is one which must be vigorously addressed if a focus on the most important issues is to be accomplished. In planning the assessment, the choices must be made between both alternative problem areas and type of information gathering and analysis activities to address a given problem area.

Obviously the assessment must have as a prinripal focus planning for the poor majority and must address the problems and alternatives solutions to problems of the target groups of infants, children and pregnant and lactating women. The assessment must address the problems of least cost alternatives to effect the health of the above important targeted populations. The assessment should attempt to address how provate indigenous sectors relate to and can be used jointly with public sector programs

The further selection of priority problem areas should be addressed in the following way: (1) the problem areas which coincide with national health sector problems, LDC and AID priorities should circumscribe the

releveant universe for sector assessment; (2) the subset of problems of this universe for which technological alternatives exist; and, (3) the subset of this set of technological alternatives for which there is probable social and political feasibility.

Once the areas are defined where scope exists for influencing policy, the following generic types of information which impact on the decision making process must be considered:

1) The idnetification of health problems which effect the poor majority.
2) Social, economic and behavioral determinants of health status;
3) The relationship of health problems and programs with problems and programs in other sectors of the economy;
4) Resources available and their costs;
5) The resources required to produce units of health services;
6) The impact of health service on health status, and
7) The impact of health programs on population growth.

Experience to date indicates that generally, little additional effort is required in the areas of information on health status or identification of government priorities. The point is an important one to make because normally health planning activities get so bogged down in collecting information on magnitude of health problems that they never progress beyond this point.

Ordinarily, however, considerable attention is paid to information concerning the social, economic and environmental causes of poor health and new data may be required to elucidate these relationships. The area of social and cultural perception of health problems is a very important one to address vigorously if viable strategies are to result from the assessment process.

Most assessments have tended to concentrate on the economics of choices between program alternatives because the area where the least adequate information exists is that of the economics of production of health services and knowledge of program impact on health status. This is also the area where assessment-like activities of other organizations are weakest.

Assessments also concentrate on administrative capacity of health institutions. This concentration is in part due to the significant gains of efficiency that can be made in health services in LCDs through improved management. More fundamentally, assessments must provide AID with knowledge of the capacity of host institutions to manage the financial and other inputs from foreign assistance.

An associated area of prioritization which will be addressed in the following section is that of choosing between the various data sources or date gathering activities to be utilized. Choices have to be made between (1) existing data, (2) expert judgement estimates, or (3) collection of new data. Normally some new data gathering activities are incorporated into health sector assessments.

IV. General Content of Health Sector Assessment

Health Sector Assessments should be structured in such a way as to:

1) Accurately identify national health policies and health problems of the population and their causitive factors

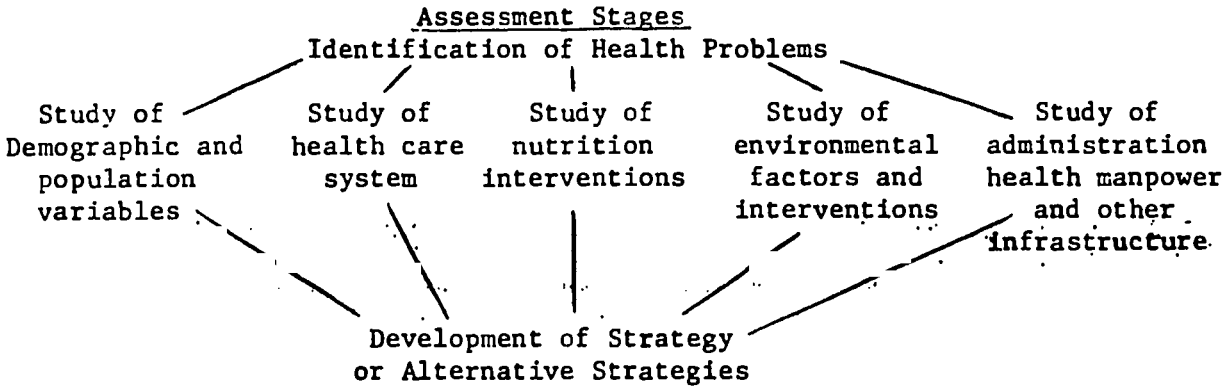
2) Estimate the resources available to the nation to address health problems;

3) Identify and study alternative technical solutions to health problems;

