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**COLOMBIA
COUNTRY SPECIFIC PROPOSAL**

submitted to

**THE UNITED STATES
AGENCY FOR INTERNATIONAL DEVELOPMENT**

for

**TECHNICAL ASSISTANCE SUPPORT
in the Development of
a Health/Family Planning Delivery System
in Cali, Colombia,
as Prototype for National Replication**

under

Contract No. AID/CM/pha-C-73-35

September 1973

**THE FAMILY HEALTH FOUNDATION
International Program**

**TULANE UNIVERSITY
Department of Applied Health Sciences
Institute for Health Services Research
School of Public Health and Tropical Medicine**



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PREFACE

THE FAMILY HEALTH FOUNDATION/TULANE UNIVERSITY STRATEGY

The Family Health Foundation/Tulane University has demonstrated the capability to develop an appropriate methodology and has acquired considerable experience in the design and implementation of health/family planning service delivery systems in the United States as reflected in the success of the Louisiana Family Planning Program and its replication in the State of Illinois. The Louisiana and Illinois family planning programs are presently the two largest state-wide family planning programs in the United States. Other health programs being carried out by The Family Health Foundation are as follows: a Community Medicine Program carried out through three New Orleans Neighborhood Health Centers under the authorization of the City Demonstration Agency, a Developmental Day Care Program, a Teenage Services Program; and a Health Manpower Training Program for Auxiliary Health Personnel.

Based on the results of studies made in Latin America in 1963 and 1964 regarding population problems, the long-range objective of The Family Health Foundation/Tulane University, through its International Program, has been to develop and implement a Latin American strategy aimed at sharing the experience of The Foundation in the development of effective methodologies for the implementation of health/family planning services with those countries requesting it. Likewise, the formulation of a generic model which could be easily adapted by each government in order to attain wide coverage at a low cost is planned. Consequently, an important phase of this strategy has been the establishment of professional relationships with universities and ministries of health of important Latin American countries, interested in the development of innovative methodologies for the delivery of health services in demonstration areas selected for this purpose. As a result there is a need for such service delivery prototypes to take into account the health and population policies of each nation and to be based on up-dated statistical data. They must take into account community groups and high risk areas, cover at least 80% of the target population and be oriented towards simplified medical care. Other necessary requirements are those of promoting community participation, providing health education, including family planning and other related topics and finally, carrying out motivation and communication activities. Given the shortage of medical personnel, their present inefficient distribution and the need for an adequate health team, the system must emphasize the optimal utilization of supervised auxiliary personnel which can be trained in adequate numbers for the delivery of services. In order to attain high coverage at a low cost, the project must have a knowledgeable management capacity in health services administration. Likewise, since this is a pilot program, it will be necessary to establish from the beginning the foundation for program evaluation and monitoring which will make it possible to submit the prototype to rigorous testing.

An essential part of the strategy is to be able to evaluate, in a closed circuit, the above-mentioned program development, thereby providing a solid basis for future expansion. The generic type of methodology which has been perfected and documented has brought forth prototype programs which can be replicated at the regional and national levels in each of the countries for which they were developed and which can possibly be replicated in other Latin American countries with all the necessary adaptations.

Another element of the strategy which is directly related to the previous one consists of giving practical experience to the staff of the International Program of The Family Health Foundation/Tulane University and of the collaborating institutions in Latin America, in order to have human resources capable of offering the technical assistance required by other countries desiring to adapt and replicate these health/family planning service delivery systems.

It is believed that the professional personnel required to plan such an ambitious program, must, in addition to health personnel, include the technical cooperation of educators, social workers, lawyers, financial experts, auditors, management experts, mathematicians, biostatisticians, specialists in manpower development issues, sociologists, social psychologists, demographers, economists, systems engineers, political scientists, psychiatrists, psychologists and technicians in the fields of communications and human relations. This multidisciplinary team must collaborate in program design and in applied research both on a short- and long-term basis.

For reasons already discussed in other documents, the countries with which professional ties and interrelationships have been established are Brazil, Colombia and Mexico.

In June 1973 an agreement was signed between the Agency for International Development (AID) and The Family Health Foundation/Tulane University which makes it possible for the latter to finance specific health/family planning technical assistance projects for selected Latin American countries. It is under the terms of this agreement (No. AID/CM-C-73-35) that this proposal for Colombia is being submitted.

The Interinstitutional Coordinating Committee, described in the chapter corresponding to Management and Coordination (page 33), ensures the participation of the various levels of the health scale in Colombia, thus facilitating the replication of the prototype at the regional and national levels.

This document provides an overall view of the prototype to be developed by PRIMOPS in Cali, through the summary information presented in the following sections:

SECTION A: PROGRAM DEVELOPMENT

SECTION B: ELEMENTS OF THE MODEL

**SECTION C: THE FAMILY HEALTH FOUNDATION/TULANE UNIVERSITY
TECHNICAL ASSISTANCE**

SECTION D: CONTRACTS AND AGREEMENTS

INTRODUCTION

The Health Services Delivery Model in Cali is to be operated in conjunction with the five health posts conveniently located in the seven barrios of the Union de Vivienda Popular (UVP) area and which are functionally related to a Health Center (Antonio Narino) and a peripheral hospital (Carlos Carmona). Patients requiring more specialized treatment will be referred to the University Hospital which is located at less than two miles from the health post. Every home within the area will be located at less than one mile from a health post. The model will cover a population of 110,000 inhabitants living in a periurban area characterized by rapid growth.

The planning of the model called, "Research Program in Health Services Delivery Systems" (PRIMOPS) is based on data collected in the community, beginning with the diagnosis of the conditions of the health services already being offered in the area, its general level of health and the population dynamics. A census, a KAP survey (Knowledge, Attitudes and Practices) on health and fertility, the vital statistics records and a study of the morbidity characteristics of the area will make it possible to obtain baseline data.

The KAP studies were carried out in UVP in the early part of 1973. Actual health services delivery was initiated in the first module of 20,000 persons in July 1973. Services in this module will be fully operational by September 1973. The feasibility study was completed in April 1973.

The crucial factor in the development and evaluation of a health services delivery system is that of having developed a methodology which is based on experience. Many aspects of the methodology used in the Cali project have been taken from the Health Services Delivery Model for Candelaria ("Simplified Health Delivery System") carried out by the Health Division of the Universidad del Valle as well as the experiences of other programs of the Ministry of Health of Colombia and of The Family Health Foundation/Tulane University in New Orleans.

The Colombian model incorporates the concepts of the regionalization system of the Ministry of Health. As a result, health promotion in the home is combined with preventive medicine, medical care and rehabilitative activities for the mother, child, couple, family and community. The regionalization system (page 14) refers to the stratified organization of the levels of medical care, that is, the health post, the health center, the peripheral hospital and the university hospital, in ascending order as regards size, complexity of services offered, degree of administrative supervision and teaching and research responsibilities. In addition to these levels of health services, the program has included systematic home visiting as a preliminary step. At the home level, some simple medical services delegated to duly supervised auxiliary personnel will be provided (pages 15-21).

The systems approach as adopted by the Cali Model follows very closely to that of the Generic Model of The Family Health Foundation (see the corresponding document) by establishing an interrelationship between five (5) basic components: Services, Human Resources Development, Administration, Management and Evaluation.

Another important consideration of the model is the harmony which exists between the program and the concepts and methodologies upheld by the Colombian Ministry of Health. Although this problem has been extensively dealt with in the "COLOMBIAN FEASIBILITY STUDY" (April 1973), it must be pointed out that the Colombian Government places high priority on MCH/Family Planning programs and that among its basic objectives it has set forth the following:

- a) Decrease maternal morbidity and mortality rates with particular attention to problems of multiparity, high abortion rates, cervical and uterine cancer and any other type of gynecological pathology.**
- b) Reduce the child mortality and morbidity rates especially by actively fighting against controllable diseases.**
- c) Contribute to the development of responsibility and family well-being by means of educational and family planning services.**

It is this health concept that the PRIMOPS program is implementing through the methodology selected. Furthermore, this methodology is in accordance with the present tendencies of the government as expressed in the law authorizing the Ministry of Health to unify and restructure planning and administration at all health service levels (project referred to as the re-designing of the Health Sector). This legislation will greatly facilitate the replicability of the prototype, since up to the present there has been a high degree of competition, duplication of functions and confusion in the delivery of health services especially at the urban level. For example, as a result of a closer coordination between the municipal and state authorities, PRIMOPS will, through a referral mechanism, be able to use the services and facilities of the recently built "Carlos Carmona Hospital" and the "Antonio Narino Health Center." Both are located in the Union de Vivienda Popular area and represent an important government contribution to the health resources of this community since the costs incurred in their construction, staffing and operation have been considerable.

SECTION A -- PROGRAM DEVELOPMENT

1. BACKGROUND AND FRAME OF REFERENCE

The following facts have been basic elements in the development of the Health Service Delivery Model in the area Unión de Vivienda Popular in Cali, and have served as a frame of reference for its design:

1.1 Community Medicine

The experience in community medicine accumulated since 1958 by the Health Division of the Universidad del Valle and other universities in the country, has made it possible to test aspects of the model such as administrative structure, the staffing pattern, the delegation of functions, etc. in specific communities.

1.2 Prior Studies

The "Human Resources Study for Health and Medical Education in Colombia," initiated in 1965 by the Ministry of Public Health and the Colombian Association of Medical Schools, made it possible to identify the following health aspects in the country:

- a) Health conditions of the Colombian population.
- b) Availability, utilization and performance of human and institutional resources for health purposes.
- c) Conditions and characteristics of medicine, dentistry and nursing training.
- d) Social and economic factors related to the foregoing.

1.3 Organizational Priorities

The results of the above-mentioned study lead to the following decisions:

- a) The inclusion of health as a priority sector within the general plan for the development of the country.
- b) The bringing together by the Public Health Ministry of a multi-disciplinary professional group in order to redesign the national health system, which has necessitated the development of a series of operational research activities in the field of health.

- c) **The decision of the Colombian medical schools to increase their participation in the study and solution of the health problems in Colombia, and to adapt the training of health human resources to the needs of the community, thus facilitating better coordination and integration with the government health agencies.**

1.4 FHF/Tulane

The technical and financial assistance provided by the International Program of The Family Health Foundation, which is described in the feasibility study (April 1973), was crucial in giving a start to this project.

2. DEFINITION OF THE PROBLEM

Colombia, like most Latin American countries, shows the following characteristics:

- a) **Low health levels, which are reflected by high mortality and morbidity rates.**
- b) **High fertility rates.**
- c) **Traditional medical care systems characterized by low coverage, and mainly oriented towards curative medicine.**
- d) **Shortage and under-utilization of human and financial resources in health care delivery.**
- e) **An accelerated urbanization process and crowding in the urban centers resulting in ever-increasing pressures in the demands for housing, public services and recreation, schools, health services, transportation and employment.**
- f) **Low levels of economic and social development.**
- g) **Traditional systems of education, characterized by minimal participation of students and teachers in the study, analysis and solution of community health problems.**
- h) **Lack of experience in the application of new technologies for solving the country's problems within the limits of the national resources.**

3. OBJECTIVES

3.1 General Objectives of the Proposed Program

In order to find a comprehensive answer to some of the above problems, this inter-institutional program will be carried out through two projects:

Project I is the Research Project in Health Delivery Models. Its general objectives will be the design, implementation, operation, evaluation and documentation of an integral health service delivery model which can be replicated in other parts of the country, with the purpose of improving the health conditions and the quality of life for a population of 100,000 as the target population. The Program includes services, technical assistance, teaching and research activities. It will constitute a demonstration area for a health service with high coverage at a low operational cost.

Project II* is the Inter-Institutional Integration Program for Teaching and Research in Health Service Delivery. Its general objective will be to show the feasibility of integrating the teaching and health delivery systems in order to join forces for the study of community health problems and its possible solutions. This will promote the organization of the health teams in keeping with realities in the communities and the characteristics of the health system.

3.2 Specific Objectives of the Health Service Delivery Model

For the mother:

- a) Decrease maternal mortality by 80 percent in five years.
- b) Decrease** the frequency and severity of the following complications:

During pregnancy:

Hemorrhage (including abortion), toxemia, urinary infection, and syphilis.

During delivery:

Hemorrhage, dystocia, and prolonged labor.

Postpartum:

Hemorrhage and infection.

* A special document containing Project II was prepared by the Universidad del Valle under the title "A Program of Interinstitutional Integration for Teaching and Research in the Delivery of Health Services."

**The rate at which these items will be decreased is to be determined during the test of the prototype phase since it will depend on the results obtained during the above phase.

For the child:

- a) **Decrease infant mortality by at least 50 percent in five years.**
- b) **Decrease** mortality in children 1 to 4 years of age.**
- c) **Decrease**the frequency and severity of the following morbidity in the neonatal period:**

Tetanus, ophthalmia of the newborn, omphalitis, septicemia, iso-immunization problems, congenital infection.
- d) **Decrease**the incidence of diptheria, tetanus, whooping cough, smallpox, measles, polio, and tuberculosis in children under 5 years of age.**
- e) **Decrease**the incidence and severity of diarrhea in children under 5 years of age, in 5 years.**

For the couple:

- a) **Decrease** the rate of unwanted pregnancies.**
- b) **Decrease** the number of pregnancies of multiparous women.**
- c) **Decrease** the frequency of pregnancies.**
- d) **Prevention of induced abortions and their consequences.**

For the family:

Decrease morbidity and mortality in the age groups not included above.**

4. A MODEL OF HEALTH SERVICE DELIVERY

4.1 Characteristics of the Health Service Delivery Model

The model proposed is to have the following characteristics:

- a) **An integration of the health activities developed by the following institutions: university, city and state health departments, I.C.S.S. and Family Welfare Institute. Initially this integration will be brought about between the university and the city health department.**

- b) Coordination of all of the health service agencies dealing with promotional, preventive, curative and rehabilitative services.**
- c) Orientation of the health services to the high-risk groups as the highest priority.**
- d) Coverage above 80 percent particularly among the most vulnerable groups, such as the mother-and-child group.**
- e) Health care both for the individual and the family throughout the life cycle, beginning at conception.**
- f) Operation within a system of urban regionalization whose administration is highly decentralized.**
- g) Permanent contact with the family through periodic visits to the home.**
- h) Meeting real and felt needs of the community.**
- i) Combined centrifugal and centripetal action, so that care is delivered to patients in the health centers as well as, and more frequently, at home.**
- j) Maximum utilization of the community's own resources, and participation of the community in planning and solving its own problems.**
- k) Efficient utilization of the professional personnel (physician, nurse, dentist), giving them responsibility in supervision and in activities having a wider scope.**
- l) Maximum utilization of auxiliary personnel, through the delegation of functions. A redefinition of the role of auxiliary personnel in health programs is to be made simultaneously.**
- m) Use of new health instruments within the system (Health Card and Health Almanac).**
- n) Easy replication in other communities.**
- o) Efficient activity at an affordable cost according to the health center budgets.**
- p) The model must be designed to allow periodic evaluation of the system and its effect upon the community.**

4.2 Selection of the Community and Sectorization

4.2.1 Selection of the Community

For the implementation of the project, the community served by the Antonio Nariño Health Center of the City Health Department of Cali, has been selected as the target population covering approximately 100,000 inhabitants (7 barrios). This community was chosen for the following reasons:

- a) It is located in an easily accessible area.
- b) The accelerated growth of the population in this area is expected to be the growth pattern of other similar areas in the future.
- c) Several studies have been conducted in the area which produced an approximate idea of the health situation of the community, its demographic structure and its socioeconomic and cultural conditions.

4.2.2 Sectorization

The community and the area where the model is to be developed have been divided into sectors as follows:

- H.P.W.U.** – This is the High Priority Work Unit. Each family having children under 5 years of age is a H.P.W.U.
- Sector** – A sector is an area with 2,500 inhabitants; in other words, 420 families (6 persons per family). Each of the families is visited by a promotora every three months.
- Barrio** – The term barrio represents each political administrative division of the city. Within the project target area each barrio has between 10,000 and 20,000 inhabitants.
- Health District** – The Health District is an area served by the Health Center: 100,000 inhabitants.
- Region** – The region is the area served by the peripheral hospital: 250,000 inhabitants.
- Zone** – The zone is the area served by the university hospital: 2,000,000 inhabitants.

