

EPI 2.2

Project Copy PDKAS 333

AID 1350-1 (10-79)	UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY AGENCY FOR INTERNATIONAL DEVELOPMENT	1. Cooperating Country Dominican Republic	Page 1 of Pages 65
		2. PIO/T No. 517-0242-3-70045	3. <input checked="" type="checkbox"/> Original or Amendment No. _____
		4. Project/Activity No. and Title 517-0242 LAC Accelerated Immunization Project	
		5. Appropriation Symbol 721171021	

11/2/87 - sent to
 12/1/87 - sent to
 12/1/87 - sent to
 12/1/87 - sent to

6. Allotment Symbol and Charge LDHA 87-25517-KG13		7. Obligation Status <input checked="" type="checkbox"/> Administrative Reservation <input type="checkbox"/> Implementing Document		8. Project Assistance Completion Date (Mo., Day, Yr.) July 31, 1991	
9. Authorized Agent AA/LAC		10. This PIO/T is in full conformance with PRO/AG 598-0643/597-0005 Date Aug. 14, 1986			
11a. Type of Action and Governing AID Handbook <input type="checkbox"/> AID Contract (HB 14) <input type="checkbox"/> PASA/RSSA (HB 12) <input checked="" type="checkbox"/> AID Grant (HB 13) <input type="checkbox"/> Other				11b. Contract/Grant/PASA/RSSA Reference Number (If this is an Amendment) N/A	

12. Estimated Financing (A detailed budget in support of column (2) is attached as attachment no. B)

Maximum AID Financing	A. Dollars	(1) Previous Total	(2) Increase	(3) Decrease	(4) Total to Date
		-0-	705,000	-0-	705,000
	B. U.S.-Owned Local Currency				

13. Mission References

STATE
 047589
 (2/18/87)
 SD5099
 (5/14/87)

14a. Instructions to Authorized Agent

The authorized agent is requested to amend grant agreement No. CAR-0005-G-00-6971-00 to reflect USAID/DR buy-in (under Mission project No. 517-0242). The terms and conditions of the original grant agreement remain in full force for purpose of the amendment.

P700098

14b. Address of Voucher Paying Office
 FM/PAFD, SA-12
 Agency for International Development
 Washington, D.C.

15. Clearances—Include typed name, office symbol, telephone number and date for all clearances.

A. The project officer certifies that the specifications in the statement of work are technically adequate		Phone No.	B. The statement of work lies within the purview of the initiating and approved agency programs	
Lee R. Hougen, HPD		Date 6/21/87	PRG: J. Philpott	
C. CRD: P. Gall		Date 6/21/87	D. Funds for the services requested are available	
			CONT: T. Bebout	

16. For the cooperating country: The terms and conditions set forth herein are hereby agreed to		17. For the Agency for International Development	
Signature _____	Date _____	Signature <u>Lee R. Hougen</u>	Date <u>6/24/87</u>
Title _____		Title <u>Chief, Health & Population Div.</u>	

Distribution made 6/26/87

AID 1350-1 (10-79)	1. Cooperating Country Dominican Republic	2. PIO/T No. 517-0242-5-70045	Page 2 of Pages 65
PIO/T	4. Project/Activity No. and Title 517-0242 LAC Accelerated Immunization Project (598-0643/597-0005)		

SCOPE OF WORK

18. THE SCOPE OF TECHNICAL SERVICES REQUIRED FOR THIS PROJECT ARE DESCRIBED IN ATTACHMENT NUMBER A HERETO ENTITLED "STATEMENT OF WORK".

19. SPECIAL PROVISIONS

- A. LANGUAGE REQUIREMENTS (SPECIFY) See Statement of Work.
(IF MARKED, TESTING MUST BE ACCOMPLISHED BY AID TO ASSURE DESIRED LEVEL OF PROFICIENCY)
- B. ACCESS TO CLASSIFIED INFORMATION WILL WILL NOT BE REQUIRED BY TECHNICIAN(S).
- C. DUTY POST(S) AND DURATION OF TECHNICIANS' SERVICES AT POST(S) (MONTHS)
- D. DEPENDENTS WILL WILL NOT BE PERMITTED TO ACCOMPANY TECHNICIAN.
- E. WAIVER(S) HAVE BEEN APPROVED TO ALLOW THE PURCHASE OF THE FOLLOWING ITEM(S) (COPY OF APPROVED WAIVER IS ATTACHED)
- F. COOPERATING COUNTRY ACCEPTANCE OF THIS PROJECT (APPLICABLE TO AID/W PROJECTS ONLY)
 - HAS BEEN OBTAINED HAS NOT BEEN OBTAINED
 - IS NOT APPLICABLE TO SERVICES REQUIRED BY PIO/T

G. OTHER (SPECIFY)

This PIO/T relates to a buy-in to an established project.

20. BACKGROUND INFORMATION (ADDITIONAL INFORMATION USEFUL TO AUTHORIZED AGENT)

See complete background information in Statement of Work, Attachment A.

21. SUMMARY OF ATTACHMENTS ACCOMPANY THE PIO/T. (INDICATE ATTACHMENT NUMBER IN BLANK)

- B DETAILED BUDGET IN SUPPORT OF INCREASED FUNDING (BLOCK 12)
- _____ EVALUATION CRITERIA FOR COMPETITIVE PROCUREMENT (BLOCK 14)
- _____ JUSTIFICATION FOR NON-COMPETITIVE PROCUREMENT (BLOCK 14)
- A STATEMENT OF WORK (BLOCK 18)
- _____ WAIVER(S) (BLOCK 19) (SPECIFY NUMBER)

AID 1350-1 (10-79)	1. Cooperating Country Dominican Republic	2. PIO/T No. 517-0242-3-70045	Page 3 of	Pages 65
	4. Project/Activity No. and Title 517-0242 LAC Accelerated Immunization Project (598-0643/597/0005).			

22. Relationship of Contractor or Participating Agency to Cooperating Country and to AID

A. Relationships and Responsibilities

See Statement of Work.

B. Cooperating Country Liaison Official

PAHO/DR, EPI staff.
SESPAS National Vaccination Program Staff.

C. AID Liaison Officials

Dr. Lee R. Hougen, Chief, Health & Population Div, USAID/DR.

LOGISTIC SUPPORT

23. Provisions for Logistic Support					
A. Specific Items (Insert "X" in applicable column at right. If entry needs qualification, insert asterisk and explain below in C. "Comments")	IN KIND SUPPLIED BY		FROM LOCAL CURRENCY SUPPLIED BY		TO BE PROVIDED OR ARRANGED BY SUPPLIER
	AID	COOPERATING COUNTRY	AID	COOPERATING COUNTRY	
(1) Office Space					
(2) Office Equipment					
(3) Housing and Utilities					
(4) Furniture					
(5) Household Equipment (Stoves, Refrig., etc.)					
(6) Transportation in Cooperating Country					
(7) Transportation To and From Country					
(8) Interpreter Services/Secretarial					
(9) Medical Facilities					
(10) Vehicles (official)					
(11) Travel Arrangements/Tickets					
(OTHER SPECIFY) (12)					
(13)					
(14)					
(15)					

B. Additional Facilities Available From Other Sources

- APO/FPO N/A
 PX N/A
 COMMISSARY N/A
 OTHER (Specify, e.g., duty free entry, tax exemption)

STATEMENT OF WORK

1. Background.

As part of its child survival strategy, USAID/DR is providing US\$705,000 to the LAC Accelerated Immunization Program in the Americas to support certain activities of the program that will be implemented in the Dominican Republic to carry out the Expanded Program of Immunization (EPI) managed by the Pan American Health Organization (PAHO) and executed by the Secretariat of State for Public Health and Social Welfare (SESPAS). Support to the SESPAS EPI program has been presented to AID/W in the Mission's FY 88-89 Action Plan.

2. Scope of Work.

A. The LAC Accelerated Immunization Program.

The rationale, goals and objectives and specific activities of the LAC Accelerated Immunization program (Projects Nos. 598-0643 and 597-0005) are contained in the Grant Agreement (No. CAR-0005-G-00-6971-00) between AID and PAHO dated August 14, 1986. This document, which is available in LAC/DR/HN and in USAID/DR, sets the overall framework for the Accelerated Immunization program. The US\$20,600,000 provided under the grant by AID/W to PAHO strengthens PAHO's headquarters and field administrative support, management, reporting and evaluation as well as the provision of materials to the overall program in the Americas. Country specific plans of action are contained in the National Plans of Action.

B. National Plan of Action for the Dominican Republic.

With technical assistance from PAHO, and in collaboration with USAID/DR, UNICEF and the Rotary Club, SESPAS has prepared a National Plan of Action for the Dominican Republic. The Plan of Action together with implementation timetables is contained in Annex 1. The original AID Grant Agreement to PAHO permits USAIDs to enter into bilateral agreements with host governments to cover costs not included in the original proposal and are anticipated to provide resources over and above the \$20,600,000 provided in the original grant. USAID/DR wishes to make its contribution of \$705,000 to PAHO for the LAC Immunization program in the Dominican Republic to be executed by SESPAS by means of a buy-in to the original grant to carry out the activities presented in the National Plan and costed out in the accompanying budget. In establishing these funding arrangements, USAID/DR is following the guidance it received from AID/W in STATE 047589, dated February 18, 1987, and the funding procedures the Mission communicated to AID/W in SANTO DOMINGO 5099 dated May 14, 1987. (See Annexes 2 and 3). Furthermore, preliminary to acceptance of the National Plan of Action, USAID/DR, PAHO/DR, UNICEF and the

Rotary Club have signed a Agreement describing the roles and responsibilities of the donors and implementors of the immunization program in the Dominican Republic. (See Annex 4).

3. Relationship of the LAC Accelerated Immunization Program to the USAID/DR Development Strategy for the Dominican Republic.

In the FY 88-89 Action Plan, the Mission set forth its commitment to a child survival program as part of the strategy to promote equitable economic growth as a means to improve living standards, and provide improved access to needed health care and family planning services. The Action Plan further states (page 3):

The USAID program is focused on those elements of poverty with which the Agency's Strategic Plan is most concerned. First, we are supporting efforts that will create or increase productive and sustained employment within the private sector. The greater individual income that results will enable poor Dominicans to secure social and other services that the public sector cannot afford to provide. This should have a significant impact on the hunger problem because malnutrition in the Dominican Republic is more a function of income level than the availability of food. However, in the short-term, immediate measures must be taken to deal with the current high rate of malnutrition found in the country.

Child survival and related efforts are needed to carry the malnourished through a critical period until the results of longer term measures that deal with the basic causes of the problem are felt. We will address other health problems by attempting to make the large and poorly financed public health system more efficient and better able to provide services to those who cannot afford to secure them on their own. To address the currently rising rate of infant mortality, we are using PVOs to implement child survival interventions and to expand the availability of potable water which is of critical importance in improving family health. For those who can afford to pay for minimum preventive and curative care, we will help broaden the coverage and lower the cost of private health service systems. We will also help the country reduce population growth by increasing the availability of voluntary family planning services.

Under the Action Plan goal of "Wider Sharing of the Benefits of Growth", Objective No. 10: "Reduce Infant and Child Mortality" provides the rationale for the immunization program for the Dominican Republic. Objective No. 10 is presented in its entirety in Annex 5.