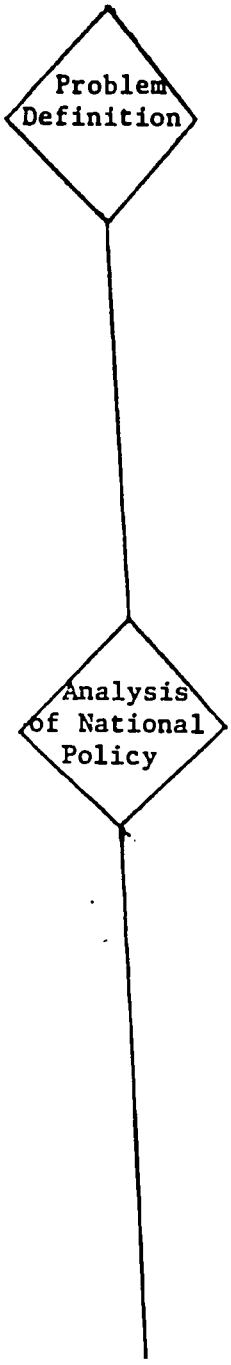
4) Identify and study administrative and other infrastructure bottlenecks to the improvement of health, and;

5) Synthesize the proceeding stages to develop a health sector strategy or alternative strategies.

Operationally many of the above steps are accomplished in a parallel fashion as shown below:

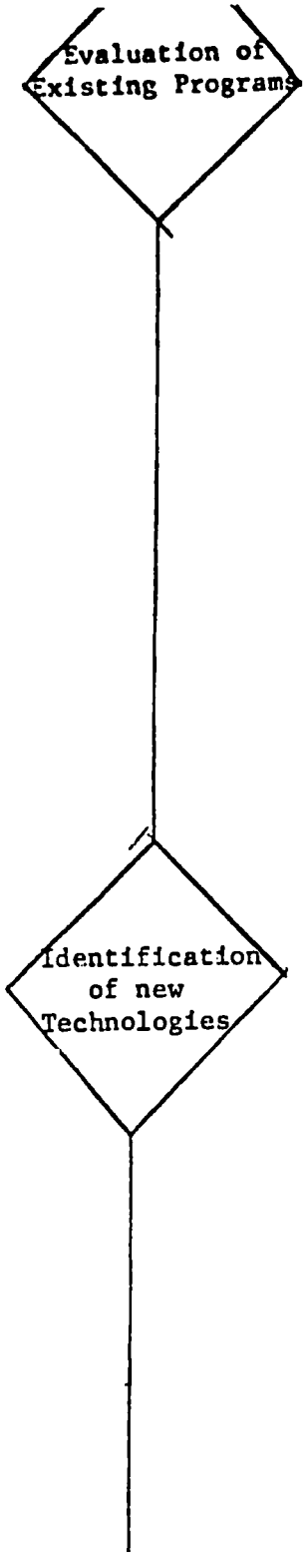


Each programmatic element in the assessment should be analyzed taking into consideration the conceptual elements identified in the following outline:



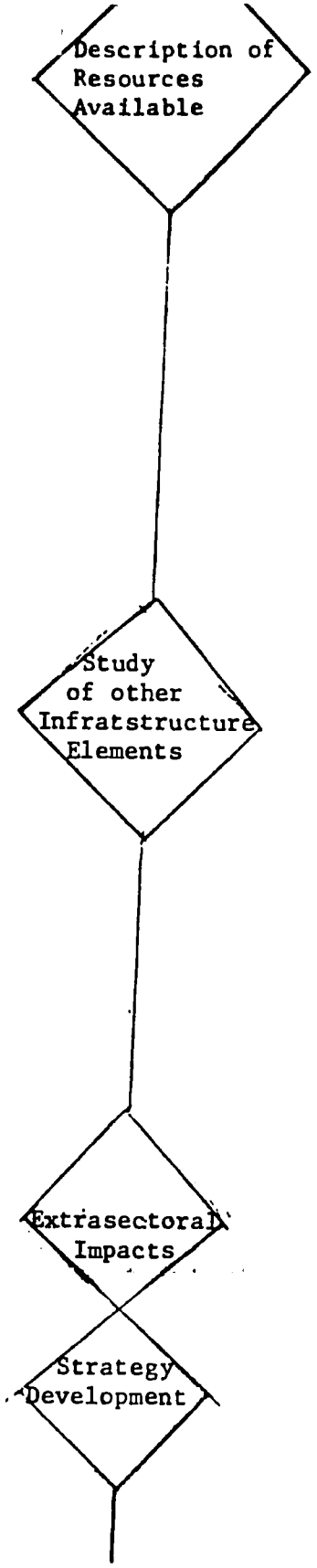
1) determination of magnitude of health* problems
2) description of epidemiological, social, economic and cultural causes of health problems;
3) description of social and cultural perceptions of health problems by the population and health care providers.
4) identification of factors to be modified in order to ameliorate health problems.