4.3 Community Participation

The community takes part in the development of the programs, as follows:

- a) **Discussing, through community action groups, the felt needs of the community and proposing concrete solutions.**
- b) **Offering for each barrio a house where the Health Post can be set up, serving as the headquarters for the para-medical personnel.**
- c) **Cooperating with the program in the recruitment of personnel in each barrio for the delivery of health services to the community in promotion, care and volunteer activities.**
- d) **Creating groups of people in each city block, by barrios, for the purpose of maintaining a reporting mechanisms to the program management of the needs of the families and whether the services are being performed satisfactorily in each unit.**

4.4 Area Profile

The existing studies of the Unión de Vivienda Popular area will be verified and supplemented by means of the following investigations:

- a) **Health and socioeconomic status of the community concerning:**

- Morbidity**
- Nutrition**
- Education**
- Occupations and income**
- Housing**
- Environmental sanitation and transportation**
- Recreation**
- Social security**

- b) **Health status determining factors:**

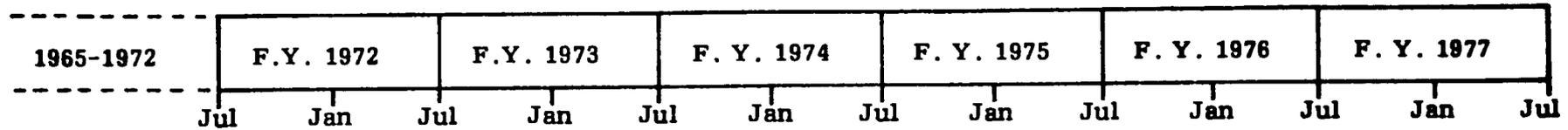
- Causal agents**
- Susceptible population**
- Environmental factors**

- c) **Demographic structure:**
 - Birth and mortality rates**
 - Migration**
 - Population growth rate**
 - Population pyramid by sex and age**
- d) **Health policies**
- e) **Inventory of the existing health resources**
- f) **Community behavior regarding health and illness**
- g) **Community behavior regarding health services**
- h) **Fertility and its determining factors**

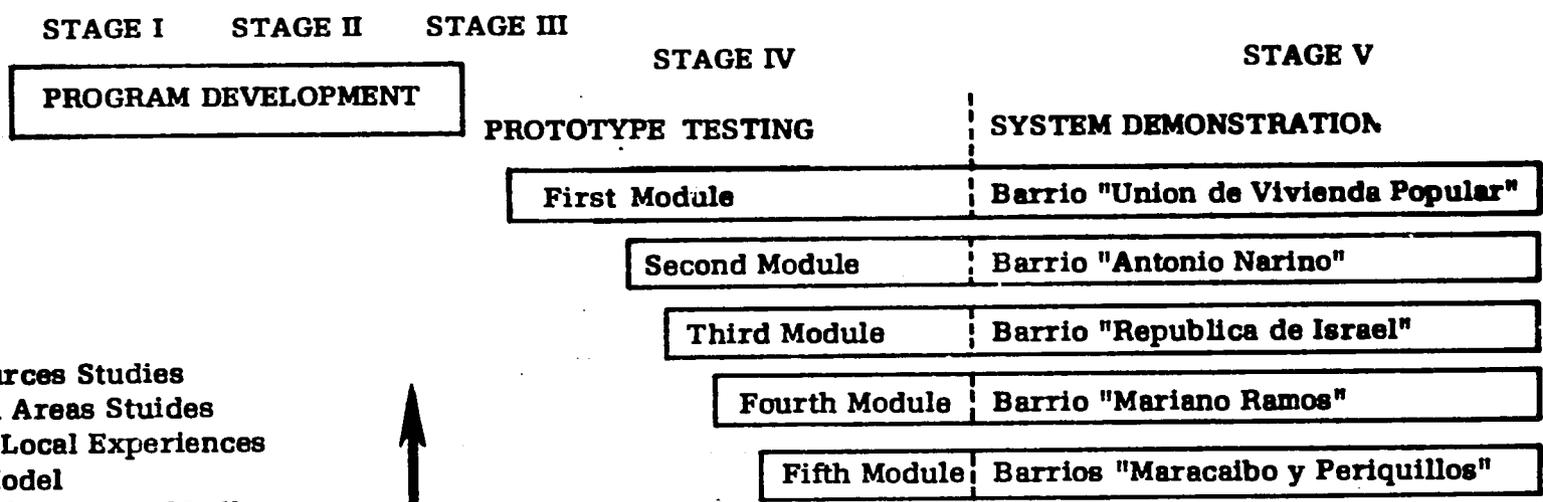
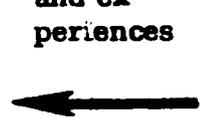
The existing health system in the target area is inadequate with regard to both physical resources and the actual delivery process for providing even the minimally needed services to 100,000 people.

The health and demographic patterns of Cali and the target area are similar to those of many Latin American cities. These cities are generally unable to meet the increasing health needs of a population with a fast-growing proportion of youths. Far from being solved, the problems increase in magnitude every year. Demands for public health services, housing, education, employment and public services are placing tremendous burdens on the economic and social resources of the urban centers.

4.5. General Timetable of Activities



**5 Years
Previous
Studies
and ex-
periences**



II

- *Human Resources Studies
- *Experimental Areas Studies
- *National and Local Experiences
- *Candelaria Model
- *Health Plan of Depart. of Valle

- *Feasibility Study
- *Research
- *Planning
- *Capacity Development

- *Orientation
- *Training
- *Staffing

- *Implementing
- *Expanding

- *Full operation of Health/Family Planning System

FHF phases out

SECTION B – ELEMENTS OF THE MODEL

1. SERVICES

As has been stated previously, the model for health services delivery in operation for the past five years in Candelaria will constitute the framework of the model. Of course, any adjustments deemed necessary for an urban population of 100,000 inhabitants will be implemented. The Antonio Narino Health Center, the central health facility for the area, is complemented by the Carlos Corrao peripheral hospital.

The system will operate within defined principles and organizational plans, but it will also develop a series of activities for operational research. Basically, the proposed program will be an epidemiographic surveillance mechanism, referring patients to the already existing facilities in the area (health center, peripheral hospital) and establishing systematic home visiting by appropriate auxiliary personnel. Only very special cases will be referred to the University Hospital.

1.1 Type of Services

Through the system, the following health services will be offered:

	<u>Type of Services</u>
MOTHER	Prenatal Control Care at Delivery Postpartum Control Early Diagnosis of Cervical Cancer Medical Care
CHILD	Care for the Sick Growth – Nutrition Control Immunization Education of the Mother on Child Care
COUPLE	Education on Family Planning Services: Family Planning Methods Follow-up of Couples Study of Sterile Couples

FAMILY **Care for Sick School-age Children and Adults**
T.B.C. Control and Treatment
Dental Health
Environmental Sanitation

COMMUNITY **Development and Integration of Health Plans**

1.2 Regionalization System

The Regionlization System mentioned in the introduction as well as the various levels of care appear in the charts on the following pages:

2. SUPPORTIVE ELEMENTS

The Supportive Elements of the model are: Human Resources, Development, Evaluation and Administration.

2.1 Human Resources Development

The Human Resources Development is a technical unit of the Research Program in Health Service Delivey Models. Its relationship with other elements of the organization is shown in the PRIMOPS organizational chart on page 34.

2.1.1 Functions

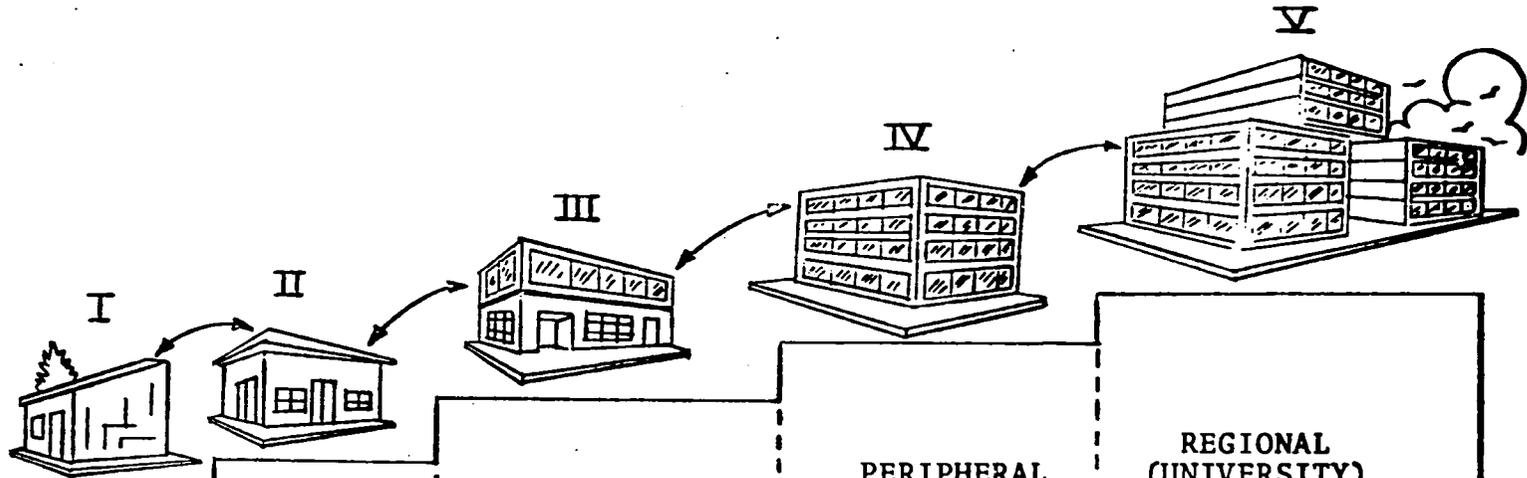
The basic functions of this unit are summarized in Diagram 1 (page 24).

2.1.2 Objectives

The objective of the Human Resources Unit is to implement models which will accomplish the following:

- a) **Select personnel who are motivated and able to produce high quality work.**
- b) **Train personnel in accordance with a curriculum which will guarantee the learning of the specific knowledge and skills required.**
- c) **Supervise and evaluate personnel from the standpoint of quality and effectiveness of job performance.**
- d) **Replicate the above-mentioned models for service and teaching programs.**

1.2 REGIONALIZATION SYSTEM



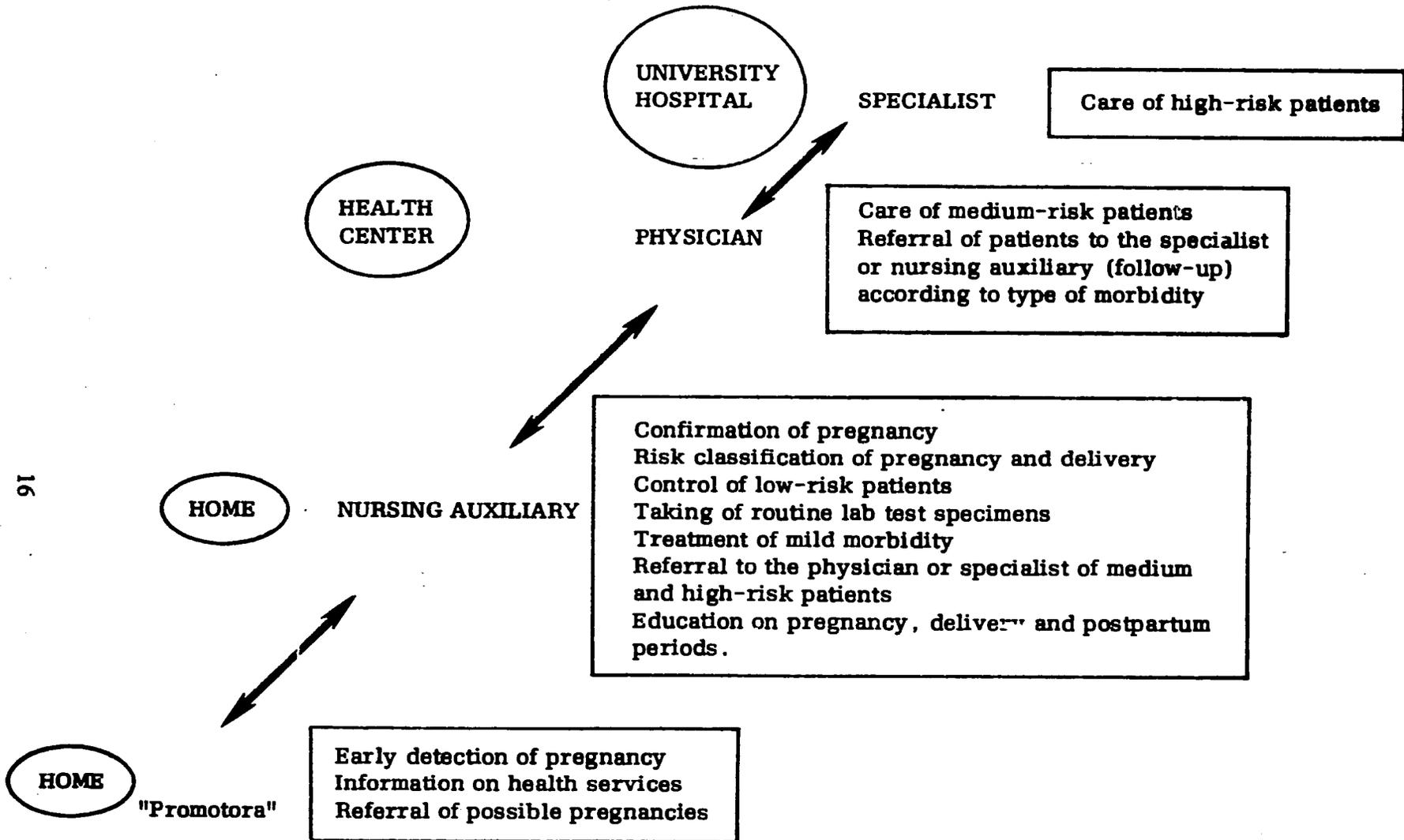
LEVEL	HOME	HEALTH POST	HEALTH CENTER	PERIPHERAL HOSPITAL	REGIONAL (UNIVERSITY) HOSPITAL
SECTORIAL DIVISION	PRIORITY WORK UNIT (P.W.U.)	BARRIO	HEALTH DISTRICT (H.D.)	AREA	REGION
POPULATION COVERED	FAMILIES WITH CHILDREN UNDER 5 YEARS OF AGE	10,000 to 20,000 INHABITANTS	100,000 INHABITANTS	250,000 INHABITANTS	2 MILLION INHABITANTS
STAFF	PROMOTORA AUXILIARY INDIGENOUS MIDWIFE	AUXILIARY PROMOTORA	M.D./DENTIST/ NURSE/TECHNICIANS/ NURSING AUXILIARIES	M.D./DENTIST/ NURSE/TECHNICIANS/ NURSING AUXILIARIES	SPECIALISTS AND "SUPERSPECIALISTS"