CICLO

PROGRAMA AMPLIADO DE INMUNIZACION

País: REPUBLICA DOMINICANA

1. PLAN DE ACCION, FINANCIAMIENTO ANUAL DE AREAS DE ACCION POR FUENTES, 1997.

(en miles de US\$)

Area de Accion: BIOLÓGICOS Y FARMACÉUTICOS

Actividad	Período	Trimestral	Unidad	Tipo	Fuente Externa										Fuente Nacional		ERPA		
					D	P	S	UNICEF	AID	BID	ICLQUE	TOTAL	%	RECIBIDOS	OTROS	TOTAL		%	TOTAL
					Feg.	PID	BID	Total		LEO	POSTAR.								
1.1 Cancelación de la deuda con el Fondo	US\$ 189,425.42	IX	SEC. ADM. INV.	INV.			1.0					0.0				0.0			
Presupuesto				FUN.			1.0					0.0		169.5		169.5	189.5		
				TOTAL	1.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	169.5	0.0	169.5	1.0	189.5	
1.2 Adquisición de biológicos	Polio: 204 2,912,000 dosis DTP: 204 2,615,145 dosis Saram. y C. 542,020 dosis TET: 204 342,000 dosis TT: 204 1,405,990 dosis	IX	INV.	INV.			1.0					0.0				0.0			
				FUN.			1.0	59.0	145.4		149.9	1143.4		58.7		58.7	202.1		
				TOTAL	1.0	0.0	0.0	1.0	59.0	145.4	0.0	149.9	1143.4	0.7	58.7	0.0	58.7	0.3	202.1
1.3 Adquisición de jeringas y agujas	Jeringas 23x1" 3,100,000 Jeringas 25x1" 450,000 Jeringas ocase 16x1 1,000 Agujas 23x3/8" 10,000	IX	INV.	INV.			1.0					0.0				0.0			
				FUN.			1.0	3.5	113.0			113.5		18.5		18.5	132.0		
				TOTAL	1.0	0.0	0.0	1.0	3.5	113.0	0.0	0.0	113.5	10.9	18.5	0.0	18.5	0.1	132.0
1.5 Adquisición de insumos para vacunación	Alcohol 2275 gal. x 84.8 Algodon 2275 libras x 43	IX	INV.	INV.			1.0					0.0				0.0			
				FUN.			1.0					0.0		17.9		17.9	17.9		
				TOTAL	1.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	17.9	0.0	17.9	1.0	17.9	
				INV.	1.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
TOTAL				FUN.	1.0	0.0	0.0	1.0	52.5	115.4	0.0	149.9	1256.9		254.6	0.0	254.6	1.5	
				TOTAL	1.0	0.0	0.0	1.0	53.5	115.4	0.0	148.0	1256.9	0.5	254.6	0.0	254.6	0.5	541.5

3)

CAPAC

PROGRAMA AMPLIADO DE INCENTIVACION

País: REPUBLICA DOMINICANA

1. PLAN DE ACCION, FINANCIAMIENTO ANUAL DE AREAS DE ACCION POR FUENTES, 1987.

(miles de US\$)

Area de Accion: CAPACITACION

Actividades	Resultado Esperado	Trimestre		Tipo de Unidad de Costo	Fuente Externa							Fuente Nacional				TOTAL					
		1	2		0	P	S	UNICEF	AID	PID	ICLUS	TOTAL	%	163E	INDIC		TOTAL	%			
		11E1314	IR		Responsible	IR	Responsible	IR	Responsible	IR	Responsible	IR	Responsible	IR	Responsible		IR	Responsible			
3.1 Seminario Nacional para revision de las normas del programa y del Esquema de Vacunacion	170 personas, 2 dias	IX	IX	DIR. EPI.	INV.	1.0			1.0									0.0		1.0	
					IFUN.				0.0											0.0	
					TOTAL	1.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	1.0	1.0			0.0	0.0	1.0	
3.2 Impresion y difusion de las normas del programa	110,000 x10.5	IX	IX	DIR. EPI.	INV.				0.0	5.0										5.0	
					IFUN.	5.0			5.0												5.0
					TOTAL	5.0	0.0	0.0	5.0	5.0	0.0	0.0	0.0	10.0	1.0			0.0	0.0	10.0	
3.3 Capacitacion Pedicos y enfermeras al nivel Regional y Provincial	130 personas, 7 cursos, 2 dias x 49	IX	IX	DIR. EPI.	INV.				0.0	5.0										5.0	
					IFUN.				0.0												0.0
					TOTAL	0.0	0.0	0.0	0.0	5.0	0.0	0.0	0.0	5.0	1.0			0.0	0.0	5.0	
3.4 Capacitacion vacunadores en tecnica aplicacion PCE	1200 personas, 2 dias x 80	IX	IX	DIR. EPI.	INV.	1.0			2.2	3.2										3.2	
					IFUN.				0.0												0.0
					TOTAL	1.0	0.0	2.2	3.2	0.0	0.0	0.0	0.0	3.2	1.0			0.0	0.0	3.2	
3.5 Reproduccion del manual del Promotor de Salud actualizado	18000 ex. x 82	IX	IX	GENACES	INV.				0.0	16.0										16.0	
					IFUN.				0.0												0.0
					TOTAL	0.0	0.0	0.0	0.0	16.0	0.0	0.0	0.0	16.0	1.0			0.0	0.0	16.0	
3.6 Capacitacion de Educadores	170 personas, 3 dias x 83	IX	IX	GENACES	INV.				2.0	2.0										2.0	
					IFUN.				0.0												0.0
					TOTAL	0.0	0.0	2.0	2.0	0.0	0.0	0.0	0.0	2.0	1.0			0.0	0.0	2.0	
3.7 Capacitacion de promotores de Salud	10140 personas, 200 cursos, 13 dias x 73	IX	IX	GENACES	INV.				9.0	9.0	10.6	52.2								72.0	
					IFUN.				0.0												0.0
					TOTAL	0.0	0.0	9.0	9.0	10.6	52.2	0.0	0.0	72.0	1.0			0.0	0.0	72.0	
3.8 Cooperacion tecnica	Asistencia tecnica del consultor inter-nale	IX	IX	GENACES	INV.				0.0												0.0
					IFUN.				0.0												0.0
					TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0			0.0	0.0	0.0	

---	---	12.3	0.3	113.2	125.2	20.3	33.2	0.3	0.3	1104.2	1	0.3	0.3	0.0	1104.2
TOTAL	IFUN.	15.0	5.0	13.0	111.0	0.0	0.0	0.0	0.0	11.0	1	0.0	0.0	0.0	111.0
TOTAL		17.0	5.0	13.2	125.2	20.3	33.2	0.0	0.0	1115.2	1	0.0	0.0	0.0	1115.2

PROGRAMA AMPLIADO DE INMUNIZACION																	
País: REPUBLICA DOMINICANA 1: PLAN DE ACCION, FINANCIAMIENTO ANUAL DE AREAS DE ACCION POR FUENTES, 1987.																	
Área de Acción: COMUNICACION SOCIAL (en miles de US\$)																	
Actividades	Resultado Esperado	Trimestral	Unidad	Tipo	Fuente Externa						Fuente Nacional						
					O	P	S	UNICEF	AID	BID	ICLUS	TOTAL	%	GOBIERNO	OTROS	TOTAL	%
		Responsable	Costo	de	Reg.	AID	BID	Total	SE	OTROS							
4.1 Diseño de un estrategia a corto y mediano plazo para producción de la vacunación	Contratación de una oficina local para el diseño de la estrategia	IXI	CENADES	INV.				1.0				0.0					0.0
				IFUN.		1.5		1.5		10.0		15.0					15.0
				TOTAL	1.0	1.5	0.0	1.5	0.0	10.0	0.0	15.0	1.0	0.0	0.0	0.0	15.0
4.2 Producción de material para los establecimientos de Salud	Difusión del esquema de vacunación	IXIX	CENADES	INV.				1.0				0.0					0.0
	Producción de la oferta			IFUN.		10.0		10.0				10.0					10.0
				TOTAL	1.0	10.0	0.0	11.0	0.0	0.0	0.0	10.0	1.0	0.0	0.0	0.0	10.0
4.3 Producción de Material Impreso Via Pública	Difusión programa nacional y jornadas	IXIX	CENADES	INV.				1.0				0.0					0.0
	Crucescalles, ...			IFUN.		1.0		1.0		10.0		15.0		10.0		10.0	25.0
				TOTAL	1.0	1.0	0.0	1.0	0.0	10.0	0.0	15.0	1.0	0.0	10.0	10.0	25.0
4.4 Acceso a los radios de comunicación	Difusión radial, televisiva y prensa escrita	IXIX	CENADES	INV.				1.0				0.0					0.0
				IFUN.		1.0		1.0				0.0		25.0		25.0	25.0
				TOTAL	1.0	1.0	0.0	1.0	0.0	0.0	0.0	0.0	1.0	0.0	25.0	25.0	25.0
4.5 Cooperación técnica	Consultoría de corta duración	IXI	CENADES	INV.				1.0				0.0					0.0
				IFUN.		1.0		1.0		5.0		5.0					5.0
				TOTAL	1.0	1.0	0.0	1.0	0.0	5.0	0.0	5.0	1.0	0.0	0.0	0.0	5.0
				TOTAL	1.0	11.5	0.0	11.5	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	1.0
				TOTAL	1.0	11.5	0.0	11.5	0.0	15.0	0.0	15.0	1.0	0.0	35.0	35.0	60.0
				TOTAL	1.0	11.5	0.0	11.5	0.0	15.0	0.0	15.0	1.0	0.0	35.0	35.0	60.0

(6)

EVAL

PROGRAMA AMPLIADO DE INMUNIZACION

País: REPUBLICA DOMINICANA

1. PLAN DE ACCION, FINANCIAMIENTO ANUAL DE AREAS DE ACCION POR FUENTES, 1987.

(en miles de US\$)

Area de Accion: EVALUACION

Actividades	Resultado Esperado	Trimestral		Tipo de Unidad de Costo	Fuente Externa					Fuente Nacional			ESAN						
		1	2		3	UNICEF	AID	SID	ICLUB	TOTAL	%	GOBIERNO		OTROS	TOTAL				
		1	2		3	1	2	3	1	2	3	1		2	3				
9.1 Conocer coberturas de vacunación por Municipio	Establecer un sistema que permita obtener estas coberturas para identificar Areas problemáticas	IX	IX	IX	ICNV	1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
					ICIR, EPI.	1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
9.2 Reunion Directores y Epidemiologos para revisar cumplimiento actividades y programar para 1988	145 personas, 2 dias x 83 de gastos transporte	IX	IX	IX	ICNV	1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
					ICIP, EPI.	1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
9.3 Cooperacion tecnica	Asistencia tecnica a corto plazo	IX	IX	IX	ICNV	1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
						1	1	1	0.0	1	1	1	0.0	1	1	1	0.0	1	0.0
									TOTAL	1	1	1	0.0	1	1	1	0.0	1	0.0
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PROGRAMA AMPLIADO DE INMUNIZACION																		
País: REPUBLICA DOMINICANA 1. PLAN DE ACCION, FINANCIAMIENTO ANUAL DE AREAS DE ACCION POR FUENTES, 1967.																		
(miles de US\$)																		
Area de Accion: INVESTIGACION																		
Actividades	Resultado Esperado	IT-Instit		Unidad de	Tipo de	Fuente Externa					Fuente Nacional		ERAM					
		1121314	Responsable			Costo	O	P	S	UNICEF	AID	BID		ICLUB	TOTAL	%	SOSIENDOTROS	TOTAL	%	TOTAL
						Reg.	AID	BID	TOTAL									
8.1 Investigacion operativa sobre practicas y actitudes (CENISMI)	Conocer la actitud de la poblacion frente a inmunizaciones	IXI	CENISMI	INV.				10.0						0.0		0.0		10.0
							110.0		110.0							0.0		110.0
							10.0	110.0	120.0	0.0	0.0	0.0	0.0	10.0		0.0	0.0	120.0
8.2 Investigacion operativa sobre actitudes de servicios hacia inmunizacion	Conocer las "oportunidades perdidas" utilizando el protocolo desarrollado por la OPS/OMS (UCMM)	IXI	UCMM	INV.				2.0						0.0		0.0		2.0
							2.0		2.0							0.0		2.0
							1.0	2.0	3.0	0.0	0.0	0.0	0.0	2.0		0.0	0.0	3.0
8.3 Investigacion sobre mortalidad por tetanos neonatal	Conocer el problema del TTN en areas de alto riesgo y proponer una estrategia para reducirlo (INTEC)	IXI	INTEC	INV.				3.0						0.0		0.0		3.0
							3.0		3.0							0.0		3.0
							0.0	3.0	3.0	0.0	0.0	0.0	0.0	3.0	1.0	0.0	0.0	3.0
							10.0	10.0	10.0	0.0	0.0	0.0	0.0	10.0		0.0	0.0	10.0
							115.0	10.0	125.0	0.0	0.0	0.0	0.0	15.0		0.0	0.0	140.0
							10.0	115.0	125.0	0.0	0.0	0.0	0.0	15.0	1.0	0.0	0.0	140.0