1) identification of national policy objectives which influence health problems and interventions to solve problems
2) description of decision making process in health, analysis of factors which have influenced health sector decisions.
3) description of bureaucratic processes and their effect on implementation of health sector programs



1) description of current programs to impact on health problems;
2) evaluation of program activities
3) identification of population affected;
4) identification of resources available and utilized;
5) identification of bottlenecks to improving services provided;
6) description of social and cultural acceptability of existing programs;
7) identification of probable impacts of program acitivities on the target population.

1) identification of new technical alternatives;
2) description of probable program activities, resources and costs;
3) prediction of social and cultural acceptability of proposed new program alternatives
4) description of probable program impacts;
5) estimate of new infrastructure requirements.

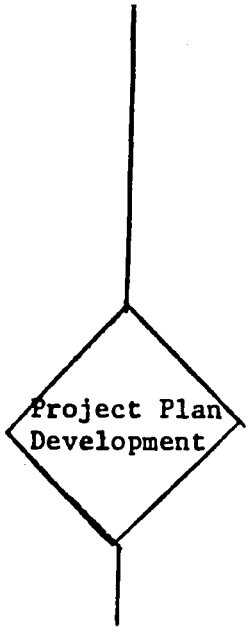


1) development of health manpower projections and current distribution;
2) inventory and description of equipment available to the sector and its distribution;
3) inventory and description of hospitals and other facilities and their current distribution;
4) identification and study of critical resource constraints and bottlenecks.

1) identification of administrative bottlenecks including logistics and supply systems;
2) study of financing systems, projections of finances available and impact of various systems on utilization and efficiency of health care
3) study of health information system

Identification of health program impacts on other sectors.

1) synthesis of proceeding stages;
2) elaboration of alternative strategies and program mixes;



3) analysis of alternative strategies and program mixes;

4) identification of dominating strategy;

5) determination of required program acitivities and estimate of resources required to implement program acitivities.

1) scheduling of projects;

2) determination of AID-National and other donor inputs.

The description of assessment activities above is cursory. Given the variety of ways in which each task listed can be accomplished and the necessity of selecting the appropriate technique for the particular national context the following section describes procedures for conducting a health sector assessment. A more detailed synthesis of several scopes of work for completed and ongoing assessments is presented as attachment A.

Always, difficult decisions must be made regarding the most useful content for the assessment, since even in the larger ones it is impossible to address the entire sector. This recognition had led to the procedure for implementing health sector assessments described in Section V of this document.

V. Procedures for Implementation of Health Sector Assessment

It is assumed that the first health sector study activity performed in conjunction with AID will normally be the preparation of a background document which provides a synthesis of descriptive materials currently available concerning the country and identifies the existing information sources, their completeness, etc. The document would serve to orient AID or contractor personnel to the problems of the country, existing programs; information availability, etc. So they can rapidly undertake sector assessment tasks. HEW under contract to AID can prepare such documents , Syncrisis study, upon request from the field.

Following the background document preparation a team will visit the country involved ifon two to three weeks to prepare the scope of work for the next phrase - usually a "health sector assessment". The scope of work teams may, of course, also advise on short term health program support, or potnetial direction of long term program support.

Health sector assessments may differ widely in terms of both the magnitude of the study and in terms of the specific direction of the study. A minimal holistic program would perhaps include 2 or 3 professionals for a period of six months to one year. Such a program could not be profoundly quantitative. It would, of course, extend the collection of data relating to the health sector. More important, such a team could perform a relatively detailed conceptual analysis of the current health activities and their appropriateness to the nation's health and sociol-economic status. Such a program could also analyze

in depth the current health plan of the country. The analysis could be extended to improving the presentation or modifying the health plan.

The Colombian Health Sector Analysis would represent a maximal program at this time. It involves approximately $500,000 in field studies and mathematical simulation. It is intended that this investment will produce a detailed quantitative model of the major components of the Colombian health sector.

Intermediate programs could extend the minimal program of sector assessment, incorporating one or more detailed, quantitative, analyses. The resources required for intermediate programs, would of course depend on the number and specific types of analyses desired. Intermediate level studies could also, of course, simply involve more field data collection. The content and magnitude of assessment, of course, are most importantly dependent upon the health problems, national health objectives and capacity of national planning institutions.