14

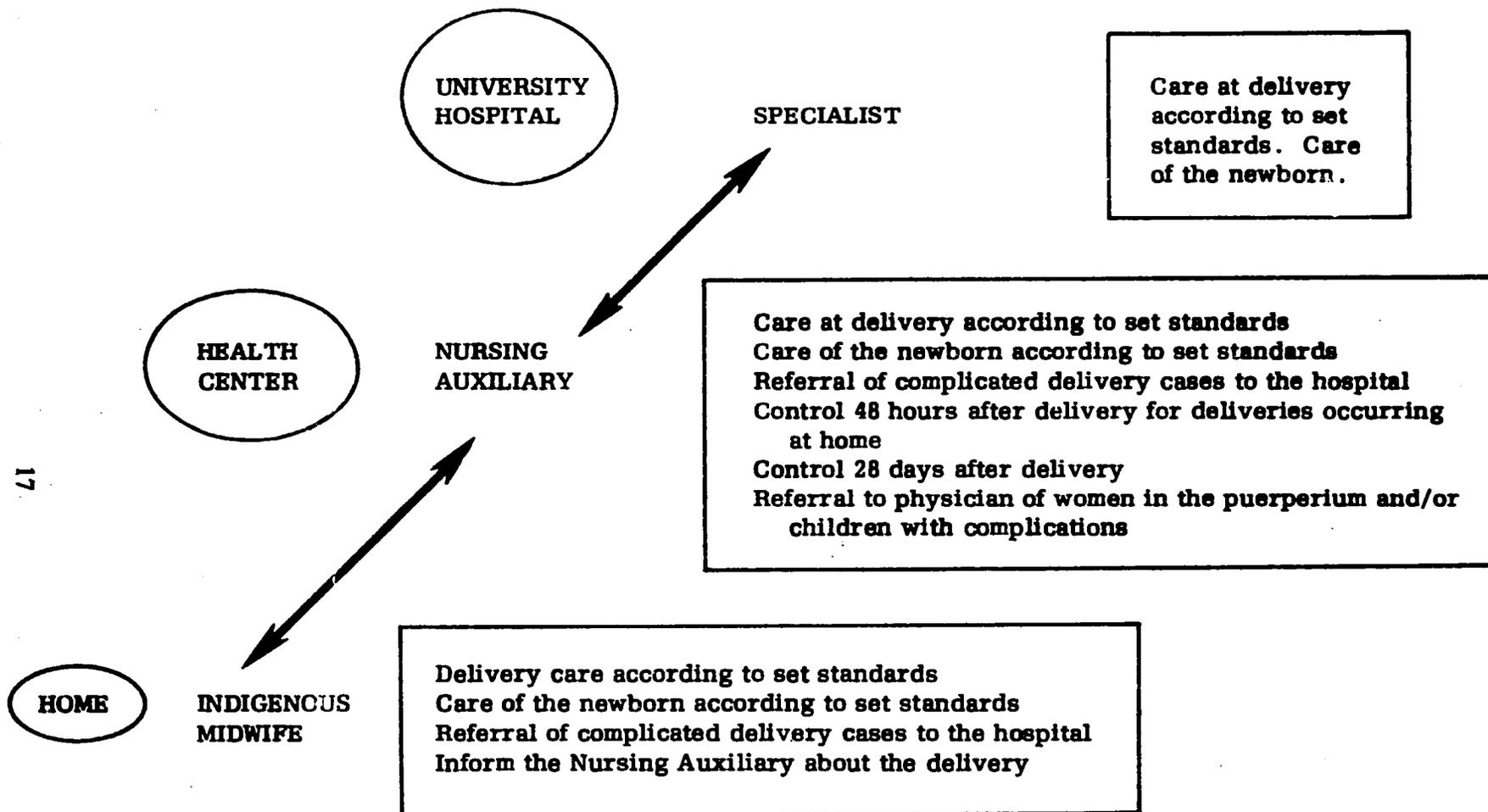
1.3 Type of Personnel Per Level of Care and Kind of Service

PERSONNEL	LEVEL OF CARE	SERVICES RENDERED
<p>Indigenous Midwife "Promotora" Nursing Auxiliary</p>	<p>Home Health Post</p>	<p>Health Education and Promotion Simplified Health Care and Prevention Treatment of Mild Morbidity Early Detection of Health Problems Referrals</p>
<p>Physician</p>	<p>Health Center Peripheral Hospital</p>	<p>Preventive Measures Medical Care Rehabilitation Referrals</p>
<p>Specialist</p>	<p>University Hospital</p>	<p>Curative Care Rehabilitation Referrals</p>

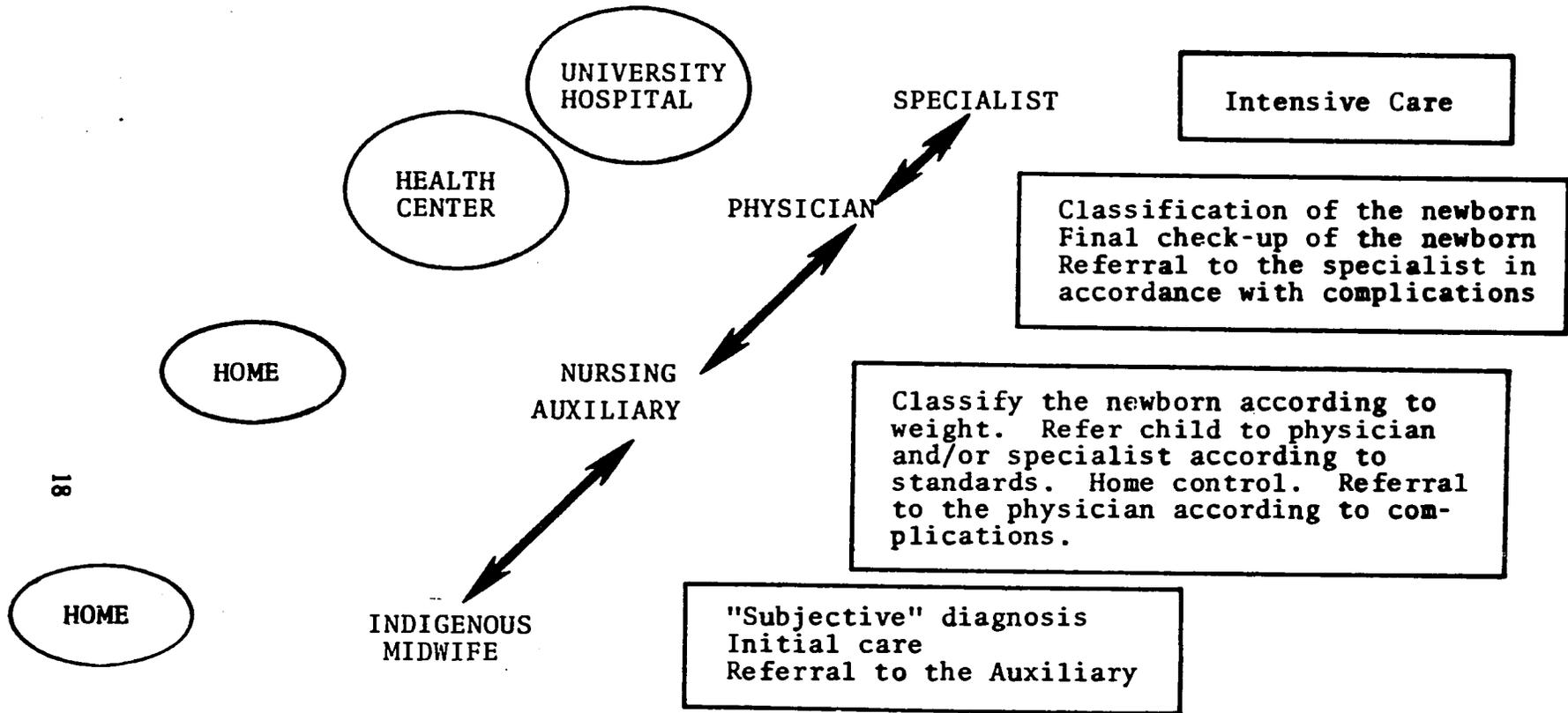
1.4 Prenatal Control



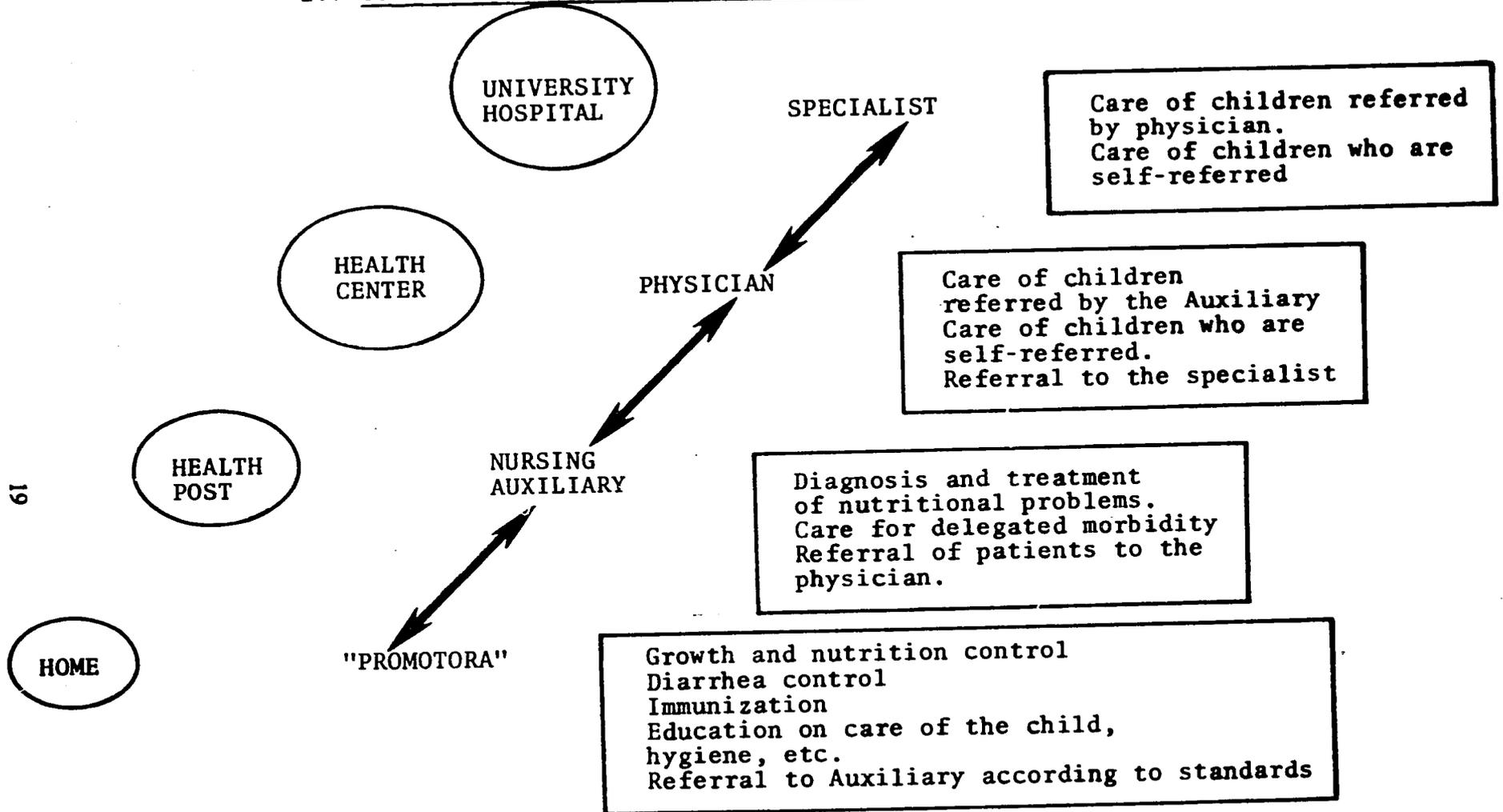
1.5 Delivery and Postpartum Care



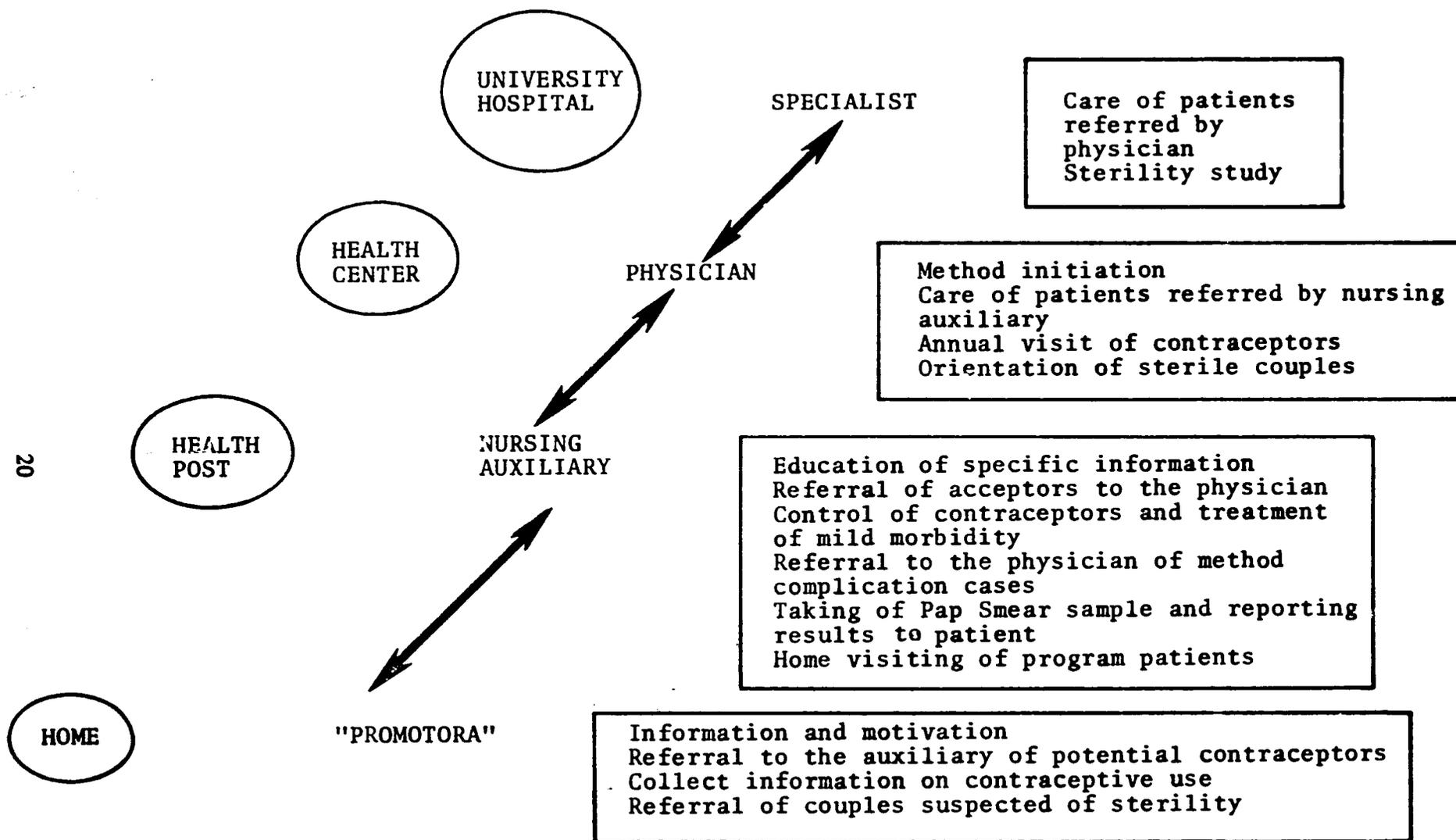
1.6 Control of Children Born Underweight