21

7.9 Cooperación técnica (Asesoría técnica del
 Consultor inter-país
 Consultor Nacional

INV. 0.0
 ANEX 1
 Page 20 of 65
 TOTAL 0.0 12.0 10.0 122.0 0.0 0.0 0.0 0.0 22.0 1.0 0.0 0.0 0.0 0.0 22.0

INV. 13.5 0.0 5.0 112.5 0.0 0.0 0.0 0.0 13.5 0.0 0.0 0.0 0.0 13.5

TOTAL FUN. 0.0 112.0 115.3 129.3 0.0 0.0 0.0 0.0 29.3 15.0 0.0 15.0 43.3

TOTAL 13.5 12.0 21.3 142.3 0.0 0.0 0.0 0.0 42.3 0.7 15.0 0.0 15.0 0.3 57.3

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PROGRAMA AMPLIADO DE INMUNIZACION

2. PLAN DE FINANCIAMIENTO POR FUENTE Y POR AREA DE ACCION, 1967.

País: REPUBLICA DOMINICANA

(miles de US\$)

Area de Accion	Tipo de Costo	FUENTE EXTERNA										FUENTE NACIONAL				ERAN TOTAL
		D	P	S	UNICEF	AID	SID	CLUB	TOTAL	%	161	DTFGS	TOTAL	%		
															Pay	
1.	INV.				0.0					0.0			0.0		0.0	
BIOLÓGICOS SUMINISTROS	IFUN.				0.0	53.5	155.4		48.0	256.9		1.0	289.6		541.5	
	TOTAL	0.0	0.0	0.0	0.0	53.5	155.4	0.0	48.0	256.9	0.5	1.0	289.6	0.5	541.5	
2.	INV.		2.0		2.0					4.8	295.0		392.8		392.8	
CAGENA DE FRIO	IFUN.	2.0		4.0	6.0					6.0		1.2		7.2		
	TOTAL	2.0	2.0	4.0	8.0	0.0	4.8	295.0	0.0	392.8	1.0	1.0	0.0	1.2	399.0	
3.	INV.		2.0	13.2	15.2	20.8	69.2			104.2			0.0	104.2		
CAPACITACION	IFUN.	5.0	6.0		11.0					11.0		0.0		11.0		
	TOTAL	7.0	6.0	13.2	26.2	20.8	69.2	0.0	0.0	115.2	1.0	1.0	0.0	0.0	115.2	
	INV.				0.0					0.0			0.0	0.0		
COMUNICACION SOCIAL	IFUN.		15.0		15.0	5.0	15.0		10.0	45.0		35.0	35.0	50.0		
	TOTAL	0.0	15.0	0.0	15.0	5.0	15.0	0.0	10.0	45.0	0.5	35.0	35.0	0.4	89.0	
	INV.		10.0		10.0					10.0			0.0	10.0		
GASTOS OPERATIVOS	IFUN.				0.0		1.0			1.0		1856.0		1857.0		
	TOTAL	0.0	10.0	0.0	10.0	0.0	1.0	0.0	0.0	11.0	0.0	1856.0	1.0	1867.0		
	INV.				0.0					0.0			0.0	0.0		
SUPERVISION	IFUN.		7.0		7.0					7.0		0.0		7.0		
	TOTAL	0.0	7.0	0.0	7.0	0.0	0.0	0.0	0.0	7.0	1.0	0.0	0.0	0.0	7.0	
	INV.				0.0					0.0			0.0	0.0		
VIGILANCIA EPIDEMIOLOGICA	IFUN.		12.0	13.8	30.8					30.8		15.0		45.8		
	TOTAL	0.0	12.0	23.9	44.3	0.0	0.0	0.0	0.0	44.3	0.7	15.0	0.3	59.3		
	INV.				0.0					0.0			0.0	0.0		
INVESTIGACION	IFUN.		15.0		15.0					15.0		0.0		15.0		
	TOTAL	0.0	15.0	0.0	15.0	0.0	0.0	0.0	0.0	15.0	1.0	0.0	0.0	15.0		
	INV.				0.0					0.0			0.0	0.0		

81

9.	INV.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EVALUACION	IFUN.	3.0	4.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0
	TOTAL	3.0	4.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0
10.	INV.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TRANSPORTE	IFUN.	15.0	15.0	8.7	8.7	8.7	8.7	8.7	8.7	8.7	8.7	8.7	8.7	8.7	8.7	8.7	8.7	8.7
	TOTAL	0.0	15.0	0.0	15.0	8.7	0.0	494.0	0.0	517.7	1.0	0.0	4.5	0.0	522.2	0.0	0.0	522.2
11.	INV.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
MANTENIMIENTO	IFUN.	0.0	0.0	0.0	0.0	0.0	0.0	60.0	60.0	60.0	60.0	60.0	60.0	60.0	60.0	60.0	60.0	60.0
	TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	60.0	60.0	60.0	60.0	60.0	60.0	60.0	60.0	60.0	60.0	60.0
	INV.	10.5	12.0	18.2	40.7	20.8	73.0	790.0	0.0	924.5	1.0	0.0	0.0	0.0	924.5	0.0	0.0	924.5
TOTAL	IFUN.	10.0	24.0	22.9	106.8	67.2	171.4	60.0	55.0	463.4	0.2	35.0	12195.3	0.8	2359.7	0.0	0.0	2359.7
5)	TOTAL	20.5	66.0	41.0	147.5	88.0	244.4	650.0	55.0	1337.9	0.4	35.0	12196.3	0.6	3594.2	0.0	0.0	3594.2

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PROGRAMA AMPLIADO DE INMUNIZACION															
3. PLAN DE FINANCIAMIENTO POR FUENTE Y POR AREA DE ACCION, PROYECCIONES 1986.															
País: REPUBLICA DOMINICANA (miles de US\$)															
Area de Accion	Tipo de Costo	FUENTE EXTERNA								FUENTE NACIONAL				ERAN TOTAL	
		O	P	S	UNICEF	AID	310	CLUB	TOTAL	X	ISOSIEMO	OTROS	TOTAL		X
		0	P	S	UNICEF	AID	310	CLUB	TOTAL	X	ISOSIEMO	OTROS	TOTAL	X	TOTAL
		0	P	S	UNICEF	AID	310	CLUB	TOTAL	X	ISOSIEMO	OTROS	TOTAL	X	TOTAL
1.	INV.				0.0				0.0				0.0		0.0
ECOLOGICOS SUMINISTROS	IFUN.				0.0	105.0	112.0		133.0	350.0		50.0	50.0		400.0
	TOTAL	0.0	0.0	0.0	0.0	105.0	112.0	0.0	133.0	350.0	0.0	50.0	50.0	0.0	400.0
2.	INV.		20.0	5.0	25.0	66.0			91.0				0.0		91.0
CADENA DE FRIO	IFUN.			6.0	5.0	10.0			16.0			42.6	42.6		58.6
	TOTAL	0.0	20.0	11.0	21.0	76.0	0.0	0.0	97.0	0.7	42.6	0.0	42.6	0.3	149.6
3.	INV.		2.0		15.0	17.0	20.0	10.0	47.0				0.0		47.0
CAPACITACION	IFUN.		5.0	6.0		11.0			11.0				0.0		11.0
	TOTAL	7.0	6.0	15.0	23.0	20.0	10.0	0.0	58.0	1.0	0.0	0.0	0.0	0.0	59.0
4.	INV.				0.0				0.0				0.0		0.0
COMUNICACION SOCIAL	IFUN.		25.0		23.0	10.0	10.4		45.4		5.0	35.0	40.0		85.4
	TOTAL	0.0	25.0	0.0	25.0	10.0	10.4	0.0	45.4	0.5	5.0	35.0	40.0	0.5	85.4
5.	INV.				0.0				0.0				0.0		0.0
EASTOS CREATIVOS	IFUN.				0.0				0.0		1855.0	1155.0		1855.0	
	TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1855.0	0.0	1155.0	1.0	1856.0
6.	INV.				0.0				0.0				0.0		0.0
SUPERVISION	IFUN.		20.0		20.0				20.0		10.0	10.0		30.0	
	TOTAL	0.0	20.0	0.0	20.0	0.0	0.0	0.0	20.0	0.7	10.0	0.0	10.0	0.3	30.0
7.	INV.		5.0		6.0	11.0			11.0				0.0		11.0
VIGILANCIA EPIDEMIOLÓGICA	IFUN.		20.0	15.0	35.0				35.0				0.0		35.0
	TOTAL	5.0	20.0	21.0	45.0	0.0	0.0	0.0	45.0	1.0	0.0	0.0	0.0	0.0	45.0
8.	INV.				0.0				0.0				0.0		0.0
INVESTIGACION	IFUN.		15.0		15.0				15.0				0.0		15.0
	TOTAL	0.0	15.0	0.0	15.0	0.0	0.0	0.0	15.0	1.0	0.0	0.0	0.0	0.0	15.0

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174

9.	INVT.	1	1	1	0.0	1	1	1	1	0.0	1	1	1	0.0	1	0.0
EVALUACION	IFUN.	1	3.0	12.0	1	15.0	1	1	1	15.0	1	1	1	0.0	1	15.0
	TOTAL	1	3.0	12.0	0.0	15.0	0.0	0.0	0.0	0.0	15.0	1.0	0.0	0.0	0.0	0.0
10.	INVT.	1	10.0	1	10.0	1	1	1	1	10.0	1	1	1	0.0	1	10.0
TRANSPORTE	IFUN.	1	20.0	1	20.0	1	1	1	1	20.0	1	33.3	1	33.3	1	53.3
	TOTAL	1	0.0	30.0	0.0	30.0	0.0	0.0	0.0	0.0	30.0	0.5	33.3	0.0	33.3	0.5
11.	INVT.	1	1	1	0.0	1	1	1	1	0.0	1	1	1	0.0	1	0.0
MANTENIMIENTO	IFUN.	1	1	1	0.0	1	15.6	1	1	15.6	1	4.0	1	4.0	1	22.6
	TOTAL	1	0.0	0.0	0.0	0.0	18.6	0.0	0.0	18.6	0.9	4.0	0.0	4.0	0.2	22.6
	INVT.	1	7.0	30.0	25.0	63.0	85.0	10.0	0.0	0.0	157.0	1.0	0.0	0.0	0.0	155.0
TOTAL	IFUN.	1	8.0	116.0	21.0	147.0	128.0	141.0	0.0	130.0	548.0	0.2	2000.9	35.0	12025.9	0.9
	TOTAL	1	15.0	1148.0	47.0	210.0	214.0	151.0	0.0	130.0	705.0	0.3	2002.9	35.0	12025.9	0.7