Prior to the site visit, discussions between AID/W, the AID Mission, and sponsoring host country agencies should clearly establish the desire for an assessment on all parts, and the role of the team.

A suitable team to define the scope of work might consist of:

a) health-planner-economist

b) a physician-epidemiologist

c) a sociologist

d) a specialist in public administration, and

e) an experienced AID program officer

Such a team should be provided with a local research assistant and with secretarial support. Additional personnel may be added if there are

special requirements for health planning expertise identified by the AID mission.

The scope of work team and field health, population and nutrition personnel will normally begin work in the country with a number of formal visits to officials of key health agencies and of the AID mission. These will be followed by interviews with the top technical officials of these same agencies. It is suggested that the health officer of the AID mission take special care that all factions of the health sector are represented in the set of meetings. The scope of work team can work with the AID office to assure this coverage.

The team will be expected to make site visits with local counterparts to assure that they observe the different regions of the country, and to familiarize themselves with the administrative system, and to see the health service delivery system in operation.

The team should then spend the major portion of their time in discussion with national counterparts in the specification of a sector assessment scope of work, identification of resources and personnel to carry out the scope of work and identification of institutional responsibility for and organization of the sector assessment that will be recommended to AID and the national government.

Experience to date indicates that the most critical element of determination of scope of work for collaborative assessments is matching the scarce resources available to do assessments with the enthusiasm and broad interest in assessment activities engendered in national

planners. Ordinarily, little resistance is met from Ministries of Health or Planning once the collaborative nature of health sector assessment is understood.

A final debriefing should be planned to present to AID officials the conclusions reached by the team. Similar meetings should be held for the host country officials and for AID Washington. The written report of the group should probably be prepared in draft after these debriefings, and in final form after comment of the AID mission staff. While intermediate briefings may be held to discuss team progress, it is suggested that the team take care not to commit themselves to any project recommendations too early ... the period of two to three weeks is itself a very short time in which to make overall judgements on a total health system.

If the health sector assessment is to realize stated objectives of upgrading the capability of host country planning institutions and personnel, considerable time and effort must be taken to identify institutions and personnel, as well as to orient them to the purpose and value of proposed assessment activities. Normally the assessment should be coordinated by a national institution and will be carried out and directed by a series of coordinating and working committees with technical assistance requirements from AID normally no greater than 25% of total effort.

Since the minimum collaborative sector assessment which has been planned to date is of 3-4 man years in magnitude, and normally is substantially greater, the workload on the mission to administer such an

activity can be quite large. An additional benefit to maximal involvement of national institutions and personnel is that the assessment can then be funded and administered as a project through a project agreement.

The mission will have various responsibilities in conjunction with the health sector assessment. Prior to the initiation of the assessment, the mission should assure staff that there is in fact an area of mutual agreement on health policy and the desire for donor assistance in the health field. Mission should also initiate contact with other donor organizations -- e.g. WHO/PAHO, IBRD, IDB -- to ascertain if they have similar or conflicting plans. Considerable efficiency may be achieved piggybacking a sector assessment on a parallel activity of another donor, if it is certain that coordination can be achieved. This may lead to a better assessment product and avoid spreading national capacity too thinly through competing efforts.

The health, population and nutrition officer will have considerable interest in the assessment. Even if a full time assessment coordinator is employed, the officer will probably be required to devote a considerable amount of time to the activity. A major portion of his responsibility will be continuing policy negotiations with the government. Such negotiations will relate to reforms to be undertaken, and the incentives appropriate to stimulate those reforms

Administrative burdens for a health sector assessment are fairly severe. Vehicles, offices and secretarial support are all required.

It is suggested that the majority of nationals involved in the assessment be assigned on a full time basis, and at least half time. Separate and adequate office space should be provided to the staff. Demands for secretarial services will be particularly great at the end of the assessment, and provision should be made for this activity. Similar provision for xerox and publication/duplication services must be made.

Although in principal data collection should be reduced to a minimum, experience with field teams to date has resulted in the need to collect some information. Resources are included in the budgets of assessments to provide for research assistants for such purposes. During such efforts, vehicles will normally be required for field work, data processing may also be a problem where statistical clerks and computer facilities are required. Survey and data processing administrative requirements are usually very intense, if only for a short period of time.

If the assessment is to be based in a national institution, it is desirable that the mission consider assistance requirements in relation to the institution's capacity to administer such a program. Experience to date suggests that the missions which carefully monitor the assessment, and provide timely administrative assistance, obtain a better assessment. If a mission chooses to set up an ad hoc group, or perceives difficulty in providing administrative support for consultants, assignment of a full time assessment coordinator should be considered either through a personal services or institutional contract.