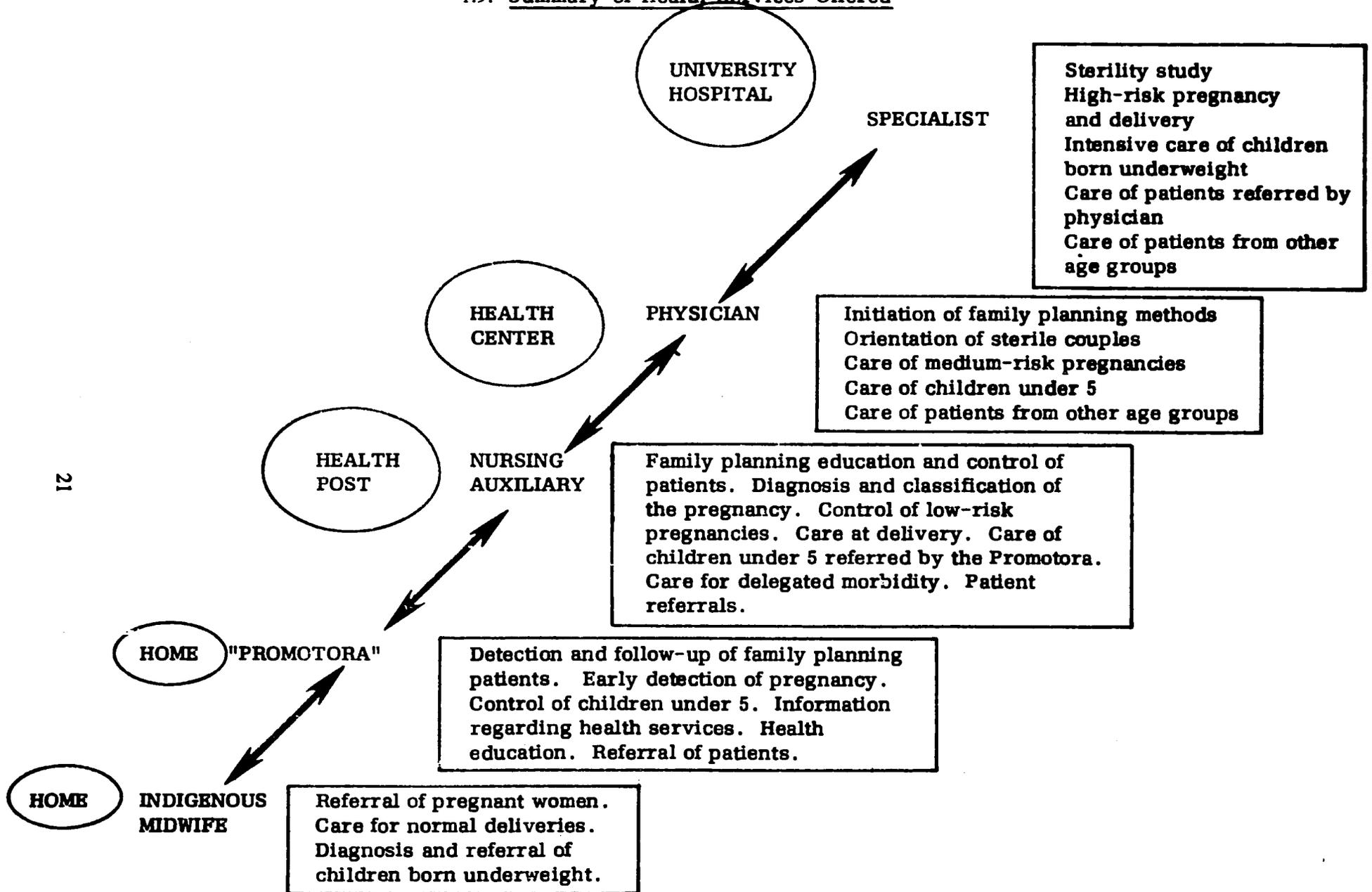
1.7 Control of Children Under Five Years of Age



1.8 Family Planning



1.9. Summary of Health Services Offered



1.10. Percentage of Services Rendered Per Level of Care

	HOME	HEALTH POST	HEALTH CENTER	PERIPHERAL HOSPITAL	UNIVERSITY HOSPITAL
<u>MOTHER</u>					
- Prenatal Control	65%	-	30%	-	5%
- Care at Delivery	60%	-	30%	-	10%
- Postpartum Control { 48 hours	60%	-	40%	-	-
{ 28 days	90%	-	10%	-	-
- Morbidity Control	-	60%	30%	-	10%
<u>CHILD</u>					
- Growth and Development	80%	10%	10%	-	-
- Immunization	100%	-	-	-	-
- Children Born Underweight	80%	-	10%	-	10%
- Morbidity Control	-	60%	30%	-	10%
<u>FAMILY PLANNING</u>					
- Education	10%	90%	-	-	-
- Method Initiation	-	-	100%	-	-
- Method Control	-	100%	-	-	-
- Morbidity Control	-	80%	20%	-	-
- Follow-up	100%	-	-	-	-
<u>SCHOOL-AGE & ADULT</u>					
- Morbidity Control { School-Age	-	-	-	95%	5%
{ Adult	-	-	-	90%	10%

* Research will determine the place where care will be provided.

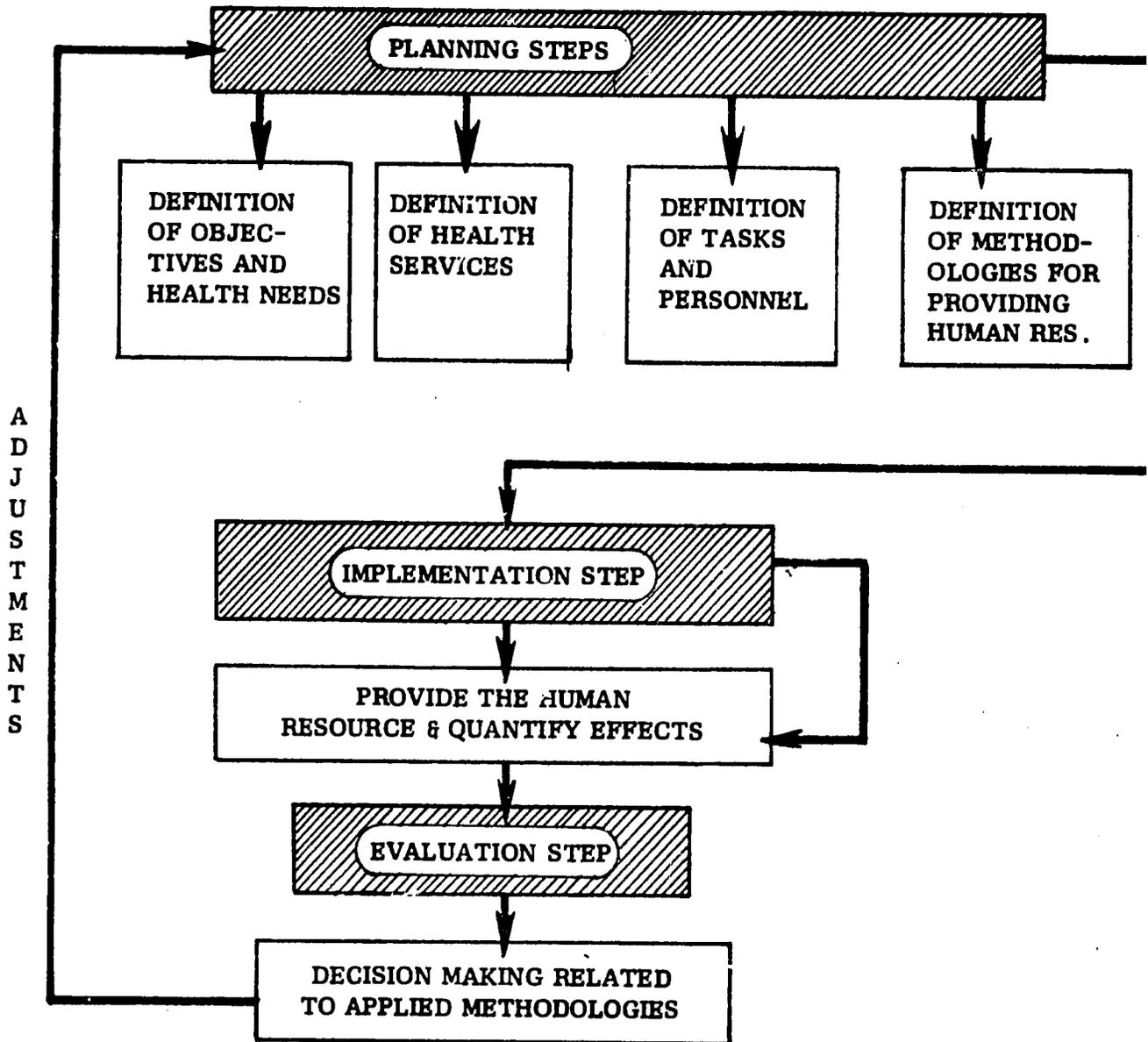
1.11. Man Years Effort (MYE)

	HOME	HEALTH POST	HEALTH CENTER	PERIPHERAL HOSPITAL	UNIVERSITY HOSPITAL
Area of Influence	2,500 inhabts.	20,000	100,000	250,000	2,000,000
Team Personnel	Indigenous Midwife 2.5 "Promotora" 1.0 Assistant 0.5 Nursing Auxilliary 0.5	Indigenous Midwife 20.0 "Promotora" 8.0 Assistant 4.0 Nursing Auxilliary 4.0 Nurse 0.1 Statistical Clerk 0.5 Secretary 1.0 Cleaning 1.0 Woman Guard 3.0			
Discharges			-	4,000	-
Deliveries	65		1,200	-	-
Consultations			-	40,000	-
Medical Hours			233	-	400

* Research will determine the place where care will be provided.

DIAGRAM 1

Diagram showing the basic activities of the H.R.D. Unit and their sequential relationship.



2.1.3 Activities

The following are the basic activities to be performed by the different elements of the H.R.D. Model:

a) Recruitment Model:

The Recruitment Model sets forth the steps to be followed in gathering a certain number of applicants from which to choose individuals who meet the proposed program requirements and who will subsequently be submitted to the selection process.

b) Selection Model:

The purpose of the personnel selection model is to evaluate each recruited applicant in order to determine whether he/she fulfills the requirements and has the qualifications which are essential to efficient on-the-job performance.

c) Training Model:

The purpose of developing the Training Model was to guarantee maximum job efficiency on the part of personnel hired by the Research Program in Health Delivery Prototype Services (PRIMOPS).

In order to prepare the Human Resource Development Unit Training Model, it was necessary to state general program objectives, program activities and the personnel required by the program. It was also indispensable to define the tasks to be performed by members of the health team in order to have a frame of reference with which to determine knowledge and skills required and/or acquired.

In addition, it was necessary to define the following: instructional objectives, training content, training strategy, training evaluation strategy as well as the place and duration of training.

d) Supervision Model:

The Supervision Model has been designed to measure the performance of members of the health team both qualitatively and quantitatively so as to determine the quality of job performance for each task. The model will be applied to each one of the health activities of the program.

e) **Evaluation Model:**

The purpose of the Evaluation Model is to measure the effectiveness of the tasks assigned to members of the health team.

2.2 **Evaluation**

2.2.1 **Definitions**

One of the crucial components of the Health/Family Planning System Model is Evaluation. Therefore, a definition of some basic concepts involved in the methodology, procedures and techniques must be stated in order to maintain a clear perspective of the evaluation parameters and their scope.

To evaluate is essentially to assign a value to the use of a resource and/or to the effect of using a resource for the purpose of making decisions. Evaluation is the process of “determining the results achieved by an activity designed to attain a goal or objective.”

The values proposed for evaluating the Cali model are:

- a) **Effectiveness:** The actual proportion of effects produced by activities performed in order to attain objectives.
- b) **Cost-Effectiveness:** The amount of money expended in attaining the effect produced by activities performed in order to attain objectives.
- c) **Efficiency:** The number of resources utilized and/or activities performed per unit of time in order to attain objectives.
- d) **Cost-Efficiency:** The amount of money expended in performing a number of activities needed to attain objectives.

The above definitions are the frame of reference to be considered in developing parameters for measuring program operation (internal evaluation) and the outcomes (external evaluation) of the model.

2.2.2 **Measurements**

The following are a number of measurements proposed for evaluating the effectiveness and efficiency of the model:

Effectiveness:

- a) Incidence and prevalence of malnutrition
- b) Incidence of mortality
- c) Incidence and prevalence of morbidity
- d) Incidence and prevalence of disability
- e) Fertility indicators:
 - Age-parity grids
 - Age-specific fertility rates
- f) Life expectancy at birth
- g) Average life expectancy
- h) Incidence of prematurity
- i) Consumer satisfaction with services received

Efficiency:

The following measurements must be compared by type of health activity, type of service, health worker and unit of time:

- a) Percentage of population coverage
- b) Percentage of referrals
- c) Number of visits
- d) Average time per visit
- e) Percentage of hospitalization
- f) Retention rates

It is evident that every indicator of efficiency must consider the three basic components of the health services structure: services, personnel, administration. In this way, the levels of efficiency attained can be related to the different components of the system.

Another important concept in evaluation is *quality control*, which is defined as compliance with norms and standards in terms of quantity, content and adequacy of activities performed to attain specific objectives. Quality control differs from efficiency in that it is not affected by time variables. The following are some examples of measurements used in quality control:

- Number of planned activities by service and health worker vs. number of activities done.**
- Completeness of tasks per activity by type of service and health worker.**
- Adequacy of activity performance by type of service and health worker.**

The above evaluation measurements will be expressed in specific rates, percentages, etc., and will be included in a manual designed for evaluation methods and techniques. The numerator and denominator for each one of these specific measurements will be obtained from the data collected systematically through home visits, clinical records, censuses, special surveys, and monthly statistical forms required by the City Health Department. Special information which is required for other evaluation aspects but which is not included in the above source, will be collected in specific standardized forms designed for specific situations.

2.2.3 Cost Analysis

A basic factor in health service evaluation is the cost estimation of operating the system and achieving its goals and objectives. A cost analysis methodology based on a five-year experience by the State Department of Health (S.S.S.) has been adapted to the model. This cost analysis methodology will provide information about the total cost of all model inputs and the direct and indirect costs of each type of service delivered. It will also provide information needed in order to estimate the costs of the different levels of efficiency and effectiveness which the model proposes to achieve. In this way, it is possible to make a cost-efficiency and cost-effectiveness analysis by comparing the processes and outcomes of our model with those of the local and regional health services.

2.2.4 Special Considerations

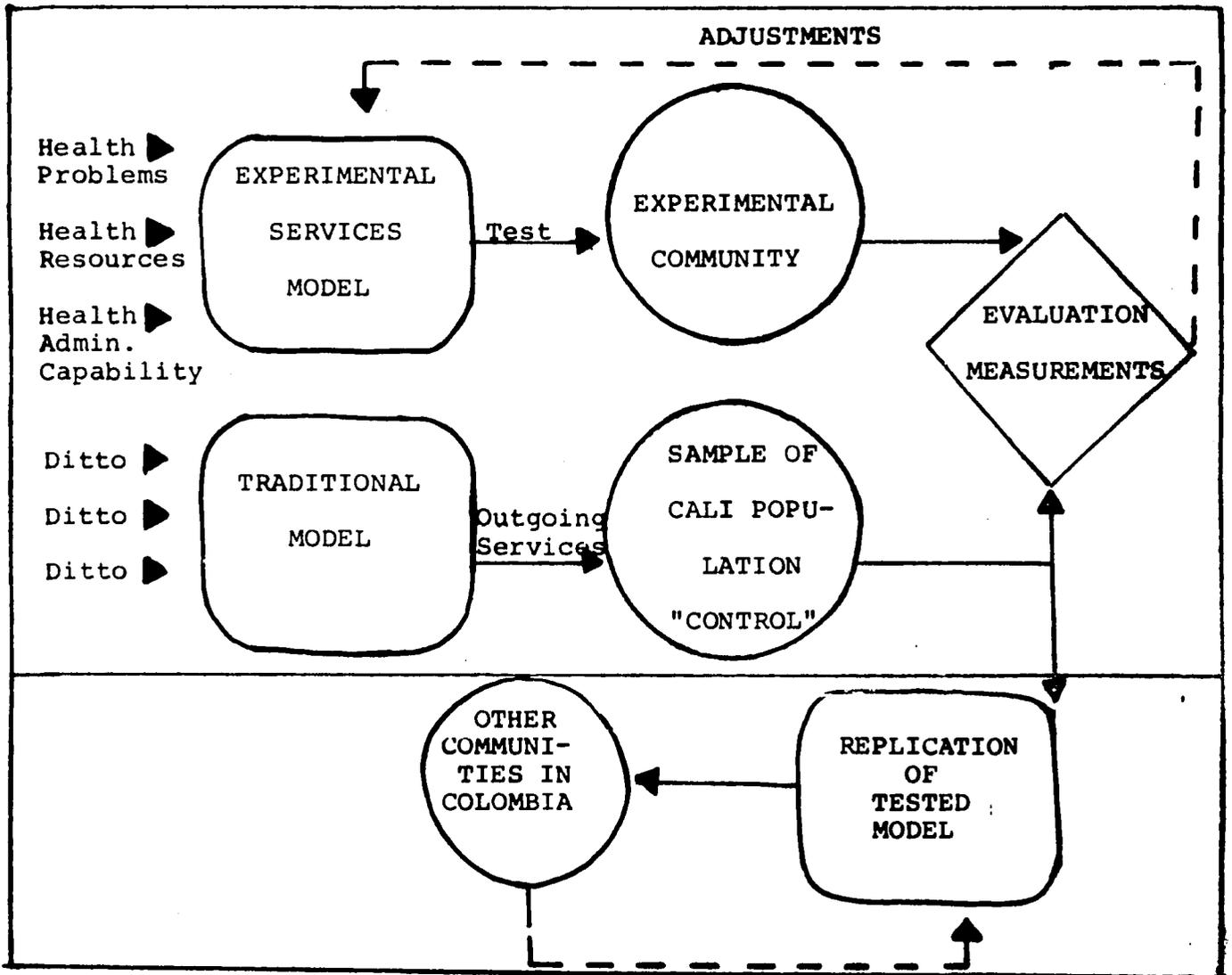
Two final points apply to the scope and evaluation methods:

- 1. In order to measure the efficiency and effectiveness of the system, some research studies must be developed in specific areas. For example, it is important to estimate the extent of change attained through certain health activities in order to formulate objectives in clear-cut, measurable terms.**

2. Cost-benefit, cost-efficiency and cost-effectiveness analyses provide basic information for making decisions of allocation of resources. These analyses also necessitate some research efforts which must be included in the evaluation program and which require the monitoring of the processes and outcomes as well as the costs of our system and another "control system" (i.e., another area in Cali with health services delivered by the Ministry of Health, or a sample of the population of Cali receiving health services from different institutions) in order to determine whether or not our system is better than others in terms of increased benefits and better efficiency and effectiveness.