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9.	INV.	1	1	1	0.0	1	1	1	0.0	1	1	0.0	1	0.0	23.0		
EVALUACION	IFUN.	1	3.0	10.0	1	13.0	5.0	5.0	1	23.0	1	1	0.0	1	23.0		
	TOTAL	1	3.0	10.0	0.0	13.0	5.0	5.0	0.0	0.0	23.0	1.0	0.0	0.0	0.0	23.0	
10.	INV.	1	1	1	0.0	1	1	1	0.0	1	1	0.0	1	0.0			
TRANSFERTE	IFUN.	1	20.0	1	20.0	1	1	1	20.0	1	35.0	1	35.0	1	55.0		
	TOTAL	1	0.0	20.0	0.0	20.0	0.0	0.0	0.0	20.0	0.4	35.0	0.0	35.0	0.6	55.0	
11.	INV.	1	1	1	0.0	1	1	1	0.0	1	1	0.0	1	0.0			
MANTENIMIENTO	IFUN.	1	1	1	0.0	10.0	15.0	1	25.0	1	10.0	1	10.0	1	35.0		
	TOTAL	1	0.0	0.0	0.0	10.0	15.0	0.0	0.0	25.0	0.7	10.0	0.0	10.0	0.3	35.0	
	INV.	1	5.0	5.0	26.0	35.0	60.0	10.0	0.0	0.0	105.0	1.0	0.0	0.0	105.0		
TOTAL	IFUN.	1	6.0	105.0	21.0	135.0	143.9	122.0	0.0	105.0	505.9	0.2	2053.2	35.0	12033.2	0.6	2575.1
	TOTAL	1	13.0	111.0	47.0	171.0	203.9	133.0	0.0	106.0	512.9	0.2	2053.2	35.0	12033.2	0.8	2701.1

24

RESUMEN		PROGRAMA AMPLIADO DE INMUNIZACION																																			
		4. RESUMEN DE DATOS FINANCIEROS Y PROMOCIONES																																			
Pais: REPUBLICA DOMINICANA		(en miles de \$US)																																			
AREA DE ACCION	Tipo de Costo	1987			1988			1989			1990			1991			TOTAL																				
		Externo	Intern.	Total	Externo	Intern.	Total	Externo	Intern.	Total	Externo	Intern.	Total	Externo	Intern.	Total	Externo	Intern.	Total																		
1.	INV.	0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0	
BIOLOGICOS ADMINISTERS	IFUN.	256.9	284.5	541.5	350.0	50.0	400.0	295.9	70.0	366.9	247.2	90.0	337.2	210.3	110.0	320.3	1361.3	604.6	1955.9																		
	ITOTAL	256.9	284.5	541.5	350.0	50.0	400.0	295.9	70.0	366.9	247.2	90.0	337.2	210.3	110.0	320.3	1361.3	604.6	1955.9																		
2.	INV.	302.8	0.0	302.8	91.0		91.0	50.0		50.0	50.0		50.0	50.0		50.0	543.8	0.0	543.8																		
CADENA DE FRIO	IFUN.	6.0	1.2	7.2	15.0	42.6	58.6	21.0	57.2	78.2	21.0	57.2	78.2	21.0	57.2	79.2	85.0	215.4	300.4																		
	ITOTAL	6.0	1.2	7.2	15.0	42.6	58.6	21.0	57.2	78.2	21.0	57.2	78.2	21.0	57.2	79.2	85.0	215.4	300.4																		
3.	INV.	104.2	0.0	104.2	47.0		47.0	45.0		45.0	45.0		45.0	45.0		45.0	266.2	0.0	266.2																		
CAPACITACION	IFUN.	11.0	0.0	11.0	11.0	0.0	11.0	11.0		11.0	11.0		11.0	11.0		11.0	55.0	0.0	55.0																		
	ITOTAL	11.0	0.0	11.0	11.0	0.0	11.0	11.0		11.0	11.0		11.0	11.0		11.0	55.0	0.0	55.0																		
4.	INV.	0.0	0.0	0.0			0.0			0.0			0.0			0.0	0.0	0.0	0.0																		
COMUNICACION SOCIAL	IFUN.	45.0	35.0	80.0	40.0	40.0	80.0	45.0	40.0	85.0	45.0	40.0	85.0	45.0	40.0	85.0	220.0	195.0	415.0																		
	ITOTAL	45.0	35.0	80.0	40.0	40.0	80.0	45.0	40.0	85.0	45.0	40.0	85.0	45.0	40.0	85.0	220.0	195.0	415.0																		
5.	INV.	10.0	0.0	10.0			0.0			0.0			0.0			0.0	10.0	0.0	10.0																		
BASTOS OPERATIVOS	IFUN.	1.0	1856.0	1857.0	0.0	1856.0	1856.0	0.0	1856.0	1856.0		1856.0	1856.0		1856.0	1856.0	1.0	9290.0	9291.0																		
	ITOTAL	1.0	1856.0	1857.0	0.0	1856.0	1856.0	0.0	1856.0	1856.0		1856.0	1856.0		1856.0	1856.0	1.0	9290.0	9291.0																		
6.	INV.	0.0	0.0	0.0			0.0			0.0			0.0			0.0	0.0	0.0	0.0																		
SUPERVISION	IFUN.	7.0	0.0	7.0	20.0	10.0	30.0	15.0	15.0	30.0	15.0	15.0	30.0	15.0	15.0	30.0	72.0	55.0	127.0																		
	ITOTAL	7.0	0.0	7.0	20.0	10.0	30.0	15.0	15.0	30.0	15.0	15.0	30.0	15.0	15.0	30.0	72.0	55.0	127.0																		
7.	INV.	13.5	0.0	13.5	11.0		11.0	11.0		11.0	11.0		11.0	11.0		11.0	57.5	0.0	57.5																		
VIGILANCIA EPIDEMIOLOGICA	IFUN.	39.8	15.0	54.8	35.0	0.0	35.0	35.0	5.0	40.0	35.0	5.0	40.0	35.0	5.0	40.0	170.8	39.0	209.8																		
	ITOTAL	39.8	15.0	54.8	35.0	0.0	35.0	35.0	5.0	40.0	35.0	5.0	40.0	35.0	5.0	40.0	170.8	39.0	209.8																		
8.	INV.	0.0	0.0	0.0			0.0			0.0			0.0			0.0	0.0	0.0	0.0																		
INVESTIGACION	IFUN.	15.0	0.0	15.0	15.0		15.0	15.0		15.0	15.0		15.0	15.0		15.0	75.0	0.0	75.0																		

52

	TOTAL	15.0	0.0	15.0	15.0	0.0	15.0	15.0	0.0	15.0	15.0	0.0	15.0	15.0	0.0	15.0	15.0	0.0	15.0
9.	INV.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EVALUACION	FUN.	7.0	0.0	7.0	15.0	0.0	15.0	23.0	0.0	23.0	23.0	0.0	23.0	35.0	0.0	35.0	193.0	0.0	193.0
	TOTAL	7.0	0.0	7.0	15.0	0.0	15.0	23.0	0.0	23.0	23.0	0.0	23.0	35.0	0.0	35.0	193.0	0.0	193.0
10.	INV.	474.0	0.0	474.0	10.0	0.0	10.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	534.0	0.0	534.0
TRANSPORTE	FUN.	23.7	4.5	28.2	20.0	33.3	53.3	20.0	35.0	55.0	15.0	40.0	55.0	15.0	49.0	55.0	93.7	152.8	246.5
	TOTAL	517.7	4.5	522.2	30.0	83.3	20.0	35.0	55.0	15.0	49.0	55.0	15.0	49.0	55.0	597.7	152.8	750.5	
11.	INV.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
MANTENIMIENTO	FUN.	60.0	0.0	60.0	18.6	4.0	22.6	25.0	10.0	35.0	25.0	15.0	40.0	20.0	20.0	40.0	145.6	49.0	194.6
	TOTAL	60.0	0.0	60.0	18.6	4.0	22.6	25.0	10.0	35.0	25.0	15.0	40.0	20.0	20.0	40.0	145.6	49.0	194.6
	INV.	924.5	0.0	924.5	159.0	0.0	159.0	106.0	0.0	155.0	106.0	0.0	105.0	105.0	0.0	105.0	1401.5	0.0	1401.5
TOTAL	FUN.	463.4	2176.3	2639.7	540.6	2035.9	2576.5	506.9	2082.2	2575.1	452.2	2118.2	2570.4	422.3	2143.2	2565.5	2335.4	110531.8	112757.2
	TOTAL	1387.9	2176.3	3564.2	699.6	2035.9	2735.5	612.9	2082.2	2701.1	558.2	2118.2	2676.4	528.3	2143.2	2671.5	3766.9	110531.8	114349.7

(24)

PIO/T No. _____
Attachment A
Annex 1
Page 34 of 65

76

UNCLASSIFIED

STATE 447539/61

HPD/KHPD

(10) ACTION: AID-S
 INFO: AMB DCM AC CHRON
 AVZCZCDG0290
 OO RUEHDG
 IE RUEHC #7589/01 6491545
 ZNR UUUUU ZZH
 O 181544Z FEB 87
 FM SECSTATE WASHDC
 TO RUEHPU/AMEMBASSY PORT AU PRINCE IMMEDIATE 6229
 RUEHNG/AMEMBASSY SANTO DOMINGO IMMEDIATE 5826
 FT
 UNCLAS SECTION 01 OF 02 STATE 047509

LOC: 109 176
 18 FEB 87 1549
 CN: 05836
 CHR: AID
 DIST: AID

ACTION: HPD	
o T. RUE	
DIR	||
DD	||
PIA	||
PRG	||
CON	||
MGT	||
HRD	||
HPO	||
PSD	||
AID	||
CHRON	||
RF	||

AIDAC

E.O. 12356: N/A

TAGS:

SUBJECT: PROJECT 598-0643/597-0005; CHILD SURVIVAL:
 PAHO ACCELERATED IMMUNIZATION PROGRAM IN THE AMERICAS -
 MISSION BUY-IN PROCEDURES

SLUG TO M. WHITE IN PORT-AU-PRINCE AND
 TO L. HOUGEN IN SANTO DOMINGO

1. SEVERAL MISSIONS HAVE INDICATED THEIR INTEREST IN PARTICIPATING IN THE SUBJECT PROJECT ON A BUY-IN BASIS. THE FOLLOWING GUIDELINES ARE PROVIDED TO ASSIST MISSIONS IN PROCESSING BUY-IN ACTIONS SHOULD THEY DECIDE TO PARTICIPATE IN THE SUBJECT PROJECT.

2. ASSUMING THE MISSION WISHES TO RETAIN BUY-IN MONEYS IN ITS OYR LEVEL, THERE ARE TWO SITUATIONS UNDER WHICH THE BUY-IN CAN TAKE PLACE.

A. NO PROJECT FUNDING: UNDER THIS SITUATION, THE MISSION DOES NOT HAVE FUNDS ALLOCATED TO ON-GOING OR UP-COMING PROJECTS WHICH ARE COMPATIBLE WITH THE SUBJECT PROJECT, OR FUNDS BECOME AVAILABLE AS A RESULT OF REOBLIGATION AND THE MISSION WISHES TO USE THEM UNDER SUBJECT PROJECT. IF AMOUNT INVOLVED IS NOT LARGE, E.G.,

UNDER POLS. 100,000, THE MISSION SHOULD ALLOCATE AVAILABLE FUNDS TO ITS PD & S HEALTH ACCOUNT AND THEN ISSUE A PIO/T REQUESTING AID/W TO AMEND THE RELEVANT A.I.D./PAHO GRANT AGREEMENT. FOR LARGER AMOUNTS, MISSION SHOULD ESTABLISH A SEPARATE CHILD SURVIVAL/ACCELERATED IMMUNIZATION PROJECT FOR THE ACTIVITY. A FULL CONGRESSIONAL NOTIFICATION DOCUMENT WOULD BE NEEDED FOR THE PROJECT. HOWEVER, NO SEPARATE AUTHORIZATION WOULD BE REQUIRED. AS WITH PD & S ABOVE, MISSION NEED ONLY ISSUE A PIO/T REQUESTING AID/W TO AMEND THE RELEVANT A.I.D./PAHO GRANT AGREEMENT. THE AMENDMENT WOULD STIPULATE THAT ALL PROVISIONS OF THE ORIGINAL AGREEMENT ARE APPLICABLE. AN ANNEX TO THE AMENDMENT WOULD INDICATE THAT THE MISSION WILL CONTINUE TO HAVE ADEQUATE MONITORING AND CONTROL OF THE BUY-IN FUNDS THROUGH THE APPROVAL OF THE COUNTRY ANNUAL WORK

Attachment A
 PIO/T No. 517-0242-3-70045
 Annex 2
 Page 35 of 65

21

PLAN AND WOULD SHOW HOW THE FUNDS ARE TO BE USED, TOGETHER WITH AN APPROPRIATE BUDGET. THE AMENDMENT WILL ALSO EMPHASIZE THAT THE ENTIRE AMOUNT IS TO BE SPENT IN THE COUNTRY.