Analytic responsibilities that normally must be carried out by the mission include:

a) evaluation of past health sector experiences of AID and development of strategies to take advantage of their lessons;

b) evaluation of the assessment itself, and agreement on mission strategy in light of the assessment; and,

c) policy level negotiation with the government.

These activities may require loan and program officers from the mission, as well as the health officers. It is suggested that continued policy supervision of the assessment by top officials of the mission is required to assure maximum quality.

VI. Consultant Personnel for Health Assessment

A variety of external consultant personnel are normally required for health sector assessments. Several sources and mechanisms exist to mobilize the required consultant expertise. AID, through a RSSA with the Office of International Health/DHEW can normally provide 25 percent of one individual's time in the field with Spanish or French language competence if required, to maintain continuity between consultants as well as provide general advise to mission and national personnel on assessment issues. In addition, AID has a small number of consultants who are frequently utilized in assessment activities. Contractual relationships with the American Public Health Association, the American Hospital Association, the Johns Hopkins University, School of Hygiene and Public Health, and the University of Michigan School of Public Health sometimes

allow ready access to personnel to provide assistance in assessments. Through Indefinite Quantity Contracts and other arrangements, supplementary personnel can be made available for assessment and other health planning activities.

Several individuals have worked in assessments as personal service contractors and provide a skilled cadre of individuals who can be mobilized for other assessment activities. TA/H or regional bureau Health, Population, and Nutrition Officers can provide listings of personnel available from the various sources listed above.

General Content of Health Sector Assessments

All health sector assessments should be specifically tailored to meet the needs of the particular national situation. The following description represents the content for a moderate sized general health sector assessment as synthesized from the scopes of work of several collaborative assessments undertaken to date.

The assessment areas presented are of four distinct types. The first area of assessment is that of assessment of health problems. Focusing on major problems and population attributes identified in this portion of the assessment, four programmatic areas for assessment are described. They are: food and nutrition services, population programs, health services, and environmental sanitation services. Three general infrastructure areas are described. They are: health manpower, drugs and supplies, and dynamics of change within the sector. The area of the relationship of health with other sectors of the economy is described. Finally, the synthesis of preceeding sections into a sector strategy is described.

1) Health Problems

a. description of health status,,including existing or modified information on morbidity, mortality, hospitalization, attention in other health service facilities, communicable disease incidence, nutritional status, and fertility rates.

b. population characteristics associated with health, nutrition, and family planning problems -- age, sex, urban-rural distribution, geographic distribution, economic level

of family relationship to educational level, relationship to environmental sanitation factors.

c. analysis of national health and socio-economic goals and nutrition.

2. Important Intersectoral Relationships

a. study of economic effects of health and nutrition status to include time lost from economic endeavor or education due to illness, and specific effects of health on other economic endeavors, particularly major developmental projects influenced by health.

b. trends in income distribution, social overhead investment and education and their probable impact on health.

c. projection of resources available to the health sector.

3. Food and Nutrition

a. description and evaluation of current nutrition programs.

b. identification of resources available for nutrition programs and projection of future resources.

c. analysis of nutrition related attitudes.

d. analysis of effects of prices on food and nutrient consumption.

e. study of costs and impacts of alternative programs to improve nutritional status including nutrition education, feeding programs, and nutrient fortification programs.

f. studies of administrative and financial constraints and facilitating mechanisms are most important in the area of nutrition.

g. modification of agriculture sector production models if such exist, to reflect nutrient availabilities.

There should be a very close coordination between agricultural sector assessments and health sector assessments. Only in this fashion can most useful nutrition strategies be developed without repeating work previously done.

4) Population Programs

a. description and evaluation of current family planning programs, factors influencing utilization of programs.

b. identification of resources available and constraints existing for delivery of family planning services.

c. analysis of determinants of fertility.

d. analysis of population demands and attitudes toward family planning services.

e. projection of rates of population growth under relevant assumptions.

f. predictions of impact of different population projections on economic growth.

g. evaluation of effects of health and nutrition programs on rates of population growth.

h. study costs and probable impacts of alternative strategies for the achievement of health and population aspects of national population policy. This analysis should address the full spectrum of alternative strategies to influence rates of population growth, including taxes and subsidies, private vendor distribution of family planning commodities, MCH and other health related delivery programs, and non-formal educational programs. The studies should attempt to identify marginal returns to alternative avtivities and identify efficient program mixes to

influence rates of population growth.