2.2.5 Diagram of the Proposed Approach for Evaluation Within the H.D.S. Model

The following diagram depicts an overall view of the system model, its evaluation and further replication.



2.3 Administration

In order to maintain the necessary authority to operate health services, the management group secured its position as a special program of the City Health Department of Cali (see Chart 2). The name given to the program, "Research Program in Health Delivery Prototypes Services" (PRIMOPS) reflects its status as a research and development effort.

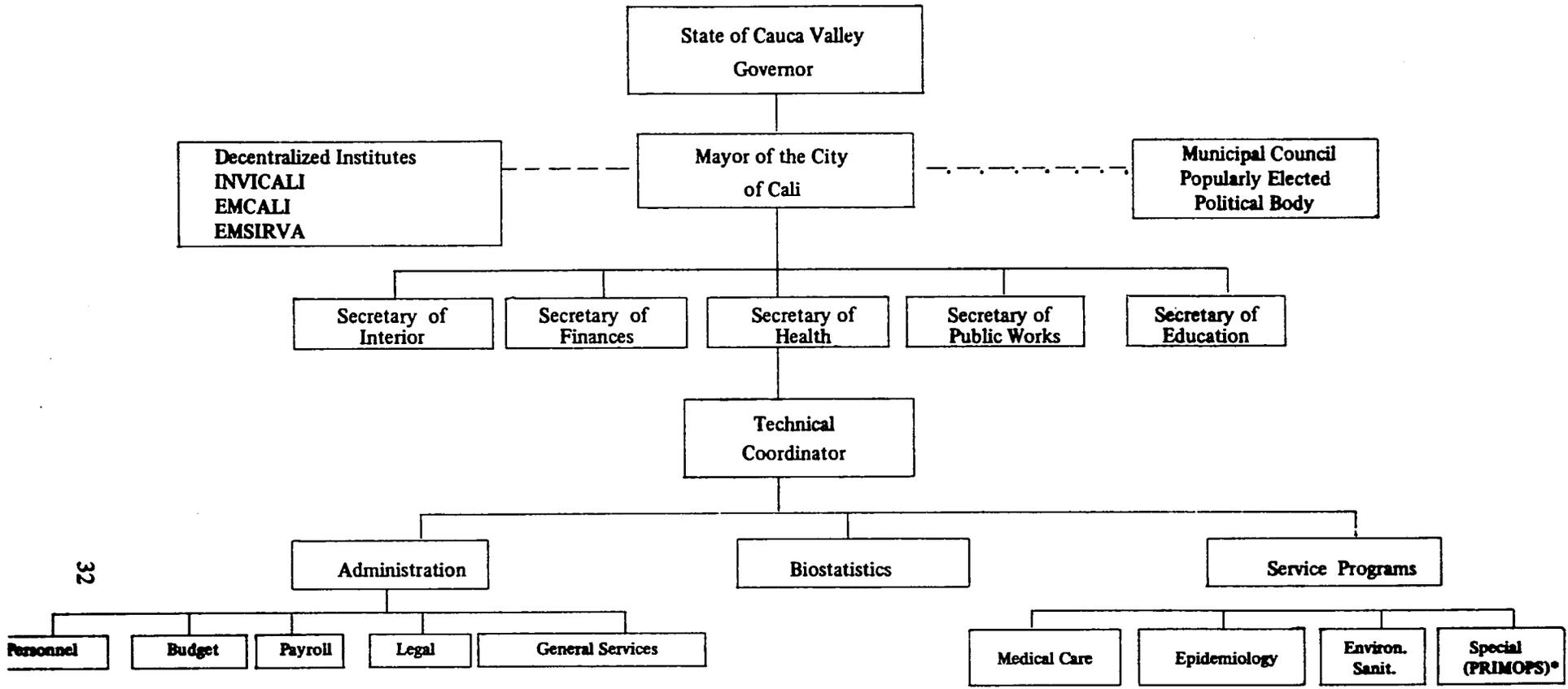
The following commitments were considered necessary to establish a workable administrative situation for the PRIMOPS program:

- a) The participation of both the Universidad del Valle and the City Health Department of Cali in the nomination and appointment of a director.
- b) The nomination of the technical coordinator of the City Health Department of Cali as Co-Director of PRIMOPS.
- c) The official designation of La Union de Vivienda Popular and its barrios for the Research Program in Health Delivery Prototype Services. This was necessary because by constitutional law community health is the responsibility of governmental health authorities and that responsibility cannot be delegated without official sanction.

The joint effort represented by the cooperation between the University and the City Health Department implies shared management for purposes of programming, implementation, administration, supervision and evaluation. Thus, the design of the Maternal and Child Health/Family Planning delivery system model, and the mechanisms and standards for management and eventual replication, are more easily approached with a view to massive application of services to the entire urban community of Cali. Moreover, it allows for very practical consideration of available and potential resources of the municipal health services.

The administrative mechanism of the PRIMOPS prototype is a complex one, since it encompasses both the delivery of the services as well as the Technical Assistance and the Training of the personnel. As will be discussed later (page 35), the funding strategy is:

- a) The present plans call for financing the Services from local sources, thus including the costs of the prototype services within the budgets of the Ministry of Health and the Cali Health District. The idea of the government is to maintain the administration of the service costs included in the regular health budgets in order to gain experience for the possible replication of the prototype.



32

Code

- line of authority
- line of informal coordination
- .-.-.-.- line of formal coordination

2.3.1. Administrative Structure of the Cali Government

* PRIMOPS = Research Program in Health Services Delivery Models Prototype Services (Our program in Cali)

Chart 2

- b) Monies for International Technical Assistance will come from The Family Health Foundation/Tulane University according to the terms of AID Contract No. CM/pha-C-73-35, June 1973. The PRIMOPS group will give T.A. to the local level. Part of these activities will be financed from the same contract monies.
- c) The operational research activities dealing with the application of specific methodologies for the operation of the PRIMOPS Program, will be funded by national (MOH, Planning Office) or international (AID, PAHO) sources.
- d) The Community Medicine Program (Project II of Universidad del Valle) is an academic program to be funded by the Pan American Federation of Medical Schools (FEPAFEM) from a grant of the Kellogg Foundation.

In this context, the funds mentioned in a) will be handled by a special account at the Cali Health District level. Funds for activities described in b), c) and d) will be channeled to Universidad del Valle and deposited in special accounts of the Foundation for Higher Education (FES).

2.3.1 Administrative Unit

The program itself will have an Administrative Unit (see Organizational Chart) which will work very closely with the Board of Directors and the Administration of the Cali Health District. This Unit will be responsible for concentrating all the information needed for establishing a complete cost accounting system for the program. Additionally, this Unit will insure that the logistical support for the operations be appropriately and timely scheduled. Also, it must develop an adequate communication system (including document reproduction), and the handling and supervision of budgets approved by the Board of Directors, as well as the preparation of the respective financial reports.

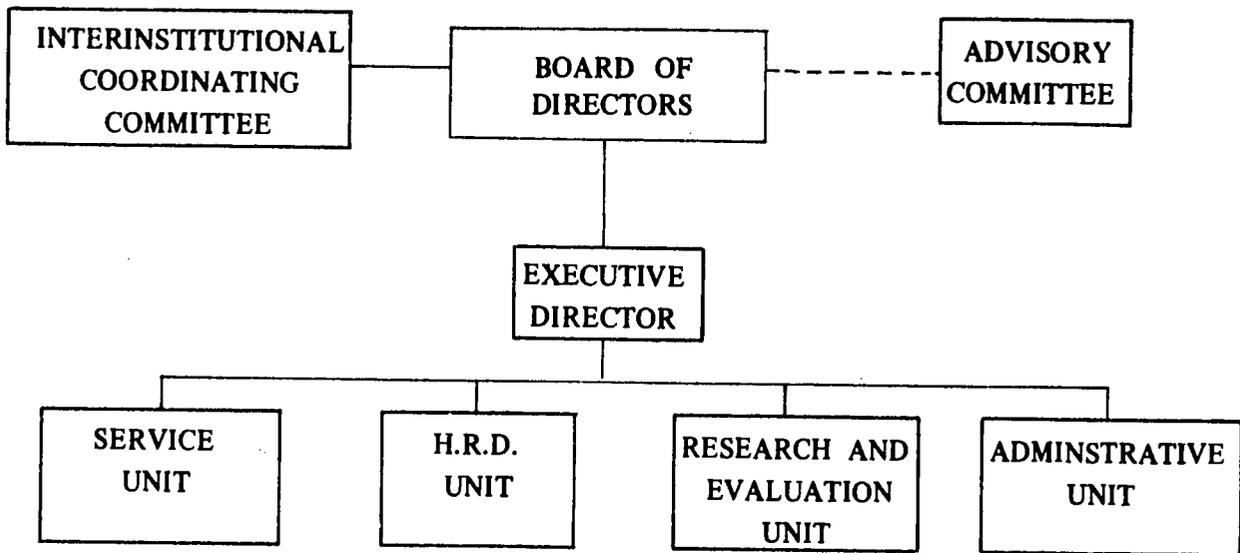
As the delivery of the Services in La Union de Vivienda Popular area will be within the province of the Cali Health District authority, a special definition of tasks and activities need to be established to avoid overlapping and interferences.

3. MANAGEMENT

3.1 Functional Organization

The functional organization of the PRIMOPS prototype, follows closely the organizational chart (page 34).

3.2 **COLOMBIA PROTOTYPE**
PRIMOPS
Cali, Colombia



Organizational Chart of the H/FP Program (Research Project in Health Delivery Models – PRIMOPS).

a) Inter-Institutional Coordinating Committee (I.C.C.)

This Committee will be composed of representatives from all Colombian organisms and institutions involved in the project at the national, state and local levels. Initially, it will have representatives from the following agencies and institutions:

National level: * Ministry of Health

State level: * Valle del Cauca Health Service

Local level: * Cali Health District
* Universidad del Valle, Division of Health

When the redesign of the Colombian Health System will be accomplished, the Social Security Institute (I.C.S.S.), the Colombian Institute for Family Welfare (I.C.B.F.), etc., will also have representatives in this Committee.

The I.C.C. intends to be a high level, general policy making group for the implementation of the PRIMOPS prototype. The cooperation shown by the different health agencies will insure an overall consistency in the Colombian health policies at the various levels. In order to accomplish such purpose, a series of internal agreements are being approved by the different parties involved (see Section D.).

This Committee will meet monthly to review the progress of the project and to establish its modus operandi. During its first meeting the Committee will determine the links between PRIMOPS and the city and state health programs, creating the final structure that will allow the actual delivery of the Services.

The Organizational Chart presented in this document (page), shows the proposed lines of authority suggested to the Committee by the PRIMOPS group. Since the actual operation of the Services is under the responsibility of the Cali Health District and the Valle del Cauca State Health Department, the supportive PRIMOPS activities must be coordinated by such agencies of the government.

4. FINANCING AND FUNDING STRATEGY

The PRIMOPS prototype requires financing of the following four main activities:

- a) Delivery of Health/Family Planning Services in the area of U.V.P. of Cali (110,000 inhabitants). The health system to be developed here must have the following characteristics: high coverage and low cost, operate within the "regionalization"

structure, use delegation of functions and develop efficient administrative systems. The funds for operating such services will come from Colombian government sources at the national, state or city levels. At the national level, the funds contributed by the Ministry of Health to this project will be utilized for the actual delivery of health services at health posts and home (see Section D, Agreement MOH/UCHD/CHD/UV). At the state and city levels, the necessary investments and allocations have been already made. (See Section D.)

- b) Technical Assistance: The Family Health Foundation will give international technical assistance to PRIMOPS for three years (See Section C). PRIMOPS itself will give the required technical assistance to the local program and the national level.
- c) Operational Research to be carried out by the PRIMOPS group in data collection, compilation and information systems, delegation of functions, referral of patients, supervision methods, community participation, health indicators and evaluation procedures. Funds for these purposes could be obtained through national (National Planning Office, Ministry of Health) or international (AID, PAHO, etc.) sources.
- d) Community Medicine Program (educational) at the Universidad del Valle, Division of Health. The aim of this program is to give to the health team (physicians, nurses, technicians, paramedical) the necessary understanding in the everyday realities of the communities as well as first-hand experience in the actual operation of an integrated health system.

Such a teaching program (undergraduate and graduate) intends to be an innovative curricular approach that will include activities at all steps of the Health System ladder: Home, Health Post, Health Center, Peripheral and University Hospitals, and the Community as a whole. The teaching responsibilities will be a commitment from all Departments of the Division of Health. Graduate training in social medicine aspects need to be stressed in order to prepare the necessary human resources to replicate the experiences mentioned above in a), b) and c) in other areas of the region, the country, or even other Latin American countries.

Several funding sources are currently being explored for graduate and undergraduate activities. Two of those are: 1) The Pan American Federation of Medical Schools (FEPAFEM) through a special grant from The Kellogg Foundation and 2) The Ford Foundation has shown some interest in supporting the training of high level professional staff able to replicate the PRIMOPS experience in Health Delivery Systems, mainly in the areas of Management, Human Resources Development and Evaluation.

TOTAL COSTS OF THE COLOMBIA PROJECT (preliminary calculation).

	Year I	Years I & II	TOTAL
I. SERVICE COSTS*	299,105	811,795	1,110,900
II. T.A. from FHF/T.U.	<u>220,513</u>	<u>275,448</u>	<u>495,961</u>
 SUB-TOTAL US\$	519,618	1,087,243	1,606,861
III. OPERATIONAL RESEARCH*	200,000	450,000	650,000
 COMMUNITY MEDICINE			
IV. AND RESEARCH IN HDS*	<u>250,000</u>	<u>330,000</u>	<u>580,000</u>
 TOTAL US\$	969,000	1,867,243	2,836,861

I. SERVICE COSTS

The Service Costs will be financed by Colombian sources and have been calculated in each of the levels of the regionalized Health System, as follows:

	Year I	Years II & III	TOTAL
I. SERVICE COSTS			
a. <u>At Health Posts</u>			
Auxiliary Personnel	38,625	244,185	282,810
Space	24,000	16,000	40,000
Equipment	6,000	7,000	13,000
Contracts/Consultants	33,200	82,500	115,700
Transportation	1,750	5,850	7,600
Consumab/Supplies	10,000	23,000	33,000
Other	4,500	11,500	16,000
SUB-TOTAL	118,075	390,035	508,110
b. <u>At Health Center</u>	29,780	72,380	102,160
c. <u>At Peripheral Hospital</u>	124,330	287,210	411,540
d. <u>At University Hospital</u>	26,920	62,170	89,090
TOTAL U.S. \$	299,105	811,795	1,110,900

*Subject to later adjustments.

At the Health Post level, the following salaries for the Auxiliary personnel comply with the Ministry of Health and the Cali Health District policies and have been the basis for the calculation of the following Table:

Category and Number	Annual Salary *	Total
1 Public Health Nurse (H.T.)	3,130	3,130
6 Auxiliary Nurses (L.P.N.'s)	1,235	7,410
10 Urban Health Promotors	480	4,800
6 Assistants to A.N. (H.T.)	250	1,500
1 Secretary	1,100	1,100
1 Statistical Clerk	1,145	1,145
3 Clerks	345	1,035
1 Surveillant	480	480
TOTAL US \$		20,600

* Subject to later adjustments.