E. PROJECT FUNDS: UNDER THIS SCENARIO, THE MISSION WOULD ISSUE A PIO/T COUNTERSIGNED BY THE PROJECT BORROWER/GRANTEE REQUESTING AID/W TO AMEND THE AGREEMENT FOR THE SUBJECT PROJECT AS INDICATED ABOVE. AS WITH THE FOREGOING SCENARIO, AN ANNEX WOULD SHOW HOW THE FUNDS WOULD BE USED, IN WHAT AMOUNTS, UNDER WHAT CIRCUMSTANCES (I.E., IN THE CONTEXT OF THE COUNTRY ANNUAL WORK PLAN), AND HOW THEIR USE WOULD RELATE TO THE PROJECT FROM WHERE THEY ORIGINALLY CAME.

3. FOR GUIDANCE, THE FOLLOWING IS A SAMPLE PIO/T FACE SHEET FOR MISSION USE;

- BLOCK 1: SELF-EXPLANATORY
- BLOCK 2: SELF-EXPLANATORY
- BLOCK 3: ORIGINAL
- BLOCK 4: PD AND S OR PROJECT
- BLOCK 5: XX-XXXXXXX.X
- BLOCK 6: XX-XXXXXXX.X
- BLOCK 7: IMPLEMENTING DOCUMENT
- BLOCK 8: JULY 31, 1991
- BLOCK 9: AA/LAC
- BLOCK 10: 598-0643 AND 597-0005 , AUGUST 14, 1986
- BLOCK 11A: AID GRANT
- BLOCK 11B: N/A
- BLOCK 12: *N/A
- BLOCK 13: MISSION TO INDICATE REFERENCES
- BLOCK 14A: THE AUTHORIZED AGENT IS REQUESTED TO AMEND GRANT AGREEMENT NO. CAR-0065-G-00-6971-03 TO REFLECT USAID/XXXXXXX BUY-IN UNDER THE PROJECT. THE TERMS AND CONDITIONS OF THE ORIGINAL GRANT AGREEMENT REMAIN IN FULL FORCE AND EFFECT FOR PURPOSES OF THE AMENDMENT.

UNCLAS SECTION 02 OF 02 STATE 047589

-BLOCK 14B: FM/PAFD, SA-12

4. IF ADDITIONAL CLARIFICATION IS REQUIRED, PLEASE CONTACT LAC/DR. SHULTZ

BT
#2500

PIO/T No: _____
Attachment _____ A
Annex 2
Page 36 of 65

28

UNCLASSIFIED

SANTO DOMINGO 5099

HPD/CRD

VZCZCDGI
RR RUEHC
DE RUEHDG #5099 134 **
ZNR UUUUU ZZH
R 141902Z MAY 87
FM AMEMBASSY SANTO DOMINGO
TO SECSTATE WASHDC PRIORITY 4684
BT
UNCLAS SANTO DOMINGO 05099

CLASS: UNCLASSIFIED
CHRG: AID 05/07/87
APPRV: DD:JEYRE
DRFTD: HPD:LHOUGEN:FG:AC
CLEAR: CRD:PGALL
DISTR: AID-2 AMB DCM
AC CHRON

*DIR
CRD
CON
P*

AIDAC

FOR: LAC/DR/HN

E.O.:12356: N/A

SUBJECT: CHILD SURVIVAL- LAC ACCELERATED IMMUNIZATION
PROJECT.

REFS: (A) STATE 047589. (B) STATE 092813.

SUMMARY: USAID/DR WISHES TO INFORM DR/HN ON THE STATUS OF SUBJECT PROJECT AND SEEKS CONCURRENCE OR ADVICE ON OUR APPROACH. END SUMMARY.

1. TO DATE PAHO/DR HAS SUPPLIED MISSION WITH DETAILED LOP BUDGET, BUT NOT A NATIONAL PLAN OF ACTION NOR ANNUAL WORK PLAN. WE HAVE REQUESTED PAHO TO WORK WITH SESPAS TO SUPPLY THE TWO DOCUMENTS AND TO CONVENE A MEETING OF THE LOCAL DONOR COMMITTEE TO DISCUSS OVERALL OBJECTIVES FOR LOP (NATIONAL PLAN) AND IMMEDIATE DETAILED STEPS FOR FIRST YEAR'S WORK PLAN. WE REQUESTED THE PLANS BY MAY 30 TO BE ABLE TO TRANSMIT THE PIO/T BY JUNE 15 TO AID/W REQUESTING A BUY-IN TO THE ORIGINAL LAC-PAHO GRANT (CAR-0005-G-00-6971-00).

2. THE WAY THE MISSION IS PROCEEDING WITH THE FUNDING OF THIS PROJECT IS AS FOLLOWS:

A. WE UNDERSTAND THAT PAHO IS THE IMPLEMENTING AGENT OF THIS PROJECT. OUR BUY-IN OF \$705,000 WILL PROVIDE PAHO WITH ADDITIONAL RESOURCES TO MEET OBJECTIVES AND SUPPORT ACTIVITIES TO BE EXPLAINED IN THE DR NATIONAL PLAN AND ANNUAL PLANS WHICH SHOULD FOLLOW THE GENERAL TERMS AND CONDITIONS SET FORTH IN THE ORIGINAL AID-PAHO GRANT AGREEMENT.

B. PER REF. A, PARA. 2 A AND B, WE WILL DEVELOP AND ISSUE A PIO/T ANNEXING A COPY OF THE PLANS DESCRIBING THE LOCAL PROJECT TO BE SUPPORTED. THE FULL \$705,000 WILL BE earmarked IN THE PIO/T TO BE AWARDED TO PAHO BY MEANS OF AN AMENDMENT TO THE GRANT AGREEMENT NO. CAR-0005-G-00-6971-00. COPY OF AMENDMENT MUST BE FORWARDED TO THE USAID/DR CONTROLLER FOR COMMITMENT OF FUNDS.

C. USAID WILL MOVE THE \$705,000 FROM ITS CURRENT FUNDING ACCOUNT AND ASSIGN THEM TO THIS ACTIVITY UNDER PROJECT NO. 517-0242 ENTITLED ACCELERATED IMMUNIZATION

PIO/T No. 517-0242-3-70045
Attachment A
Annex 3
Page 37 of 65

29

UNCLASSIFIED

SANTO DOMINGO 5099

PROJECT. MISSION WILL PREPARE CN AS REQUESTED

D. THE ACCELERATED IMMUNIZATION PROJECT WILL COMPLEMENT, BUT NOT BECOME A FORMAL PART OF THE CHILD SURVIVAL PROJECT AND COOPERATIVE AGREEMENT CURRENTLY UNDER DEVELOPMENT. THE TWO PROJECTS WILL BE COORDINATED IN THEIR IMPLEMENTATION; HOWEVER, THEIR MANAGEMENT WILL REMAIN SEPARATE IN RECOGNITION OF THE DIFFERENT ADMINISTRATIVE ARRANGEMENTS FOR EACH ACTIVITY.

- E. THE MISSION WILL MONITOR THE EXECUTION OF THE PROJECT AS IT DOES WITH ANY OTHER CENTRALLY FUNDED PROJECT, REALIZING THAT PAHO/DR IS TASKED WITH DAY-TO-DAY MANAGEMENT, TA AND COLLABORATION WITH SESPAS STAFF. USAID/DR WILL BE MEMBER OF LOCAL DONOR COMMITTEE WHO WILL MONITOR IMPLEMENTATION AS WELL.

- F. USAID/DR RECOMMENDS TO LAC/DR/HN THAT APPROVAL OF ANNUAL DISBURSEMENTS TO PAHO BE CONTINGENT ON MISSION CONCURRENCE WITH ANNUAL WORK PLANS AND OUR ASSESSMENT OF PERFORMANCE AGAINST PRIOR YEAR'S WORK PLAN.

- G. USAID/DR CONTROLLER ASSUMES AID/W WILL BE DISBURSING AGENT FOR PROJECT. PLEASE CONFIRM.

- 3. USAID AND PAHO/DR AWAIT THE STANDARD MULTI-DONOR MEMORANDUM OF UNDERSTANDING WHICH MUST ARRIVE SOONEST IN ORDER FOR PAHO/DR TO FORMALIZE LOCAL MULTI-DONOR AGREEMENT AND, IN TURN, SEND PIO/T TO AID/W BY JUNE 15. SAID MEMO OF UNDERSTANDING WAS MENTIONED IN REFTEL B.

- 4. PER REFTEL B, KINDLY ALSO SEND COPY OF THE FINAL LAC GRANT AGREEMENT, AND ANY IMPLEMENTATION LETTERS RELATED TO PLAN PREPARATION AND APPROVAL, AND FINANCIAL MANAGEMENT FOR OUR INFORMATION. (WE HAVE THUS FAR BEEN WORKING FROM THE PAHO PROJECT PROPOSAL).

5. PAHO/DR HAS NOT REQUESTED TA FROM USAID TO DEVELOP REQUIRED PLANS. AT THIS MOMENT WE BELIEVE PAHO AND SESPAS CAN COMPLETE THE DOCUMENTS ON SCHEDULE. KILDAY

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UNCLASSIFIED

SANTO DOMINGO 5099

PICT No. _____
Attachment _____ A
Annex 3
Page 38 of 65

30

MEMORANDUM OF UNDERSTANDING
BETWEEN THE GOVERNMENT OF THE DOMINICAN REPUBLIC
THE U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT,
ROTARY CLUB INTERNATIONAL,
THE UNITED NATIONS CHILDREN'S FUND AND
THE PAN AMERICAN HEALTH ORGANIZATION/
WORLD HEALTH ORGANIZATION
FOR THE EXECUTION OF THE FIVE-YEAR PLAN OF ACTION 1987-1991
FOR THE EXPANDED PROGRAM ON IMMUNIZATION

Among the Government of the Dominican Republic ("the Government"), represented by the Ministry of Health in the person of its incumbent, Dr. Ney B. Arias, the Agency for International Development ("AID"), represented by the Acting Mission Director in the person of Mr. John R. Eyre, Rotary Club International ("the Rotary Club"), represented by the Rotary's Governor Mr. Pablo Juan Toral in the person of the Chairman of the District Committee Polio Plus and UNICEF's Principal Dr. Jorge A. Hazoury Balhès, the United Nations Children's Fund ("UNICEF"), represented by Mission Representative in the person of Mr. Crisdstomo Pizarro, and the Pan American Health Organization, Regional Office of the World Health Organization ("PAHO/WHO"), represented by the Mission Representative in Dominican Republic, Dr. Guillermo Torres Cortés, the present Memorandum of Understanding is made for the execution of the National Five-Year Plan of Action 1987 - 1991 ("the National Plan of Action") for the Expanded Program of Immunization ("EPI"), subject to the following Consideration and Clauses:

WHEREAS:

1. In October 10, 1952 the Government and PAHO/WHO signed a Basic Agreement on Privileges and Immunities and Technical Cooperation;
2. In February 15, 1952 the Government and UNICEF signed an Agreement on Technical and Financial Cooperation.
3. In September 1983 PAHO/WHO and UNICEF signed a Memorandum of Understanding in which it was recognized that the parties, as specialized agencies of the United Nations, have received the mandate to give priority to collaboration in the solution of health problems in accordance with the needs of the people and within the framework of national policies;
4. In August 1986 AID awarded to PAHO/WHO grant CAR-005-G-00-6971-00 under the Child Survival Program: the Accelerated

Immunization Program in the Americas, for the sum of US\$5,632,000, with a total contribution estimated at US\$20,600,000, with effect until July 31, 1991. Subsequently, the USAID/DR Mission agreed to provide an additional US\$705,000,000 in a bilateral grant for country-specific immunization activities described in the National Plan of Action. USAID will contribute these funds to PAHO, which in turn, will provide technical assistance and general management support to SESPAS for the execution of the EPI through July 31, 1991.