5) Health Services

a. description and evaluation of current health services.

b. identification of resources available for delivery of health services.

c. analysis of population demands and attitudes toward health services.

d. study of costs and impacts of alternative health systems to accomplish national goals. Attempt to identify marginal returns to alternative technologies and levels of manpower and capital investment by analysis of production functions for delivery of health services. Includes private sector as well as a variety of public sector institutions.

e. study of health sector financing to include not only identification of alternative sources of financing, but also price elasticities of supply and effects of alternative health services.

f. a description and study of relevancy of information systems is ordinarily included.

g. a study of health sector administration.

6. Environmental Health

a. description and evaluation of current environmental health activities.

b. identification of principal environmental problems and hazards including housing and transit systems.

c. identification of resources available for environmental health programs.

d. study of costs and impacts of alternative environmental programs to address principal problems. In the areas of water supply and sanitation,pre-existing IBRD sector studies should be utilized, reinforced and updated. Where existing engineering feasibility surveys exist for new projects, these projects should be ranked within relevant social groups (when rural, etc.) and presented in terms of cost per capita served.

e. identification of major occupational health hazards and study of costs and impacts of alternative programs to resolve them.

f. preliminary identification of human environmental impacts of major development projects. Specifically the efforts of agricultural and capital development projects on disease incidence should be identified.

7. Studies of Health Manpower

a. identification and description of training institutions and their capacity for production of health manpower.

b. development of current estimates of manpower availability (normally requires informal surveys).

c. study of internal and international migration of health manpower.

8. Drugs and Supplies

Since these inputs into the sector ordinarily comprise about one-third of total sector expenditures, they warrant study within the context of a sector analysis:

a. inventory of types and quantities of drugs and supplies

used in the sector.

b. study of prices and influence of prices and other factors on purchase and utilization of drugs.

c. study of probable effects of alternative policies to influence use of drugs and supplies -- generic drug formularies tariff and pricing policies, controlled purchase versus uncontrolled purchase of drugs, free or subsidized distribution of drugs rather than commercial purchase of drugs.

d. study of purchasing, storage, distribution and inventory systems of public sector institutions.

9) Dynamics of Change Within the Health Sector

a. identification of demands for and attitudes toward health and health services by the population and documentation of ways in which this behavior has been changed over time.

b. identification of social and political importance of health in society: amount of resources dedicated to, prestige accorded to health sector (analysis of newspaper content concerning the health sector, social standing of health sector providers, influence of health and health services as an important political factor).

c. identification of power groups influencing health sector decisions. their values and potential tradeoffs within the sector and between sectors, documentation of trends in government policy, influence of external organizations.

d. administrative and technical responsiveness of the system to new orientation or goals within the sector.

10) <u>Development of Health Sector Strategies</u>

a. synthesis of previous portions of analysis into broad program strategies; development of mix of health, nutrition, family planning and environmental sanitation programs to efficiently address health status problems identified.

b. identification of critical resource requirements to implement strategy.

c. identification of probable assistance to be received from other donors.

d. development of AID sector strategy.

The above described assessment activities were directed and managed by national institutions, normally several national institutions chiefly through the mechanism of coordination and policy committees.

Appendix B

Annotated Bibliography

Feldstein, M.S., Health Sector Planning in Developing Countries. Economica (London) 37:139-163, 1970.
"This paper describes a method of allocating the scarce health sector funds, manpower and facilities of an underdeveloped country among different disease control programs and individual activities in the way which yields the optimum feasible reductions of mortality, morbidity and economic losses. The linear programming formulation provides a natural framework for incorporating the multiple benefits and costs of health care programs."

Prest, A.R. and R. Turvey, "Cost-Benefit Analysis: A Survey." The Economic Journal, 75:683-735, December, 1965.
A general discussion of some of the elements and problems in measuring the costs of death and illness including: how to measure the value of housewives' services (opportunity cost vs. replacement cost) and what to do with consumption (whether to include as a loss to society or not).

Dahl, T., "Operations Research on Health Care in Chile: An Experiment." International Journal of Health Services 1:271-284, August, 1971.
Applying operations research techniques in a real setting is the subject of this paper. A group of faculty members at the University of Chile studied operations research in theory and practice at the University and at the same time collected statistical information in the field, and formulated a flow model of the pediatric services system in the North Area of Santiago. Integration of the flow of patients, resources, and records led to the development of a simultaneous equation model reflecting an operating health services system which is described in some detail. This in turn spurred a set of recommendations for translating these results into policy measures. The experiment proved that health care professionals can be trained quickly and effectively for complex analytical tasks, and that such training is applicable to real-world problems.