H.T. = Half Time

L.P.N. = Licensed Practical Nurse

Salaries include Fringe Benefits

As the Program Development includes the periodical and sequential opening of five modules for an average of 22,000 people each, the following Table explains the calculated auxiliary personnel for the five modules, according to the present plans:

Beginning of Services in each Module	Year I	Years II & III **	TOTAL
First Module, July 1973	21,630	49,970	71,600
Second Module, January 1974	11,330	49,970	61,300
Third Module, April 1974	5,665	49,970	55,635
Fourth Module, July 1974	--	49,970	49,970
Fifth Module, October 1974	--	44,305	44,305
TOTAL US \$	38,625	244,185	282,810

** A 10 percent salary increase (1973 = 100) has been calculated. Salaries include Fringe Benefits.

In order to establish the approximate distribution of the Health activities and their probable average cost at each level of health care, a rough calculation has been made taking into consideration the estimated population receiving the benefit of the services, in the following two tables:

Level of Care	Year I (One module fully operational, two partially)			
	Percentage	Population	Cost in US \$	Per capita
Health Post	70%	24,500	\$118,075	\$ 4.82
Health Center	18%	6,300	\$ 29,780	\$ 4.73
Peripheral Hospital	10%	3,500	\$124,330	\$35.52
University Hospital	2%	700	\$ 26,920	\$38.45
TOTAL	100%	35,000	\$299,105	\$ 8.55

	Years II & III (All modules fully operational)			
	Percentage	Population	Cost in US \$	Per capita
Health Post	70%	154,000	\$390,035	\$ 2.53
Health Center	18%	39,600	\$ 72,380	\$ 1.84
Peripheral Hospital	10%	22,000	\$287,210	\$13.05
University Hospital	2%	4,400	\$ 62,170	\$14.13
TOTAL	100%	220,000	\$811,795	\$ 3.69

Thus, the total per capita cost for services will decrease from \$8.55 the first year, when the operation is being building up, to \$3.69 when all the modules will be in operation by the third year.

II. TECHNICAL ASSISTANCE, OPERATIONAL RESEARCH AND PROGRAM DEVELOPMENT COSTS.

The following Table will give a breakdown of the basic items of the budget for such purposes. A more detailed information will appear in SECTION C of this document.

II. TECHNICAL ASSISTANCE, OPERATIONAL RESEARCH AND PROGRAM DEVELOP- MENT COSTS	YEAR I	YEARS II & III	TOTALS
A. Personnel	* 164,500	161,500	326,000
1. T.A. Teams (N.O.)	(5.1) 104,500	(5.5) 109,500	(10.6) 214,000
a. H.R.D.	(1.7) 30,600	(1.5) 28,500	(3.2) 59,100
b. Services Delivery	(0.8) 19,700	(0.5) 12,500	(1.3) 32,200
c. Evaluation	(2.0) 36,000	(3.0) 54,000	(5.0) 90,000
d. Management	(0.6) 18,200	(0.5) 14,500	(1.1) 32,700
2. Host Country Staff	(5.0) 60,000	(4.3) 52,000	(9.3) 112,000
B. Consultants	9,000	7,000	16,000
1. U.S. Hired	5,000	4,000	9,000
2. In Country Hired	4,000	3,000	7,000
C. Travel	8,000	27,900	35,900
D. Supplies	900	9,500	10,400
E. Equipment	---	7,500	7,500
F. Other	4,000	14,000	18,000
G. GYA (27.87% of U.S. Costs)	34,113	48,048	82,161
T.A./O.R. and P.D. TOTAL in U.S. \$	220,513	275,448	495,961

* Numbers in parenthesis represent Man Years Effort (MYE).

The funds for this activity will come from the FHF/TU Contract with AID No. CM/CH/pha-C-73-35 as presently being requested by this document. If we calculate the cost per capita, following the corresponding Tables for Service Costs, the total per capita costs for the program will be:

	Year I	Years II & III
<u>Per capita costs</u>		
I Service	8.55	3.69
II TA, for O.R./P.D.	6.30	1.25
TOTAL US \$	14.85	4.94

It is important to state that total costs of the proposed program, including Technical Assistance, is planned to be less than U.S. \$5.00 per capita per year, when the program will be fully operational. Moreover, it is useful to know that high level Technical Assistance, as it is discussed in this document, will represent only 25 percent, or one fourth, of the cost of operating the program. It is also anticipated that the replication process will be less expensive, since the program will let a valuable field experience and most of the instruments used will be already tested.

III. OPERATIONAL RESEARCH

There are specific studies (pages 35 and 36) that are considered important for developing the HDS methodology taking the PRIMOPS program as a pilot area. Some of these studies are even included within the requirements of the Health Sectorial Loan Agreement signed on February 28, 1973 between the Republic of Colombia, the Ministry of Health, the National Planning Department and the United States of America (AID Loan No. 514-L-069).

The calculated costs of such activities are:

	Year I	Years II & III	TOTAL
Operational Research AID and/or PAHO	200,000	450,000	650,000

IV. COMMUNITY MEDICINE, RESEARCH IN HEALTH DELIVERY SYSTEMS.

As a complement to the PRIMOPS prototype service program, an academic program is currently being planned by the Universidad del Valle under Project II entitled: "A Program of Inter-Institutional Integration for Teaching and Research in the Delivery of Health Services." Such Program is in the preliminary phase and the following sources or terms are being thought about:

	Year I	Years II & III	TOTAL
FEPAFEM (KELLOGG FOUNDATION Grant in Community Medicine)	150,000	180,000	330,000
FORD FOUNDATION Grant for Operational Research in HDS.	100,000	150,000	250,000
TOTAL US \$	250,000	330,000	580,000

The Community Medicine Program intends to promote the training of the various levels of health personnel based on the realities found in the communities and helping the students to understand the complexities of the delivery of integrated health services, by "living the experience" of the systems approach.

The basis of the program is to expose medical and public health students, nurses and paramedical personnel to the real community problems. Such an exposure will be: a) for the undergraduate, throughout the various years of his career and b) for the candidate to become a specialist in Community Medicine, a two (2) year training. In both instances, a special curriculum has been designed, which includes theoretical courses and extensive field experience. For candidates to a degree in Community Medicine, a special dissertation on Health Delivery Systems will be required.

The general objective of this Program of Inter-Institutional Integration in Community Medicine, developed by Universidad del Valle is to overcome the usual shortcomings of the traditional trained health personnel, by complementing the ongoing academic programs with the direct experience gained by working closely in a tested community laboratory. Another

purpose of the program, is to prepare a high level health team, able to replicate the Service Model to other areas of the country and to give technical assistance to other Latin American countries. In addition to Colombian candidates, a quota for foreign students has been considered by the Universidad del Valle.

The Research in Health Delivery Systems, is aimed to use the experience gained in the PRIMOPS Service Program in order to extract its generic characteristics and establish a generic model to be used in Colombia and other Latin American countries. The areas of Management, Evaluation and Training of health personnel are the main areas considered for this program. Also, the possibility of creating a high-level health team able to work at the national and international level is being considered. Thus, this Research Program will be developed in close relationship with the Community Medicine Program.

**SECTION C. – FAMILY HEALTH FOUNDATION
TECHNICAL ASSISTANCE TO PRIMOPS**

1. INTENDED TECHNICAL ASSISTANCE INPUTS

Technical assistance and related inputs by The Family Health Foundation will be of three types: 1) FHF Core Management, Administrative and Supportive Staff, 2) FHF Technical Assistance Teams, and 3) Travel, Consultants, Equipment, Consumables and Other Related Support.

1.1 Core Management, Administrative and Supportive Staff

Important for the development of PRIMOPS will be the efforts of a FHF core staff to support overall management, funding, administrative and related requirements of the project. Based primarily in New Orleans, this staff will enable the technical assistance program to derive the full benefit of manpower and methods resources of FHF's other Louisiana based activities. This arrangement will provide for the effective sharing of expertise with PRIMOPS, and between PRIMOPS and other FHF/Latin America associated projects. The core staff will centrally coordinate and advise regarding technical assistance activities.

Some activities of the core staff will be broad in nature, to include full liaison and coordination with Colombian, United States and International organizations and agencies involved. Other activities will be more specific with reference to program planning organization, scheduling, reporting, fiscal control, staffing and staff management, communications and public relations, and fund raising. While the core staff will guide the activities of other U.S. based staff involved in the technical assistance effort, it will also provide supplementary backup to the Technical Assistance Teams in supporting the development of an independent operational capacity for the services delivery system.

The team will be composed of professionals in the medical, health, management, planning, administration, language translation and research fields. Clerical and secretarial support will be provided as required.

Core staff inputs for the first year of PRIMOPS through June 30, 1974, have been accounted for under Category I Expenses for that period under the existing AID contract. Estimated core inputs for the second and third years of project operation will be based on the same level of staffing.

1.2 FHF Technical Assistance Teams

FHF Teams of professionals will provide task-directed support to PRIMOPS in the following four areas of technical assistance: a) Human Resources Development, b) Patient Services Delivery, c) Evaluation, and d) Management. Team members will assist Colombian professionals in the design, adaptation and application of principles and concepts appropriate to quality health and family planning service delivery. They will assist Colombian agencies and institutions to prepare for the training of nationals to fill project positions, and will assist senior host country staff to assume full responsibility for their activities within the Management and Supportive Units of the operational model. Each area of technical assistance is further discussed below:

a) Human Resources Development Team

These professionals will give Technical Assistance to counterpart institutions and staff to: (1) establish systems for manpower planning, (2) devise mechanisms for the recruitment and selection of personnel, (3) develop training curricula, (4) establish guidelines for the supervision and evaluation of personnel, and (5) implement and refine approaches to staff development. The central focus of these efforts will help to equip Colombian professionals with the additional skills and materials they will require to maximize internal training capabilities for all aspects of program operation. Human Resources Development Team members will include specialists in task analysis, job design, manpower planning and evaluation, staff recruitment and selection, staff training and development.

b) Patient Services Delivery Team

Professionals of this team will give Technical Assistance to counterpart institutions and staff to: (1) plan and implement operational program components and service procedures, (2) establish standards for patient care, (3) institute mechanisms for patient recruitment and maintenance, and (4) develop and maintain the necessary patient records systems. Activities of the team will be integrated with those of medical and health personnel in the Cali area. Emphasis will be placed on providing host country managers and decision makers with additional information and techniques to select from among several alternatives for patient services delivery. Team members will help prepare host country service managers to introduce, test and refine techniques of health care. The team will be comprised of specialists in maternal and child health services, nutrition services, family planning services, patient education and clinic administration.

c) Evaluation Team

Evaluation team members will assist counterpart institutions to (1) define and arrange the mechanisms for baseline data acquisition, (2) implement the methodology for program monitoring, (3) establish the means for internal and external evaluation, and (4) supervise the experimental, research and demonstration aspects of PRIMOPS. Team members will include persons with expertise in social demography, data analysis, statistics, health systems economics, and systems analysis.

d) Management Team

The management team will be composed of individuals whose expertise encompasses the fields of finance, program planning and development, law and program administration. These professionals will assist counterpart institutions and staff to: (1) plan field aspects of overall project development and implementation, (2) formulate internal and external project policies, (3) develop the logistic and management mechanisms necessary to initiate and sustain project operation, and (4) design systems for monitoring project activities.

1.3 Travel, Consultants, Equipment, Consumables and Other Related Support

Other inputs in support of the PRIMOPS technical assistance effort will include travel, equipment, consultant fees, supplies, and other items of support as set forth in the technical assistance budget.

2. PHASING OF TECHNICAL ASSISTANCE ACTIVITIES

Technical assistance to PRIMOPS will be phased relative to the anticipated schedule for establishing patient services (see page 11). Essential methodologies and service delivery components will be built in a coordinated manner.

3. INTENDED OUTPUTS

In line with the foregoing, the following outputs are expected over the course of the project as a direct result of FHF technical assistance:

- Upgraded host country personnel capable of managing, supporting and replicating, as well as giving Technical Assistance on service delivery, human resources development, evaluation and management elements of the proposed prototype. The staff will include nine (9) full-time professionals and eleven (11) part-time experts, as follows:

... **Management**

- 1 **Project Director (F.T.)**
- 1 **Co-Director (H.T.)**
- 1 **Financial Officer (H.T.)**
- 1 **Liaison Officer (F.T.)**
- 1 **System Analyst (H.T.)**

... **Human Resources Development Supportive Unit**

- 1 **Unit Head (F.T.)**
- 1 **Training Coordinator (F.T.)**
- 1 **Counselor (H.T.)**
- 1 **Educational Administrator (H.T.)**

... **Evaluation Supportive Unit**

- 1 **Unit Head (F.T.)**
- 1 **Social Demographer (F.T.)**
- 1 **Statistician (H.T.)**
- 1 **Programmer (H.T.)**

... **Administrative Supportive Unit**

- 1 **Unit Head (F.T.)**
- 1 **Administrative Assistant (H.T.)**
- 1 **Inventory Manager (H.T.)**

... **Services Supportive Unit**

- 1 **Unit Head (F.T.)**
- 1 **Ob-Gyn Physician (H.T.)**
- 1 **Pediatrician (H.T.)**
- 1 **Nutritionist (H.T.)**

- **Increased FHf capability to provide technical assistance and administrative/management support adapted to the Latin American Region.**
- **Specific manuals for the following aspects of the prototype system:**

- ... **Clinic operations, administration and procedures.**
- ... **Delegation of functions to promotoras, indigenous midwives and auxiliary nurses.**
- ... **Record System and routing slip.**
- ... **Patient identification, outreach and maintenance.**
- ... **Cost accounting.**
- ... **KAP surveys.**
- ... **Cost analysis data collection.**
- ... **Patient and community education and information.**
- ... **Patient referral.**
- **Community household mapping and numbering system; clinic internal record system, patient history forms; mechanisms for updating patient history; patient and worker scheduling and monitoring systems; internal cost analysis system; mechanisms and systems for initiating and updating epidemiographic monitoring on such considerations as disease incidence and prevalence, morbidity and mortality by cause and degree of severity; and pregnancy history, status and outcome as related to clinic attendance and form of contraceptive and follow-up.**
- **Internal program monitoring system and annual reporting system for internal and external evaluation.**
- **An internally developed third year annual report, based on the format developed; a report on community impact regarding fertility, mortality, morbidity and patterns of health and family planning facility use; and a documented reevaluation of program planning with designs for implementing the evaluation system in additional areas.**
- **Tested and documented management techniques for analysis of institutional/agency needs, and for determining the most feasible programming strategies.**

- Established service delivery program, information/education program, training programs, record keeping systems, and independent evaluation capability.
- Effective operation of all components in tandem, and documentation of the process through which the management capacity was developed and transferred to host country staff, with a phasing out of external assistance in the management and operation of the program in the designated areas.

The means for verifying obtainment of the above outputs will be:

- Numbers of host country professional and auxiliary personnel trained.
- Percentage of target population receiving health/family planning services.
- Numbers of operation manuals, training curricula, and program documents designed, documented and disseminated.
- Data bank in operation and evaluation system fully functioning.
- Numbers of contractor staff qualified to provide technical assistance to other Latin American areas.

Verification will be accomplished by annual AID or independent evaluation of implementation against the project plan, by performance evaluation of trained staff on the job, by technician reports, and site inspections.

Critical to the obtainment of outputs will be that the prototype delivery system be culturally acceptable and economically supportable by the Colombian government in the long run. Equally critical will be that the host countries have the institutional capacity to undertake the task, and that agreements with the host countries will allow recruitment and selection of personnel who will respond favorably to training and job opportunities as well as responsibilities.