5. In September 1985 the Rotary Club confirmed its commitment to provide up to US\$10,700,000 in support of the EPI;
6. In September 1986 UNICEF confirmed its commitment to provide up to US\$17,700,000 in support of the EPI in order to attain the goal of overall immunization of children and eradication of the wild poliomyelitis virus in the Americas by the year 1990;
7. In January 1987, at the Third Meeting of the EPI Inter-Agency Coordinating Committee ("ICC"), composed of representatives from AID, IDB, Rotary Fundation, UNICEF and PAHO, the members of the ICC resolved, inter alia:
 - 1) To coordinate their efforts in support of the EPI in order to avoid duplication of efforts and resources and to strengthen the contribution of each agency in support of the EPI; and
 - 2) To establish, at the country level, a national Inter-Agency Coordinating Committee (the "National ICC") that will meet periodically to discuss the EPI and to coordinate the execution of the National Plan of Action.
8. In February 1987 PAHO/WHO confirmed its commitment to provide resources in kind with a value of up to US\$5,750,000 for the EPI, subject to allocation of funds by its Governing Bodies;
9. In February 1987 the Inter-American Development Bank ("IDB") and PAHO/WHO signed Agreement ATN/SF-2851-RE for technical cooperation on the eradication of the wild poliomyelitis virus in the Latin American countries that are members of the Bank, for the sum of US\$5,550,000, with effect until June 5, 1992;
10. In May 1987 the Government presented its National Plan of Action for the EPI to AID, the Rotary Club, UNICEF and PAHO/WHO ("the Agencies for International Cooperation"), with a goal of universal immunization of children by 1990, the eradication of poliomyelitis, and the reduction of child

CLAUSE THREE. Execution and Administration.

The direct responsibility for execution of the activities at the national level shall rest with the Ministry of Health, in accordance with the provisions of the National Plan of Action. Each Party shall assume responsibility for administration of the resources that correspond to it under the National Plan of Action. In the case of USAID/DR, resources shall be granted to PAHO, which will make them available to SEGPAS to fund activities as described in the National Plan of Action.

CLAUSE FOUR. Commitments of the Government.

The Government agrees:

- 1) To provide on a timely basis the professional, technical, auxiliary and administrative personnel necessary for adequate development of the project, in accordance with the indications in Annex 1 of the National Plan of Action. The Government shall present evidence that the national cadre of personnel has been designated and establish which is sufficient for proper execution of the National Plan of Action.
- 2) To provide the resources indicated in Annex 2 of the National Plan of Action under the heading "National Source", for an estimated amount of US\$10,406,800.
- 3) To provide, from its available resources, local transportation, assistance in locating suitable lodging, sites, services, equipment, communication costs, and such other installations as may be required for proper execution of the activities, as well as for the National ICC meetings to be held as provided for under Clause Nine of the present Memorandum of Understanding.
- 4) To convoke, and act as the secretarial for, the National ICC meetings to be held as provided for under Clause Nine of the present Memorandum of Understanding.
- 5) To keep the Agencies for International Cooperation informed of the progress and results of the EPI by means of quarterly and annual reports. (Please see CLAUSE NINE for a description of the annual reports). Quarterly reports should set forth the objectives for the quarter, accomplishments, problems encountered and their resolutions, and objectives for the next quarter. The due date for the quarterly reports will be four (4) weeks after the termination of the quarter.

- 6) To operate and manage the EPI according to its standards for administration of immunizations, training, information, reporting, procurement and control of funds.
- 7) To develop uniform written procedures and manuals, to be used in program operations and training, and describe the implementation of the different components of the program. The procedures and manuals will be distributed to all health facilities and regional offices so as to facilitate the institutionalization and continuity of the program.
- 8) To present detailed implementation plans as a prerequisite to disbursements of funds for activities specified in the National Plan of Action.
- 9) To sustain the project's objectives subject to resources availability once the international cooperation has expired.

CLAUSE FIVE. Commitments of AID-Dominican Republic.

AID, subject to its regulations and standard procedures, agrees:

- 1) To provide SESPAS, via PAHO, the resources indicated in Annex 2 of the National Plan of Action under the heading "External Source/AID", for an estimated amount of US\$705,000.00.
- 2) To actively participate in the National ICC in accordance with the provisions of the present Memorandum of Understanding.

CLAUSE SIX. Commitments of the Rotary Club.

The Rotary Club, subject to its regulations and standard procedures, agrees:

- 1) To provide the resources indicated in Annex 2 of the National Plan of Action under the heading "External Source/ROTARY CLUB", to consist mainly of polio vaccines, for an estimated amount of US\$251,000.00.
- 2) To actively participate in the National ICC in accordance with the provisions of the present Memorandum of Understanding.

CLAUSE SEVEN. Commitments of UNICEF-Dominican Republic.

UNICEF, subject to its regulations and standard procedures, agrees:

- 1) To provide the resources indicated in Annex 2 of the National Plan of Action under the heading "External Source/UNICEF", for an estimated amount of US\$968,400 (1987-1991)(*).
- 2) To actively participate in the National ICC in accordance with the provisions of the present Memorandum of Understanding.

CLAUSE EIGHT. Commitments of PAHO/WHO-DOR-PUR.

PAHO/WHO, subject to its regulations and standard procedures, and within the limits of its financial and human resources as well as the funds provided by each source of financing as provided for in Annex 2 of the National Plan of Action, agrees:

- 1) To provide technical cooperation services through technical advice and information given by personnel from Headquarters, the Regional Programs, and the Country Representative's Office.
- 2) To provide the resources indicated in Annex 2 of the National Plan of Action under the heading "External Source/PAHO", in the three columns marked "Reg.", "AID", and "IDB", respectively, for an estimated amount of US\$865,500.
- 3) To administer according to current norms governing extrabudgetary funds, those resources indicated in Annex 2 of the National Plan of Action under the heading "External Source/AID" for an estimated amount of US\$705,000.00.
- 4) To actively participate in the National ICC in accordance with the provisions of the present Memorandum of Understanding.

(*) 480,000.00 noted funds subject to commitment of donors

CLAUSE NINE. Follow-up and Evaluation.

1. The Parties agree to meet once each quarter in order to follow up and evaluate the National Plan of Action for that year. In this meeting, representatives of the parties should conduct a joint analysis of the activities carried out, based on reports provided to the ICC by SESPAS, the use of resources by the country, and the results achieved, and should prepare a report, including pertinent recommendations. It is understood that in managing the execution of the activities under the National Plan of Action, the Agencies for International Cooperation should take into account the results of this quarterly evaluation.
2. At least once a year, the parties shall review and determine the degree of achievement in executing the previous year's implementation plan and make recommendations to SESPAS on ways to improve performance for the following year. This annual evaluation meeting shall take place no later than twelve (12) weeks after the termination of the previous year's work. If the ICC finds that progress has not been satisfactory in the implementation of the objectives of the prior year, the Committee shall make recommendations for improvements which, if not made within a reasonable amount of time, will constitute grounds for discontinuation of funding on behalf of the donors.

CLAUSE TEN. Privileges and Immunities of the Agencies for International Cooperation.

1. The Agencies for International Cooperation shall be exempt from all taxes and customs duties for the supplies and equipment provided as international cooperation.
2. The Government shall assume responsibility for handling all claims as may be presented by third parties against the Agencies for International Cooperation, their experts, agents or employees, in accordance with the provisions of the respective Agreements with the country that govern this matter; and
3. Nothing in or related to the present Memorandum of Understanding shall be deemed to constitute any waiver, express or implied, of the immunities, privileges, exemptions, or facilities enjoyed by the Agencies for International Cooperation under international law, international conventions or agreements, or the domestic legislation and laws of its Member Countries.

CLAUSE ELEVEN. Interpretation.

The agreements recited in the Whereas Clauses of the present Memorandum of Understanding, as well as the terms of any Basic Agreement or treaty now or hereafter in force that governs the general relations of the Parties shall remain wholly integrated and in full force and effect as provided therein; under no circumstances shall the present Memorandum of Understanding be interpreted to alter, modify, or restrict them. The present Memorandum of Understanding shall be interpreted as a wholly integrated document unto itself, in accordance with the objectives of the technical cooperation and the purpose of this multilateral agreement, as recited herein.

CLAUSE TWELVE. Entry into Force, Modification, Duration, and Termination.

The present Memorandum of Understanding shall enter into force upon signature by the Government and a majority of the Agencies for International Cooperation, and shall remain in effect until December 31, 1991. The present Memorandum of Understanding shall remain open to all Parties for acceptance by signature of any Party for a period of up to three month from the date of the first signature by any of the Parties.

The present Memorandum of Understanding may be modified or extended by express written consent of the Government and a majority of the Agencies for International Cooperation. Any Party may withdraw from the present Memorandum of Understanding by written notification to all other Parties, on sixty (60) days advance notice. The present Memorandum of Understanding can also be terminated as to all Parties by express written consent of the Government and a majority of the Agencies for International Cooperation, on sixty (60) days advance notice.

The obligations, assumed by the Parties under the present Memorandum of Understanding shall survive the expiration or termination thereof as necessary in order to permit the liquidation of accounts between the Parties, the handling of matters relative to the international staff, the fulfillment of any commitments that may have been assumed, and the removal from the country of the staff, funds, and property of PAHO/WHO and the other Agencies for International Cooperation.

The Agencies for International Cooperation shall not be responsible if they cannot fulfill their commitments, whether in whole or in part, for reasons of force majeure, including war, natural disasters, civil or labor disturbances, and any other cause beyond the control of the Agencies for International Cooperation.

IN WITNESS WHEREOF, the undersigned, duly authorized for this purpose, hereby affix their signatures to the present. Memorandum of Understanding in five copies of equal force and validity, in the places and on the dates indicated below.

FOR THE GOVERNMENT OF THE DOMINICAN REPUBLIC.

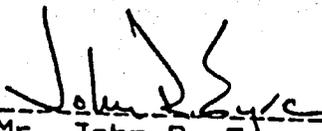


Dr. Ney B. Arias
Secretario de Estado de Salud
Pública y Asistencia Social

Place: Santo Domingo, D. N.

Date: June 15, 1987

FOR THE U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

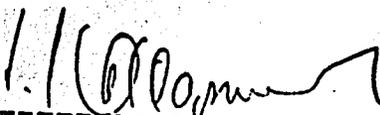


Mr. John R. Eyre
Acting Mission Director

Place: Santo Domingo, D. N.

Date: 6/19/87

FOR ROTARY CLUB INTERNATIONAL

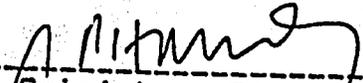


Dr. Jorge A. Hazoury Balhès
Chairman of the District Committee
Polio Plus Rotary Club International

Place: Santo Domingo, D. N.