Chorba, R.W. and J.E. Sanders, "Planning Models for Tuberculosis Control Programs." Health Services Research 6:144-164, Summer, 1971.
Discrete-state, discrete-time simulation model of tuberculosis is presented, with submodels of preventive interventions. Preventive and control programs and their optimal budgets may be planned by using the model for cost-benefit analysis: costs are assigned to program components and disease outcomes to determine ratio of program expenditures to future savings on medical and socioeconomic costs of tuberculosis. Optimization is achieved by allocating funds in successive increments to alternative program components in simulation and identifying those components that lead to greatest reduction of prevalence for given level of expenditure.

Axnick, N.W., Shavell, S.M. and Witte, J.J., "Benefits Due to Immunization against Measles." Public Health Reports 84:673-680, August, 1969.
Net dollar savings due to immunization against measles are detailed for 1963-1965 and 1966-1968, as well as health benefits (in terms of such factors as cases averted, workdays and school days saved, and cases of retardation averted).

Correa, H., "Health Planning." Kyklos 10:909-922, 1967.
An explanation of a basic econometric model for use in making the optimum allocation of resources for preventing or curing disease. The output index used is number of deaths - specifically, minimization of the number of deaths. (Other indices might be number of days of health, or economic losses, but these have statistical limitations as well as theoretical difficulties.) The basic model is presented and an expanded version incorporating a means of evaluating two specific parameters (the number of cases that can be avoided by spending $1, and the number of deaths that can be avoided by spending $1). A numerical example of data on whooping cough in Northern Santiago, Chile, is given. A non-linear model is briefly discussed leading to the conclusion that for a minimum number of deaths, the marginal return of money in prevention must be equal to marginal return of money used in treatment. Allocation of resources with regard to several diseases is discussed; interdependences among diseases and health activities is noted.

Weisbrod, Burton A., Economics of Public Health: Measuring the Economic Impact of Diseases. Philadelphia: University of Pennsylvania Press, 1961.
This classic volume in the field of human capital measures economic losses from morbidity and mortality due to cancer, tuberculosis, and poliomyelitis in terms of the present value of net future earnings (discounted at 4 and 10 percent). Various methodologic problems are discussed, and two appendices deal with consumption and the value of women's household production in some detail.

Packer, A.H., "Applying Cost-Effectiveness Concepts to the Community Health System." Operations Research 16:227-253, 1968.
Ways in which concepts of model building and cost-effectiveness can be applied to the health planning process are investigated and large-scale digital-computer simulation techniques are recommended. The applicability of a measures of effective (as defined in the paper) and other measures to specific health problems is discussed. Finall problems of estimating costs are examined in terms of the various kinds and who bears them.

Feldstein, Martin S., "An Aggregate Planning Model of the Health Care Sector." Medical Care 5:369-381, 1967.
A simultaneous non-linear multiple regression model for estimating parameters of hospital use in a given population is developed as a preliminary to a larger econometric model. Methodologic concepts and procedures are explained. A study of supply and demand of hospital inpatient services is used to illustrate ways the model might be utilized as a means of predicting the effects of alternative policies.

Zemach, R., "A Model of Health-Service Utilization and Resource Allocation." Operations Research 18:1071-1086, 1970.
This paper presents the initial basis for a descriptive mathematical model of the total utilization of personal health and medical services by the population of a community or region, the allocation of resources used to provide these services, and the cost of health care as derived from the prevailing costs of resources. A simplified illustrative example is presented. The patterns by which resources are allocated to provide services, and the patterns by which the population groups use the total mix of services available, are identified as parameters in the model. On the basis of past data, the model can be used to predict allocation and use of services over time, as a function of population dynamics. Problems of implementation are discussed.

Fanshel, S., and Bush, J.W., "A Health-Status Index and its Application to Health-Services Outcomes." Operations Research 18:1021-1066, 1970.
Operational definitions of health, time, and target population are developed and used to give a quantitative definition of the output of a health program "as the changes in the functional history of the target population resulting from the intervention of the health program (or system)." Program effectiveness and health status of the population are also defined quantitatively. The paper also examines the relationship between health program output and modern decision theory. Two illustrations of the method are presented in the paper. Over 50 references are cited.