4. TECHNICAL ASSISTANCE BUDGET

FHF PROJECT EXPENSES

SUMMARY BUDGET

	<u>YEAR 1</u>	<u>YEARS 2 & 3</u>	<u>TOTAL</u>
A. SALARIES & WAGES	\$164,500	\$161,500	\$326,000
B. CONSULTANTS & CONTRACTS	9,000	7,000	16,000
C. TRAVEL, TRANSPORTATION, PER DIEM	8,000	27,900	35,900
D. SUPPLIES	900	9,500	10,400
E. EQUIPMENT		7,500	7,500
F. OTHER DIRECT COSTS	4,000	14,000	18,000
G. G & A (27.87% of U.S. COSTS)	<u>34,113</u>	<u>48,048</u>	<u>82,161</u>
 TOTALS	 <u><u>\$220,513</u></u>	 <u><u>\$275,448</u></u>	 <u><u>\$495,961</u></u>

YEAR 1
DETAILED BUDGET

	<u>SUB-TOTALS</u>	<u>TOTALS</u>
A. <u>SALARIES & WAGES</u>		
1. FHF Core Staff (covered by Core Budget)	-----	
2. FHF TA Teams		
a. Human Resources Development (1.7 MYE)* \$30,600		
b. Services Delivery (0.8 MYE) \$19,700		
c. Evaluation (2.0 MYE) \$36,000		
d. Management (0.6 MYE) <u>\$18,200</u>	\$104,500	
3. Host Country Personnel		
a. Management/Admin. (5.0 MYE)	<u>60,000</u>	
b. Supportive Units		
(TOTAL SALARIES & WAGES)		\$164,500
B. <u>CONSULTANTS & CONTRACTS</u>		
1. U.S. Hired Consultants 20 Man-Days @ Average \$125/day	\$ 2,500	
2. U.S. Data Processing	2,500	
3. In-Country Hired Consultants 40 Man-Days @ Average \$50/day	2,000	
4. In-Country Data Processing	<u>2,000</u>	
(TOTAL CONSULTANTS & CONTRACTS)		\$ 9,000

**Man-Years of Effort*

	<u>SUB-TOTALS</u>	<u>TOTALS</u>
C. <u>TRAVEL, TRANSPORTATION, PER DIEM</u>		
1. <u>Domestic</u>		
Air Travel (2 trips @ Average \$200/trip)	\$ 400	
Ground Travel	100	
Per Diem (12 days @ Average \$24/day)	<u>300</u>	
		\$ 800
2. <u>International</u>		
Air Travel (12 trips @ Average \$400/trip)	\$4,800	
Ground Travel	480	
Per Diem (96 days @ Average \$20/day)	<u>1,920</u>	
		<u>\$7,200</u>
(TOTAL TRAVEL, ETC.)		\$ 8,000
D. <u>SUPPLIES</u>		
Administrative & Instructional Supplies		\$ 900
E. <u>EQUIPMENT</u>		-----
F. <u>OTHER</u>		
Insurance, Subscriptions, Publications, Telephone, Repairs, Postage, etc.		\$ 4,000
G. <u>G & A (27.87% of U.S. Costs)</u>		<u>\$ 34,113</u>
1st YEAR TOTAL		<u><u>\$220,513</u></u>

YEARS 2 & 3
DETAILED BUDGET

	<u>SUB-TOTALS</u>	<u>TOTALS</u>
A. <u>SALARIES & WAGES</u>		
1. FHF Core Staff (to be covered by Core Budget)		
2. FHF TA Teams		
a. Human Resources Development (1.5 MYE)	\$28,500	
b. Services Delivery (0.5 MYE)	\$12,500	
c. Evaluation (3.0 MYE)	\$54,000	
d. Management (0.5 MYE)	<u>\$14,500</u>	
	\$109,500	
3. Host Country Personnel (4.3 MYE)	<u>52,000</u>	
(TOTAL SALARIES & WAGES)		\$161,500
B. <u>CONSULTANTS & CONTRACTS</u>		
1. U.S. Hired Consultants 20 Man-Days @ Average \$125/day	\$ 2,500	
2. U.S. Data Processing	1,500	
3. In-Country Hired Consultants 30 Man-Days @ Average \$50/day	1,500	
4. In-Country Data Processing	<u>1,500</u>	
(TOTAL CONSULTANTS & CONTRACTS)		\$ 7,000

	<u>SUB-TOTALS</u>	<u>TOTALS</u>
C. <u>TRAVEL, TRANSPORTATION, PER DIEM</u>		
1. <u>Domestic</u>		
Air Travel (20 Trips @ Average \$200/Trip)	\$ 4,000	
Ground Travel	1,000	
Per Diem (100 Days @ Average \$25/day)	<u>2,500</u>	
		\$ 7,500
2. <u>International</u>		
Air Travel (32 Trips @ Average \$400/Trip)	\$12,800	
Ground Travel	1,600	
Per Diem (300 Days @ Average \$20/day)	<u>6,000</u>	
		<u>\$20,400</u>
(TOTAL TRAVEL, ETC.)		\$ 27,900
D. <u>SUPPLIES</u>		
Administrative & Instructional Supplies	<u>\$ 9,500</u>	\$ 9,500
E. <u>EQUIPMENT</u>		
Simultaneous Interpretation Equipment	\$ 5,000	
Language Instruction Equipment	\$ 600	
Education & Other	<u>\$ 1,900</u>	\$ 7,500
F. <u>OTHER</u>		
Insurance, Subscriptions, Publications, Telephone, Repairs, Postage, etc.		\$ 14,000
G. <u>G & A (27.87% of U.S. Costs)</u>		<u>\$ 48,048</u>
YEAR 2 & 3 TOTAL		<u><u>\$275,448</u></u>

SECTION D. CONTRACTS AND AGREEMENTS

In order to insure the approval of the Ministry of Health regarding the PROMOPS Program and its replicability and financing, a series of contracts and agreements were negotiated as follows:

a) June 16th, 1972

Agreement between the City of Cali and the Universidad del Valle, whereby a research program in health service delivery models (PRIMOPS) was to be developed in the urban area of Cali. Signed by the Mayor of Cali and the Rector of the Universidad del Valle. Copies of such agreements appear in the following pages, in order to show the Colombian commitment for the PRIMOPS Program.

b) September 21st, 1972

Contract between the Public Health Service of the State of Valle del Cauca and the City Health Department for integrating their health services - signed by the Ministry of Health, the Governor of Valle del Cauca State, the Cali City Official, the Mayor of Cali and the Chief of the Health Service of Valle del Cauca State.

c) July 1st, 1973

Agreement between The Family Health Foundation and the Universidad del Valle (Health Division) for testing and documenting HDS in the Union de Vivienda Popular area of the City of Cali. Signed by the FHF Chairman of the Board and the Dean of the Health Division, Universidad del Valle.

d) September 20th, 1973

Agreement between the Ministry of Health, the Valle del Cauca State Health Department, the Cali Health District and the Universidad del Valle, to establish the participation of the above-mentioned agencies represented in the "Research Program in Health Delivery Service Models"—PRIMOPS.

T r a n s l a t i o n

PRELIMINARY AGREEMENT BETWEEN THE CITY OF CALI
AND UNIVERSIDAD DEL VALLE

PURPOSE: To establish a "RESEARCH PROGRAM IN HEALTH SERVICES DELIVERY MODELS" between the City of Cali (Public Health Department) and Universidad del Valle (Health Division).

It is agreed between the undersigned CARLOS HOLGUIN SARDI and HERNAN CRUZ RIASCOS, who are respectively the Mayor and Representative of the CITY OF SANTIAGO DE CALI, who will henceforth be referred to as the "MUNICIPIO," on one hand and on the other, HUGO RESTREPO RAMIREZ, Rector of Universidad del Valle, who will henceforth be referred to as the UNIVERSITY, with identifying documents appearing after the signatures:

FIRST: THE MUNICIPIO and THE UNIVERSITY commit themselves to jointly carry out a RESEARCH PROGRAM IN HEALTH SERVICES DELIVERY MODELS (See Appendix 1), in the urban area of the Municipio of Cali, served at present by the Municipal Health Center which encompasses the "barrios" Antonio Nariño, Unión de Vivienda Popular, Villa del Sur (Periquillo phase 2) and Maracaibo.

SECOND: THE MUNICIPIO appoints the City Health Department of Cali as the agency in charge of advancing said program on its behalf, and in turn, the UNIVERSITY delegates this responsibility to its Health Division.

THIRD: The health services to be delivered through or as a result of the program will be delivered regardless of race, religion or political convictions.

FOURTH: The execution of the Program will remain within the framework of the objectives, criteria and procedures which are to be established jointly between the MUNICIPIO and the UNIVERSITY, based upon the responsibility of the MUNICIPIO for health coverage of the Cali communities - a responsibility which cannot be delegated nor diminished by the program or as a result of it.

FIFTH: The joint execution of the Program implies a shared management for all purposes of PROGRAMMING, IMPLEMENTATION, SUPERVISION, EVALUATION and SERVICES, for which the MUNICIPIO through the City Health Department and the UNIVERSITY through the Health Division, will each designate a professional linked with them, who after consultation with their respective Institutions will define the policies and priorities of the Program, will promote its financing, will draw up an annual budget for it and will propose the mechanisms for the coordination and implementation of the activities.

SIXTH: Bearing in mind the stability of the program in its initial development stages, the UNIVERSITY ratifies the appointment of Dr. Alfredo Aguirre Castaño as a Co-director of the Program and the MUNICIPIO in turn, through Resolution No. 002 of January 21, 1972 of the City Health Department, designates Dr. Oscar Henao Cabal as Co-director, with the stipulation that either party may remove their own representative after previous notice to the other party.

SEVENTH: THE UNIVERSITY AND THE MUNICIPIO agree to establish five (5) OPERATING UNITS for the development of the program, that is: 1) INFORMATION UNIT, 2) EVALUATION UNIT, 3) HUMAN RESOURCES UNIT, 4) COMMUNICATION AND MOTIVATION UNIT and 5) ADMINISTRATIVE SERVICES UNIT. The first four units correspond to the functions of research design and control and will fall under the supervision of the co-directors.

The fifth unit is an administrative unit which will fall directly under the supervision of the City Health Department of Cali.

EIGHTH: The administrative unit for health services will be composed of personnel, equipment, resources, standards and functions assigned by the MUNICIPIO through the City Health Department, to the Health Center described in the First Clause of this contract.

NINTH: The design of the health services delivery models and the mechanisms and standards for evaluation should be approached with a view to the possibility of a massive application of said services to the entire urban community of Cali within the financial and medical means of the municipal health services.

TENTH: The delivery of services to the area which is at present served by the City Health Center located in the Barrio Antonio Nariño, will gradually incorporate into its present objectives of maternal and child care, the purposes, objectives, standards and procedures established by the Research Program, to the extent that the results of such research make this advisable, in the opinion of the MUNICIPIO.

ELEVENTH: The financing of the program will be the joint responsibility of the UNIVERSITY and the MUNICIPIO as follows: the UNIVERSITY will be responsible for financing, with special funds obtained for this purpose, the services which are developed with the sole aim of rendering the research viable. The MUNICIPIO in turn will be responsible for financing the present delivery of health services at the Antonio Nariño Center as well as additional services to be delivered to the community as a consequence of the research according to the aims and means examined in the NINTH clause of this agreement.

TWELFTH: The research activities which are carried out by personnel of any academic level or by personnel who join in the delivery of services in the Antonio Nariño Center or which fall within the sphere of influence of the program must be coordinated with the MUNICIPIO, through its Research Program.

THIRTEENTH: The program will be developed in accordance with the following phases:

Phase 1: Feasibility Study: undertaken between the date on which the agreement was signed and December 31 of nineteen hundred and seventy-two.

Phase 2: Operational: for a four-year (4) period, that is between January 1 of nineteen hundred and seventy-three and December 31 of nineteen hundred and seventy-six.

Phase 3: Evaluation: from January 1 through December 31 of nineteen hundred and seventy-seven. The development of phases 2 and 3 will be a logical consequence of the achievements of phase 1.

FOURTEENTH: The duration of this agreement will be until the 31st of December of nineteen hundred and seventy-seven (1977) when phase 3 of the program will end. However this agreement can be rescinded voluntarily by either one of the parties on December 31 of any of the calendar years between 1972 and 1976.

Signed in the city of Cali on the _____ day of the month of
nineteen hundred and seventy-two

t r a n s l a t i o n

CONTRACT BETWEEN THE PUBLIC HEALTH SERVICE OF VALLE DEL CAUCA STATE
AND THE CITY OF CALI FOR THE INTEGRATION OF HEALTH SERVICES
IN THE CALI METROPOLITAN AREA

This agreement is signed between Hernan Perez Alvarez, adult, resident of Cali with I.D. No. 2697080 issued at Zarzal on behalf of the Public Health Service of Valle del Cauca State (hereafter referred to as the Service) as chief of the latter and Dr. Carlos Holguin Sardi (I.D. 6075955 - issued in Cali) and Hernan Cruz Riascos (I.D. No. 225076 - Issued in Dagua), Mayor and Councilman of the City of Cali respectively duly authorized by municipal agreement No. 0014 of 1967, Article 17 to represent the city of Cali (hereafter referred to as the City). Municipal agreement No. 0014 of 1967 was the instrument for restructuring the Cali City Health Department and Article 10 empowered such department to implement an integration plan for all health services in Cali in accordance with executive order No. 1499 of 1965. Article 13 of the above-mentioned municipal agreement recognized that there would be occasions when it might become necessary for the City Health Department to cooperate in the implementation of health policies with neighboring municipalities or to participate in health efforts involving areas larger than the city of Cali, through the City Health Department. Bearing in mind all of the preceeding, the Service and the City agree to celebrate the present contract for the integration of health services subject to the following clauses:

FIRST: The purpose of this agreement is the technical and administrative integration of all health services in Cali and surrounding areas through the Cali City Health Department which is hereby designated as the Cali Health District.

SECOND: The legal instruments for the constitution of the Cali Health District and on which basis this agreement is signed are the following:

a) Integration Agreement for the Valle State Health Services signed between the Ministry of Health and Community Improvement organizations, signed on October 26, 1966; b) Act No. 12 of 1963, National Decree No. 1499 of 1966 and Valle State Health Service Resolution No. S-39 of 1971 and Cali City Council Agreement No. 0014 of 1967.

THIRD: Valle State Health Service Resolution No. S-30 of 1971 will be applicable to the Cali Health District, especially whenever it pertains to extending jurisdictional powers of the municipalities of Cali, Yumbo, Jamundi, La Cumbre, Dagua, and Vijes. The Service recognizes that the special characteristics of the Cali Health District make it necessary to set up certain special conditions for the implementation of this agreement and accepts that the District Director's post be vested in the person of the Secretary of Health for the City of Cali, a position which is to be filled by appointment made by the mayor of the city of Cali with concurrent dismissal powers and vests above-said secretary with the authority of jurisdiction over all health matters for all municipalities of the Cali Health District in accordance with Resolution S-39 of 1971.

FOURTH: Income and Revenue. The income and revenue for the Cali Health District are comprised of: a) regular and extraordinary appropriations by the Ministry of Health through the Service for health service programs within the municipality; b) regular appropriations made by the Valle State Health Service for health programs within the Cali Health District; c) regular and extraordinary appropriations made by the Ministry of Health through the Service for health programs in the Cali District; d) all other private and public funds appropriated for the same purpose; e) national and international grants and bequests that either natural or judicial entities

make to health programs within the Cali Health District.

FIFTH: Special obligations of the City and the Service. The City and the Service hereby commit themselves to maintain funds appropriated to be invested in the establishment and operation of the Services for the Health District in an amount of not less than fiscal appropriations of 1972. Fund increases will be made proportionate to increments in the respective budgets.

PARAGRAPH: It is understood that the payment of the funds that each contractual party agrees to contribute will be subject to obtaining the respective budgetary appropriations.

PARAGRAPH: The contributions of the Service and the national government will be transferred to the Treasurer of the District who will maintain them in a special account and, in turn, will transfer funds to the District Director as needed. In the same manner as soon as the City Council has approved the contributions of the City, these will be paid.

SIXTH: Organizational Structure. The Cali Health District will represent the local operational level for health activities within the area of its jurisdiction, operating under the supervision and evaluation of the Service. The latter will constitute the sectional level and will operate within the framework of standards set by the Ministry of Health which constitutes the national level.

SEVENTH: The Cali Health District will have the following functions:

- a) direction, programming and supervision of the health activity in the district in accordance with the State Health Plan within the conditions established in the second and third clauses of this agreement not withstanding all other currently valid regulations;
- b) Document and contract processing including statutory bylaws of the participating institutions for the approval of the Service and the Ministry of Public Health;
- c)

collection, receiving, management, investment and supervision of all monies due to the Cali Health District; d) Issuance of legal standards in health matters in accordance with guidelines set by the Ministry of Health and the Valle State Sectional Health Service; e) imposition of penalties for violations against health regulations.

EIGHTH: On the Director's Position. The Secretary of Health for the City of Cali will be the Director for the Cali Health District, appointments which will be made by the Mayor of Cali subject to dismissal by the same authority.