Date: 6/19/87

FOR THE UNITED NATIONS CHILDREN'S FUND



Mr. Crisdstomo Pizarro
Mission Representative

Place: Santo Domingo, D. N.

Date: June 18, 1987

FOR THE PAN AMERICAN HEALTH ORGANIZATION/
WORLD HEALTH ORGANIZATION



Dr. Guillermo Torres Cortés
PAHO/WHO Representative
in Dominican Republic

Place: Santo Domingo, D. N.

Date: June 22, 1987

SPANISH VERSION

MEMORANDUM OF UNDERSTANDING

**ACUERDO DE ENTENDIMIENTO
ENTRE EL GOBIERNO DE LA REPUBLICA DOMINICANA,
LA AGENCIA PARA EL DESARROLLO INTERNACIONAL DE LOS EUA,
EL CLUB ROTARIO INTERNACIONAL,
EL FONDO DE LAS NACIONES UNIDAS PARA LA INFANCIA, Y
LA ORGANIZACION PANAMERICANA DE LA SALUD/
ORGANIZACION MUNDIAL DE LA SALUD
PARA LA EJECUCION DEL
PLAN DE ACCION QUINQUENAL 1987 - 1991
DEL PROGRAMA AMPLIADO DE INMUNIZACION**

Entre el Gobierno de la República Dominicana ("el Gobierno"), representado por la Secretaria de Estado de Salud Pública y Asistencia Social (SESPAS) en la persona de su titular, el Dr. Ney B. Arias, la Agencia para el Desarrollo Internacional ("AID"), representada por el Director a.i. de la Misión, en la persona del Sr. John R. Eyre, el Club Rotario Internacional ("el Rotary Club"), representado por el Gobernador del Distrito Rotario Sr. Pablo Juan Toral, en la persona del Presidente del Comité Distrital de Polio Plus y Rector de UNIBE Dr. Jorge A. Hazoury Bahlés, el Fondo de las Naciones Unidas para la Infancia ("el UNICEF"), representado por el Oficial de Programas Residente, en la persona del Sr. Crisóstomo Pizarro y la Organización Panamericana de la Salud, Oficina Regional de la Organización Mundial de la Salud ("la OPS/DMS"), representada por el Representante en República Dominicana Dr. Guillermo Torres Cortés, se celebra el presente Acuerdo de Entendimiento para la ejecución del Plan de Acción Nacional Quinquenal 1987 - 1991 ("el Plan de Acción Nacional") del Programa Ampliado de Inmunización ("el PAI"), sujeto a los Considerandos y Cláusulas siguientes:

CONSIDERANDO:

1. Que en fecha 10 de Octubre de 1952 el Gobierno y la OPS/DMS firmaron un Acuerdo Básico sobre Privilegios e Inmidades y Cooperación Técnica;
2. Que en fecha 15 de Febrero de 1952 el Gobierno y el UNICEF firmaron un Acuerdo de Cooperación Financiera y Técnica.
3. Que en Septiembre de 1983 la OPS/DMS y el UNICEF firmaron un Acuerdo de Entendimiento, en el cual reconoce que éstas, como agencias especializadas de la Organización de las Naciones Unidas, han recibido el mandato de colaborar en forma prioritaria en la solución de los

problemas de salud de acuerdo con las necesidades de los pueblos y dentro del marco de las políticas nacionales;

4. Que en Agosto de 1986 la AID concedió a la OPS/OMS la donación CAR-0005-G-00-6971-00 dentro del Programa para la Supervivencia Infantil: Programa de Inmunización Acelerada en las Américas, por un monto de US\$5,632,000, con una contribución total estimada en US\$20,600,000, en vigencia hasta el 31 de Julio de 1991. Posteriormente, la misión USAID/DR acordó proveer JS\$705,000 adicionales como subsidio bilateral para las actividades de inmunización específicas del país descritas en el Plan de Acción Nacional. USAID entregará esos fondos a la OPS, quien a su vez brindará cooperación técnica y apoyo gerencial a la SESPAS para la ejecución del PAI hasta el 31 de Julio de 1991;
5. Que en Septiembre de 1985 el Rotary Club confirmó su compromiso de proporcionar hasta US\$10,700,000 en apoyo al PAI;
6. Que en Septiembre de 1986 el UNICEF confirmó su compromiso de proporcionar hasta US\$17,700,000 en apoyo al PAI para alcanzar la meta de Inmunización Global de los Niños y Erradicación del virus salvaje de la poliomielitis en las Américas para el año 1990;
7. Que en Enero de 1987, en la Tercera Reunión del Comité de Coordinación Interagencial del PAI (el "CCI"), compuesto de representantes de la AID, el BID, el Rotary Club, UNICEF y la OPS, los miembros del CCI decidieron, inter alia:
 1. Coordinar sus esfuerzos en apoyo al PAI para evitar duplicación de esfuerzos y recursos y para reforzar la contribución de cada agencia en apoyo al PAI; y
 2. Establecer, a nivel de país, un Comité de Coordinación Interagencial Nacional (el "CCI Nacional") con el fin de celebrar reuniones periódicas para discutir el PAI y coordinar la ejecución del Plan de Acción Nacional.
8. Que en Febrero de 1987 la OPS/OMS confirmó su compromiso de proporcionar recursos en especie por un valor de hasta US\$5,750,000 para el PAI, sujeto a asignación de fondos por sus Cuerpos Directivos;

9. Que en Febrero de 1987 el Banco Interamericano de Desarrollo (en lo adelante "el BID") y la OPS/OMS firmaron el Convenio ATN/SF-2851-RE para cooperación técnica para la erradicación del virus salvaje de la poliomielitis en los países latinoamericanos miembros del Banco, por un monto de US\$5,550,000, en vigencia hasta el 5 de Junio de 1992;
10. Que en Mayo de 1987 el Gobierno presentó su Plan de Acción Nacional para el PAI a la AID, el Rotary Club, el UNICEF y la OPS/OMS ("las Agencias de Cooperación Internacional"), objetivando la inmunización universal de los niños hasta 1990, la erradicación de la poliomielitis y la disminución de la morbilidad infantil por enfermedades inmunoprevenibles, el cual se anexa y forma parte íntegra del presente Acuerdo de Entendimiento.

ACUERDAN:**CLAUSULA PRIMERA. Del objeto del Acuerdo de Entendimiento.**

El presente Acuerdo de Entendimiento tiene por objeto:

1. Formalizar el papel del CCI Nacional como el instrumento por el cual todas las Partes del presente Acuerdo de Entendimiento puedan intercambiar información respecto a los avances del Plan de Acción Nacional, para poder asegurar que se cumpla lo máximo posible con los objetivos técnicos del PAI, dado la disposición de recursos para este efecto;
2. Coordinar los esfuerzos de las Agencias de Cooperación Internacional con los Gobiernos, por medio del CCI Nacional, para ejecutar el Plan de Acción Nacional de una manera unificada y solidaria; y
3. Clarificar la responsabilidad de cada una de las Agencias de Cooperación Internacional ante el Gobierno para asegurar que sus contribuciones bilaterales al país tomen en cuenta las recomendaciones del CCI Nacional.

Sin perjuicio de lo anterior, el presente Acuerdo de Entendimiento no modifica los términos de los otros acuerdos suscritos por cualesquiera de las Partes con respecto al país. Cada Parte reserva el derecho de modificar o dar terminación a cualesquiera de dichos otros acuerdos, siempre que cada Parte coopere de buena fe con las demás partes de manera consistente con el presente Acuerdo de Entendimiento.

CLAUSULA SEGUNDA. Del objetivo de la Cooperación Técnica.

La cooperación técnica contemplada bajo el presente Acuerdo de Entendimiento tiene como metas generales la inmunización de todos los niños y la erradicación del virus salvaje de la poliomielitis en la Región de las Américas para el año 1990. Las metas específicas son las que se detallan en el Plan de Acción Nacional.

CLAUSULA TERCERA. De la Ejecución y Administración.

La responsabilidad directa por la ejecución de las actividades a nivel nacional recae en la Secretaría de Salud, según lo indicado en el Plan de Acción Nacional. Cada Parte asume la responsabilidad por la administración de los recursos que le corresponda, según el Plan de Acción Nacional. En el caso de USAID/DR, los recursos serán entregados a la OPS, quien los administrará para que la SESPAS desarrolle las actividades descritas en el Plan de Acción Nacional.

CLAUSULA CUARTA. De los Compromisos del Gobierno.

El Gobierno se compromete a:

1. Proporcionar oportunamente el personal profesional, técnico, auxiliar y administrativo necesario para el desarrollo adecuado del proyecto, según lo indicado en el Anexo 1 del Plan de Acción Nacional. El Gobierno deberá presentar evidencia de que se ha designado y establecido el cuadro de personal nacional suficiente para el desarrollo adecuado del Plan de Acción Nacional.
2. Proporcionar los recursos indicados en el Anexo 2 del Plan de Acción Nacional bajo el encabezamiento "Fuente Nacional", por un monto estimado de US\$10,406,800.
3. Proporcionar, dentro de sus posibilidades, las facilidades de transporte interno, asistencia para obtener alojamiento adecuado, locales, servicios, útiles y gastos de comunicación y toda otra capacidad instalada que se requiera para la ejecución cabal de las actividades, así como para la realización de las reuniones del CCI Nacional, de acuerdo con lo previsto en la Cláusula Novena del presente Acuerdo de Entendimiento.
4. Convocar y servir de secretariado para las reuniones del CCI Nacional, de acuerdo con lo previsto en la Cláusula Novena del presente Acuerdo de Entendimiento.

5. Mantener informadas a las Agencias de Cooperación Internacional sobre los progresos y resultados del PAI mediante informes anuales y trimestrales. (Favor ver la Cláusula Nueve que describe los reportes anuales). Los reportes trimestrales deberán determinar los objetivos para el trimestre, cumplimiento, problemas encontrados y sus soluciones y objetivos para el próximo trimestre. La fecha de vencimiento de los reportes trimestrales será de cuatro (4) semanas después de la terminación del trimestre respectivo.
6. Operar y manejar el PAI de acuerdo con sus normas para la administración de inmunización, educación, información, reporte, gestión y control de fondos.
7. Desarrollar procedimientos y manuales uniformes para ser usados en la gerencia del programa y en la capacitación y describir la implementación de los diferentes componentes del programa. Los procedimientos y manuales serán distribuidos a todos los servicios de salud y oficinas regionales, para facilitar la institucionalización y continuidad del programa.
8. Presentar los planes de implementación detallados como prerrequisito al desembolso de fondos para actividades especificadas en el Plan de Acción Nacional.
9. Continuar el proyecto en la medida que lo permitan sus recursos, una vez se haya puesto fin a la cooperación internacional.

CLAUSULA QUINTA. De los Compromisos de la AID-República Dominicana.

La AID, sujeta a sus normas y reglamentos, se compromete a:

1. De acuerdo con los términos del Acuerdo Bilateral de Asistencia, con sus modificaciones posteriores correspondientes, proporcionar los recursos indicados en el Anexo 2 del Plan de Acción Nacional bajo el encabezamiento "Fuente Externa/AID", por un monto estimado de US\$705,000.00 a través de OPS.
2. Participar activamente en el CCI Nacional, de acuerdo con los términos del presente Acuerdo de Entendimiento.

CLAUSULA SEXTA. De los Compromisos del Rotary Club.

El Rotary Club, sujeto a sus normas y reglamentos, se compromete a:

1. Proporcionar los recursos indicados en el Anexo 2 del Plan de Acción Nacional bajo el encabezamiento "Fuente Externa/CLUB ROTARY", consistiendo principalmente de vacunas antipoliomielíticas, por un monto estimado de US\$251,000.00.
2. Participar activamente en el CCI Nacional, de acuerdo con los términos del presente Acuerdo de Entendimiento.