McDermott, W., "Environmental Factors Bearing on Medical Education in the Developing Countries. A. Modern Medicine and the Demographic -- Disease Pattern of Overly Traditional Societies -- A Technologic Misfit." Journal of Medical Education 41: Supplement 137-162, September, 1966.
In developing societies with high birth rates and a large proportion of young children, these children are particularly vulnerable to disease and death, a situation reinforcing high fertility. In such societies, it may be that the reduction of infant and child mortality must precede fertility reduction.

Navarro, V., "Systems Analysis in the Health Field." Socio-Economic Planning Sciences 13:179-189, 1969.
The use of systems analysis, particularly certain planning models, in the field of health service planning is examined. The place of health in global development models is discussed, as well as the use of health status as an indicator of social development levels.

Wiseman, J., "Cost-Benefit Analysis and the Health Service Policy." Scottish Journal of Political Economy 10:128-145, 1963.
The application of cost-benefit analysis on a "global" basis (to determine the overall size of the health sector) and on a more restricted basis)to guide resource allocation within the health sector) is discussed. Deficiencies in such studies are noted, particularly as they stem from a failure to consider adequately the institutional structure through which the resource allocation takes place.

Optional

1. PAR NO.	2. PAR FOR PERIOD	3. COUNTRY	4. PAR SERIAL NO.
9 1-11-999-004-12	May 1, 1974 TO April 30,75	Worldwide	

5. PROJECT TITLE

OIH/RSSA

6. PROJECT LAST EXTENSION	7. DATE LATEST PIP	8. DATE PRIOR PAR
Is indefinite	N/A	None

10. U.S. Obligation	a. Cumulative Obligation Thru Prior FY: $	b. Current FY Estimated Budget: $	c. Estimated Cost to Complete After Current FY: $

11. KEY ACTION AGENTS (Contractor, Participating Agency or Voluntary Agency)

a. NAME	b. CONTRACT, PASA OR VOL. AG.
Department of Health, Education and Welfare Office of International Health	

12. ACTIONS PROPOSED AND REQUESTED AS A RESULT OF THIS EVALUATION

A. ACTION (X)			B. LIST OF ACTIONS	C. PROPOSED ACTION COMPLETION DATE
	X		Transfer Dr. Smith to MEDEX RSSA	
	X		Query bureaus for FY 1976 requirements	
	X		Review country health profile content and publication requirements	
	X		Examine the need for provision of funds to OIH for consultant time in excess of planned manpower levels to be utilized as needed.	

REVISED OR NEW: ☐ PPOP ☐ PIP ☐ PPO AS ☐ PIO/T ☐ PIO/C ☐ PIO/P

E. DATE OF MISSION REVIEW

PROJECT MANAGER: R. Don Newman

Lee M. Howard, MD

PURPOSE:

To provide AID with professional health resources to support AID/W, Regional Bureaus and USAIDs to provide for health development activities in response to the Congressional mandate.

BACKGROUND:

OIH/HEW is organized into two divisions that provide services to AID through this resources agreement. The Division of Planning and Analysis has a staff of fourteen, eleven of whom are AID-funded. This staff provides staff work for Country health profiles. Some of these documents are published as Syncrisis. The balance of the professional staff provides guidance, leadership and technical review of scopes of work and finished products of health sector analysis and participate in these programs to the extent time is available. Near the end of FY 1975 funds were provided to increase the manpower of this latter professional group by five professionals to increase the ability of OIH to cope with greatly expanded Regional Bureau requirements for health sector assessment over the next year or two.

The Division of Development and Coordination has a staff of twenty-three, nine funded by AID, six through this resources agreement. These staff members provide resources for coordination of international health programs, development of policy and other guidance as a staff resource to AID, an information resource for international health activities and responds to special requests of AID for personnel for short-term assignments.

In addition, AID supports administrative backstopping within OIH which includes the services of an Administrative Assistant, Office Service Supervisor, Accounting Technician and one secretary. These services appear to be adequate and reasonable.

REVIEW PANEL MEMBERS:

John Welty, PPC

Maura Brackett, LA/DR

Dr. Ed Cross, Africa Bureau

Sue Gibson, NESA/TECH

R. Don Newman, TA/H

Discussions were held with these panel members, the Director of OIH and his staff, and other representatives of TA/H on April 30,1975. A list of actions are included on the face sheet of th is PAR.

GENERAL CONCLUSIONS:

Agency representative agrees that it is necessary to continue a resources agreement with OIH for professional consultation. It may be useful and helpful to the Regional Bureaus to provide funds for undefined short term consultants through the RSSA agreement who could be named as situations arise.