PARAGRAPH: The Director will act within the District as the personal representative of the Service and within the municipality the Director will be considered the top health official.

NINTH: On the Cali Health District Board. The Cali Health District will have a board composed of four members: one hospital director, representing all hospitals in the area and elected by the directors of these; two representatives for the city - one of whom is a physician appointed by the Mayor of Cali and one Technical Coordinator of the del Valle Health Service.

PARAGRAPH: The Hospital Director and the representatives of the City of Cali will have a one-year term of office, beginning with the date on which they assume office.

SECOND PARAGRAPH: The Secretary of Health for Cali as District Director will attend the Board meetings and have a vote in the event of a tie.

TENTH: On the Functions of the Cali Health District Board: These functions are as follows: a) to determine the structure and regulations for the District and all further amendments proposed by the Director; b) to approve the total budget for the District and all amendments proposed by the Director; c) Prepare internal regulations for the District Board; d)

determine personnel policies for the Cali Health District Staff; e) Supervise the implementation of standards within the Health District, the Service, and the Ministry of Health; f) Approve a health plan for the District on the basis of a proposal prepared by the Director and submit it to the Service for approval; g) Advise District Director on all health matters.

PARAGRAPH: In order to validate activity covered by items a) and b), it is necessary to have the approval of the city municipality and the service.

ELEVENTH: The Cali Health District Director will have 60 days to submit to the Board the proposed regulations and organizational structure for the District. Municipal agreement 0014 of 1976 will be instrumental. Amendments will serve only to adjust the structure of the Health District to its functions.

PARAGRAPH: The validity of this agreement is subject to the approval of the structure and the regulations of the Health District by the Mayor's Office and the Service.

TWELFTH: To carry out the functions of the Cali Health District, the Director will have a minimal staff as follows: one Technical Coordinator (Public Health Physician); one Director of the Medical Care Program (Public Health); one Director of the Epidemiology Program (Public Health Physician); one Director of Sanitation (Public Health or Sanitation Engineer); one Administrator-Disburser (Economist or Business Administration); one Public Health Nurse; one Statistician (Intermediate level).

PARAGRAPH: Appointments to these positions will be made by the District Director and approved by the City and the Service.

PARAGRAPH: It is understood that the members of the Call Health District Staff will be considered public employees and as such will be subject to the provisional regulations for municipal employees. They will work full-time and will not be permitted to hold any other governmental position simultaneously.

THIRTEENTH: The terms of this agreement can be applied individually or extended according to the needs of the District by means of additional amendment clauses to be signed by the contracting parties, thus becoming part of this agreement.

FOURTEENTH: The present agreement supersedes the agreement signed on June 10, 1967 between the Service and the City.

FIFTEENTH: The term of this agreement will be until December 31, 1973 with an option to extend it for additional yearly periods.

PARAGRAPH: It is understood that yearly extensions will be in force automatically unless one of the contracting parties notifies the other of its decision to rescind the agreement within 60 days prior to the expiration date.

SIXTEENTH: The present agreement requires the approval of the Governor of Valle State and the fiat of the Minister of Public Health.

SEVENTEENTH: Default in any of the contractual obligations contained in the present agreement will entitle the other contracting party to consider it annulled.

EIGHTEENTH: This agreement does not require stamped legal paper or tax applied to documents and will be published in the Valle State official bulletin.

Signed on the 21st day of September, 1972.

HERNAN PEREZ ALVAREZ
Chief of the Public Health
Service of Valle del Cauca State

CARLOS HOLGUIN SARDI
Mayor of Cali

HERNAN CRUZ RIASCOS
Cali City Official

APPROVED BY:

MARINO RENGIFO SALCEDO
Governor of Valle State

fiat

JESUS MARIA SALAZAR BUCHELI
Minister of Public Health

TRANSL/REQ

3-7-73

AGREEMENT

PART 1 (of 2 parts)

THIS AGREEMENT, entered into as of this 1st day of July, 19 73, by and between THE FAMILY HEALTH FOUNDATION, of the Parish of Orleans, State of Louisiana, hereinafter referred to as "THE FOUNDATION", and UNIVERSIDAD DEL VALLE - DIVISION DE SALUD of the City Cali Country of Colombia, hereinafter referred to as the "CONTRACTOR".

WITNESSETH THAT:

THE FOUNDATION and the CONTRACTOR do mutually agree as follows:

1. The CONTRACTOR shall, in a satisfactory and proper manner as determined by THE FOUNDATION, perform the following:
 - a. Test and provide documentation for the health delivery system's performance in the first module of 15,000 persons at the Union de Vivienda Popular (U.V.P.). The documentation will include cost, referral, logistics and appointments records.
 - b. Prepare census U.V.P.
 - c. Morbidity profile of U.V.P.

THE FOUNDATION shall furnish the following services, data and information to the CONTRACTOR:
Technical expertise and minor clerical assistance.

2. The CONTRACTOR shall commence performance of this contract on the 1st day of July, 19 73, and shall complete performance to the satisfaction of THE FOUNDATION no later than the 31st day of December, 19 73.

3. The CONTRACTOR shall maintain such records and accounts, including property, personnel and financial records, as are deemed necessary by THE FOUNDATION or its funding agencies, to assure a proper accounting for all project funds, both Federal and non-Federal shares. These records will be made available for audit purposes to THE FOUNDATION or the Comptroller General of the United States or any authorized representative, and will be retained for three years after the expiration of the contract unless permission to destroy them is granted by both THE FOUNDATION and the funding agency.

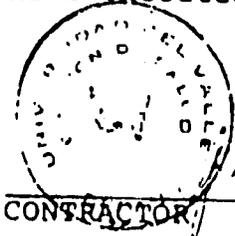
4. Compensation. For travel and related expenses. Should travel be required to complete performance on the part of the CONTRACTOR, the CONTRACTOR shall submit to THE FOUNDATION a travel expense account, itemizing such expenses. Maximum allowance per mile by automobile, maximum per diem subsistence expenses and other travel related expenses shall be set in compliance with the General Provision of the Agency for International Development (A.I.D.). Such travel must be authorized in writing before the actual travel is commenced, or such expenses are not reimbursable.

5. Method of Payment. THE FOUNDATION agrees to pay CONTRACTOR the sum of Six Thousand and No/100 Dollars (\$6,000.00) per month. Payments will be made monthly with the first payments due on the 1st day of July, 1973, and subsequent payments on the 1st day of each month until the end of the term of this agreement.

6. It is expressly understood and agreed that in no event will the total amount to be paid by THE FOUNDATION, to the CONTRACTOR under this agreement exceed \$36,000.00 for full and complete satisfactory performance.

7. This agreement is subject to and incorporates the attached Part II; "TERMS AND CONDITIONS GOVERNING CONTRACTS FOR PROFESSIONAL OR TECHNICAL SERVICES TO THE FAMILY HEALTH FOUNDATION".

8. IN WITNESS WHEREOF, THE FOUNDATION and the CONTRACTOR have executed this agreement as of the date first above written.



CONTRACTOR

[Handwritten signature]

Joseph D. Beasley, M.D.
THE FAMILY HEALTH FOUNDATION

POSITION

[Handwritten signature]
WITNESS

Carol Beaumont
WITNESS

PART II (of 2 parts)

TERMS AND CONDITIONS GOVERNING CONTRACTS FOR PROFESSIONAL OR TECHNICAL SERVICES TO THE FAMILY HEALTH FOUNDATION

In addition to any conditions specified in Part I, this contract is subject to all of the conditions listed below. Waiver of any of these conditions must be upon the express written approval of an authorized representative of THE FOUNDATION, and such waiver shall be made a part of this contract.

1. TERMINATION OF CONTRACT. If, through any cause, the CONTRACTOR shall fail to fulfill in timely and proper manner his obligations under this contract, or if the CONTRACTOR shall violate any of the covenants, agreements, or stipulations of this contract or if the grant funding this contract is terminated by the funding agency THE FOUNDATION shall thereupon have the right to terminate this contract by giving written notice to the CONTRACTOR of such termination and specifying the effective date thereof. If the CONTRACTOR is unable or unwilling to comply with such additional conditions as may be lawfully imposed by the funding agency on the grant, the CONTRACTOR shall have the right to terminate the contract by giving written notice to THE FOUNDATION, signifying the effective date thereof. In the event of termination all property and finished or unfinished documents, data, studies, and reports purchased or prepared by the CONTRACTOR under this contract shall, at the option of THE FOUNDATION, become its property and the CONTRACTOR shall, at the option of THE FOUNDATION, become its property and the CONTRACTOR shall be

entitled to compensation for unreimbursed expenses necessarily incurred in satisfactory performance of the contract. Notwithstanding the above, the CONTRACTOR shall not be relieved of liability to THE FOUNDATION for damages sustained by THE FOUNDATION by virtue of any breach of the contract by the CONTRACTOR, and THE FOUNDATION may withhold any reimbursement to the CONTRACTOR for the purposes of set-off until such time as the exact amount of damages due THE FOUNDATION from the CONTRACTOR is agreed upon or otherwise determined.

2. CHANGES. THE FOUNDATION may, from time to time, request changes in the scope of the services of the CONTRACTOR to be performed hereunder. Such changes, including any increase or decrease in the amount of the CONTRACTOR'S compensation, which are mutually agreed upon by and between THE FOUNDATION and the CONTRACTOR, must be incorporated in written amendments to the contract.

3. TRAVEL EXPENSES. If the CONTRACTOR is to be reimbursed for travel expenses, and (1) if the CONTRACTOR is a public agency, expenses charged for travel shall not exceed those allowable under the customary practice in the government of which the agency is a part; or (2) if the CONTRACTOR is a private agency, expenses charged for travel shall not exceed those which would be allowed under the rules of the United States Government governing official travel by its employees.

4. COPYRIGHTS. If the contract results in a book or other copyrightable material, the author is free to copyright the work, but THE FOUNDATION and the funding agency reserves a royalty-free, nonexclusive and irrevocable license to reproduce, publish, or otherwise use, and to authorize others to use, all copyrighted material and all material which can be copyrighted resulting from the contract.

5. PATENTS. Any discovery or invention arising out of or developed in the course of work aided by this contract shall be promptly and fully reported to THE FOUNDATION and the funding agency for determination as to whether patent protection on such inventory or discovery shall be sought and how the rights in the invention or discovery, including rights under any patent issued thereon, shall be disposed of and administered, in order to protect the public interest.

6. COVENANT AGAINST CONTINGENT FEES. The CONTRACTOR warrants that no person or selling agency or other organization has been employed or retained to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee. For breach or violation of this warrant, THE FOUNDATION shall have the right to annul this contract without liability or, in its discretion, to deduct from the compensation, or brokerage or contingent fee.

7. **DISCRIMINATION IN EMPLOYMENT PROHIBITED.** The CONTRACTOR will not discriminate against any employee employed in the performance of this contract, or against any applicant for employment in the performance of this contract because of race, creed, color, or national origin. The CONTRACTOR will take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their race, creed, color, or national origin. This requirement shall apply to, but not be limited to, the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation, and selection for training, including apprenticeship. In the event that the CONTRACTOR signs any contract which would be covered by Executive Order 10925 (March 6, 1961) or Executive Order 11114 (June 22, 1963), the CONTRACTOR shall include the equal-employment opportunity clause specified in section 301 of Executive Order 10925, as amended.

8. **DISCRIMINATION PROHIBITED.** No person in the United State shall, on the ground of race, creed, color or national origin, be excluded from participation in, be denied the proceeds of, or be subject to discrimination in the performance of this contract.

9. **POLITICAL ACTIVITY PROHIBITED.** None of the funds, materials, property or services contributed by THE FOUNDATION or the CONTRACTOR under this contract shall be used in the performance of this contract for any partisan political activity, or to further the election or defeat of any candidate for public office.

10. **RELIGIOUS ACTIVITY PROHIBITED.** There shall be no religious worship, instruction or proselytization as part of or in connection with the performance of the contract.

11. **COMPLIANCE WITH LOCAL LAWS.** The CONTRACTOR shall comply with all applicable laws, ordinances, and codes of national and local governments in which THE FOUNDATION is authorized to expedite its grant function.

12. **REPORTS AND INSPECTIONS.** The CONTRACTOR shall make financial program progress, and other reports as requested by THE FOUNDATION or the funding agency's representatives at the request of either.

– TRANSLATION –

**AGREEMENT BETWEEN THE MINISTRY OF HEALTH, THE VALLE DEL CAUCA
STATE HEALTH DEPARTMENT, THE CALI HEALTH DISTRICT AND THE
UNIVERSIDAD DEL VALLE**

The undersigned, JOSE MARIA SALAZAR BUCHELI, Minister of Public Health; HERNAN PEREZ ALVAREZ, Head of the Valle del Cauca State Health Department; HUMBERTO LORES, Director of the Cali Health District; and ALBERTO LEON, Rector of the Universidad del Valle, have signed the following agreement:

WHEREAS:

- a) An agreement was signed on June sixteenth (16), 1972 between the City of Cali and the Universidad del Valle, whereby a research program in health service delivery models was to be developed and implemented in the urban area of Cali;
- b) A contract was signed on September twenty-first (21), 1972 between the Valle del Cauca Health Department and the Cali City Health Department integrating their health services;
- c) The Ministry of Public Health has a special interest in participating in and directing the research program currently being carried out and utilizing its results.

THEREFORE, the above-mentioned parties agree on the following:

CLAUSE I. – OBJECTIVE. – The objective of this agreement is to describe in detail the participation of the agencies represented in the “Research Program in Health Service Delivery Models.”

CLAUSE II. – The Ministry of Health and the Valle del Cauca State Health Department adhere and accept to participate in the “Research Program in Health Services Delivery Models” together with the signing parties of the aforementioned agreement signed on June 16, 1970.

CLAUSE III. – For the purpose of carrying out such research a technical committee will be created, composed of a representative from each of the undersigned agencies and having the following functions: a) to formulate work regulations; b) to supervise the execution of the research project; c) to advise program management; d) to propose program adjustments needed for easy replication in other areas; e) to ensure that the agreement is fully complied with; f) to provide a continuous flow of information to the agencies involved.

CLAUSE IV. – The obligations of the City Health Department (Cali Health District) and of the Universidad del Valle will be those established in the agreement signed between them at the outset of the research project.

CLAUSE V. – The obligations of the Ministry of Public Health will be: a) to contribute the sum of \$1,000,000 Colombian Pesos during the 1973 fiscal year; b) to provide guidelines for the research project by means of its technical units (Planning Office, Human Resources Development Division, Medical Care Division).

PARAGRAPH 1. The funds contributed by the Ministry of the research project can only be utilized in the actual delivery of health services. The Cali Health District will be in charge of managing such funds and they will be administered as part of its own budget.

PARAGRAPH 2. Subsequent additional funds by the Ministry will be made available in accordance with the results of periodical program evaluation and the funds available to the Ministry. Such allocations will be made by means of additional amendments to this agreement.

CLAUSE VI. – The Valle del Cauca State Health Department will have the following obligations: a) to collaborate in the research by means of its technical and operational units; b) to supervise directly the management of the funds contributed by the Ministry of Health.

CLAUSE VII. – Program management will, through the technical committee, place at the disposition of the signing agencies all of the documents and progress reports at every stage of the research process. The signing agencies will be able to make use of these documents and reports and will be able to adopt the program proposals and results according to their own judgment.

CLAUSE VIII. – The “Research Program in Health Service Delivery Models” can be visited by officials of the undersigned agencies who will receive any orientation and training needed to replicate the results in other areas if such an action is desirable.

CLAUSE IX. – All publications resulting from the research project must mention the participation of the signing agencies.

CLAUSE X. – This agreement will be of the same duration as that signed between the Cali City Health Department (Cali Health District) and the above-mentioned Universidad del Valle. That agreement is considered incorporated into this one.

CLAUSE XI. – This agreement is exempt from any legal dues (stamp and seal). It is effected and signed in the City of Bogota, on the 20th day of the month of September of 1973.

(signed)

(signed)

JOSE MARIA BUCHELI, M.D.
Minister of Public Health

HERNAN PEREZ ALVAREZ, M.D.
Head of the Valle del
Cauca State Health Department

(signed)

(signed)

HUMBERTO LORES, M.D.
Head of the Cali Health District

ALBERTO LEON, PH.D.
Rector,
Universidad del Valle

TRANSL./REQ-VA
9-13-73