CLAUSULA SEPTIMA. De los Compromisos del UNICEF-República Dominicana.

1. Proporcionar los recursos indicados en el Anexo 2 del Plan de Acción Nacional bajo el encabezamiento "Fuente Externa/UNICEF, por un monto estimado de US\$968,000 (1987-1991) (*).
2. Participar activamente en el CCI Nacional, de acuerdo con los términos del presente Acuerdo de Entendimiento.

CLAUSULA OCTAVA. De los Compromisos de la OPS/OMS-República Dominicana.

La OPS/OMS, sujeta a sus normas y reglamentos y dentro de la disponibilidad de sus recursos financieros y humanos y los fondos proporcionados por cada fuente de financiamiento según lo dispuesto en el Anexo 2 del Plan de Acción Nacional, se compromete a:

1. Proporcionar servicios de cooperación técnica mediante asesoría y orientación técnica a través de su personal en la Oficina Central, en los Programas Regionales y en su Representación en el país.
2. Proporcionar los recursos indicados en el Anexo 2 del Plan de Acción Nacional bajo el encabezamiento "Fuente Externa/OPS", en las tres columnas marcadas "Reg.", "AID" y "BID" respectivamente, por un monto estimado de US\$865,500.

(*) US\$480,000 son fondos anotados sujetos a la provisión de donantes..

3. Administrar de acuerdo con las normas vigentes para manejo de fondos extrapresupuestarios, los recursos indicados en el Anexo 2 del Plan de Acción Nacional bajo el encabezamiento "Fuente Externa/AID", por un monto estimado de US\$705,000.00.
4. Participar activamente en el CCI Nacional, de acuerdo con los términos del presente Acuerdo de Entendimiento.

CLAUSULA NOVENA. Del Seguimiento y Evaluación.

Las Partes se comprometen a reunirse cada trimestre para hacer el seguimiento y evaluación del Plan de Acción Nacional del año que corresponda. En dicha reunión, los representantes de las Partes deberán hacer un análisis conjunto de las actividades ejecutadas, de los recursos utilizados y de los resultados logrados, y deberán preparar un informe, e incluir sus recomendaciones pertinentes. Se entiende que al supervisar la ejecución de las actividades del Plan de Acción Nacional, las Agencias de Cooperación Internacional deberán tomar en cuenta los resultados de esta evaluación trimestral.

Por lo menos una vez al año, las Partes realizarán una revisión del plan y determinarán el grado de cumplimiento alcanzado en la ejecución del plan de implementación del año previo y harán recomendaciones a la SESPAS con el objeto de mejorar la implementación del año siguiente. Esta reunión anual de evaluación se llevará a cabo dentro de las 12 semanas después de la terminación del año respectivo. Si el CCI encuentra que el progreso en la implementación de los objetivos del año anterior no ha sido satisfactorio, el CCI hará recomendaciones para su corrección, las cuales, de no llevarse a cabo en tiempo prudencial, constituirán suficiente razón para la retención de los fondos por parte de los donantes.

CLAUSULA DECIMA. De los Privilegios e Inmunidades de las Agencias de Cooperación Internacional.

1. Las Agencias de Cooperación Internacional serán exentas de todo impuesto y derecho de aduana para los suministros y equipos que sean provistos por la cooperación internacional;
2. El Gobierno tomará a su cargo el trámite de todas las reclamaciones que se presenten por terceras partes contra las Agencias de Cooperación Internacional, sus

expertos, agentes o empleados, de acuerdo con las disposiciones de sus respectivos Acuerdos con el país que puedan regular esta materia.

3. Nada de lo relacionado con el presente Acuerdo de Entendimiento debe considerarse constitutivo de una renuncia expresa o tácita de las inmunidades, privilegios, excepciones o facilidades adquiridas por las Agencias de Cooperación Internacional, amparadas en la ley internacional, convenciones internacionales, acuerdos o la legislación doméstica y leyes de los Países Miembros.

CLAUSULA DECIMOPRIMERA. De la Interpretación.

Los convenios citados en la Parte Considerativa del presente Acuerdo de Entendimiento, así como cualquier Acuerdo Básico o Tratado que esté en vigencia actualmente o que entrara en vigencia posteriormente, que rijan las relaciones generales de las Partes, conservarán la integridad y la validez de sus disposiciones, y bajo circunstancia alguna se interpretará que el presente Acuerdo de Entendimiento los altera, modifica o restringe. El presente Acuerdo de Entendimiento se interpretará como unidad en sí mismo, tomando en cuenta los objetivos perseguidos y su naturaleza operativa multipartidista.

CLAUSULA DECIMOSEGUNDA. De la Entrada en Vigor, Modificación, Duración y Terminación.

El presente Acuerdo de Entendimiento entrará en vigor al ser firmado por el Gobierno y la mayoría de las Agencias Internacionales de Cooperación y permanecerá en vigencia hasta el 31 de Diciembre de 1991. El presente Acuerdo de Entendimiento quedará abierto a todas las Partes para su aceptación por firma, por un período de tres meses a partir de la primera fecha de firma por cualquiera de las Partes.

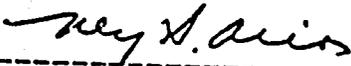
El presente Acuerdo de Entendimiento puede ser modificado o prorrogado por consentimiento mutuo por escrito del Gobierno y la mayoría de las Agencias Internacionales de Cooperación. Cualquiera de las Parte puede retirarse del presente Acuerdo de Entendimiento por aviso escrito a todas las demás Partes, con sesenta (60) días de anticipación. Además, el presente Acuerdo de Entendimiento puede ser terminado con respecto a todas las Partes por consentimiento mutuo por escrito del Gobierno y la mayoría de las Agencias Internacionales de Cooperación) días de anticipación.

Las obligaciones que asumen las Partes bajo el presente Acuerdo de Entendimiento, sobrevivirán la expiración o terminación del mismo en la medida que sea necesario para permitir la liquidación de cuentas entre las Partes, la tramitación de asuntos de compromisos adquiridos y la salida del país del personal, fondos y haberes de la OPS/OMS y otras agencias.

Las Agencias Internacionales de Cooperación no serán responsables si no pueden cumplir total o parcialmente sus compromisos por razones de fuerza mayor, incluyendo guerras, desastres naturales, disturbios civiles o industriales y cualquier otra causa que escape la intervención de las Agencias Internacionales de Cooperación.

EN FE DE LO CUAL, los suscritos, debidamente autorizados para tal efecto, firman el presente Acuerdo de Entendimiento en cinco ejemplares de igual tenor y validez, en los lugares y fechas abajo indicadas.

POR EL GOBIERNO DE LA REPUBLICA DOMINICANA

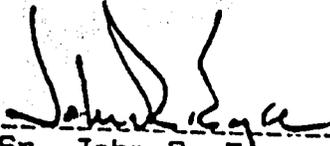


Dr. Ney B. Arias
Secretario de Estado de Salud
Pública y Asistencia Social

Lugar: Santo Domingo, D. N.

Fecha: 15 de Junio de 1987

POR LA AGENCIA INTERNACIONAL PARA EL DESARROLLO

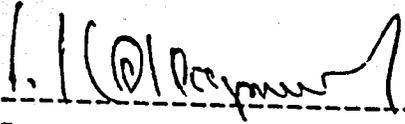


Sr. John R. Eyre
Director a.i. de la Misión

Lugar: Santo Domingo, D. N.

Fecha: 6/19/87

POR EL CLUB ROTARIO INTERNACIONAL

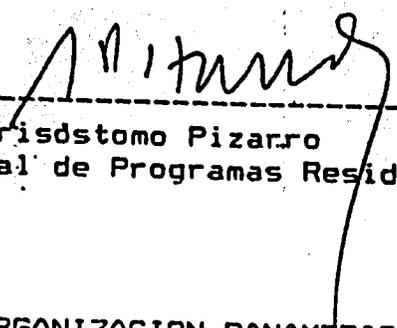


Dr. Jorge A. Hazoury Balhès
Presidente Comité Distrital Polio Plus
Club Rotario Internacional

Lugar: Santo Domingo, D. N.

Fecha: 6/19/87

POR FONDO DE LAS NACIONES UNIDAS PARA LA INFANCIA



Sr. Cristostomo Pizarro
Oficial de Programas Residente

Lugar: Santo Domingo, D. N.

Fecha: 18 de Junio de 1987

POR ORGANIZACION PANAMERICANA DE LA SALUD/
ORGANIZACION MUNDIAL DE LA SALUD



Dr. Guillermo Torres Cortés
Representante de la OPS/OMS
en República Dominicana

Lugar: Santo Domingo, D. N.

Fecha: 22 de Junio de 1987

STANDARD FORM FOR PROVIDING INFORMATION ON OBJECTIVES

1. OBJECTIVE No. 10: Reduce Infant and Child Mortality

LAC INDICATORS/UNITS OF MEASURE:

A. Infant mortality (0-1 years) per 1,000 live births.

2. PERFORMANCE UNDER LAC INDICATORS	1984 ACTUAL	1985 ACTUAL	1986 PROJ.	1986 ACTUAL	1987 PROJ.	1988 PROJ.	1989 PROJ.
A. Infant mortality rate	- 1/	- 1/	- 1/	75-80 2/	78	76	74

1/ CELADE projections show infant mortality rates of 67, 65, and 63 in 1984, 1985, and 1986, respectively. However, more recent evidence indicates that the rates were actually higher.

2/ UNICEF/Santo Domingo in its February 1987 report on The Status of Children in the Dominican Republic provides an infant mortality figure of 75/1,000 for 1986. The data are revised figures provided by CELADE. The 1986 Demographic and Health Survey conducted by the Dominican Republic's National Council on Population and the Family (CONAPOFA) and Westinghouse Health Systems shows an average infant mortality of 80/1,000 based on a representative sample of 8,000 households. The range in infant mortality was from 72/1,000 to 90/1,000 depending on the health region sampled. While some of the difference between actual and projected rates for 1986 is due to differences in sampling techniques, we believe that the Dominican Republic did experience an increase in infant mortality during the period 1985/1986 because the country's deteriorating economic situation led to significant declines in real incomes, particularly among its poorer working class (see block 3).

3. ACTUAL VS. PLANNED ACCOMPLISHMENTS UNDER BENCHMARKS FOR FY-1986 AND EARLY FY-1987 IN LAST YEAR'S ACTION PLAN:

Our FY-1987/1988 Action Plan did not include specific targets for FY-1986/1987. Nevertheless, we expected 95,000 beneficiaries to participate in the Title II MCH program in FY-1986 and early FY-1987. The actual number was 87,760--a modest accomplishment, particularly since most of the Title II distribution programs still do not incorporate nutrition education or the set of child survival interventions that can reduce malnutrition and infant mortality. Beginning in FY-1987, we will monitor the number of Title II beneficiaries who participate in a minimum set of child survival interventions consisting of nutrition education (individual and group instruction at least once per month), growth monitoring (child weighings every three months), immunizations (according to the LAC Accelerated Immunization Program schedule), and availability of ORT. We estimate that, by the end of 1986, 10% of the beneficiaries had access to all the elements of this minimum child survival intervention package.

With regard to infant mortality, the Mission last year projected a rate of 65/1,000 by 1987/1988. This projection was based on data provided by CELADE that appear, in light of more recent evidence, to have significantly underestimated actual rates. The Mission believes that rates of infant mortality have probably increased during the past three years because of: (a) recent high rates of unemployment and underemployment; (b) rapid increases in the basic cost of living, which have made it necessary for poor families to consume less; and shift their consumption to less costly and less nutritive foods; (c) an increasing number of low weight births and malnourished children; and (d) a deterioration in the level of basic health services offered by the public sector occasioned by budget constraints in the mid-1980's.

4. KEY ASSUMPTIONS ON WHICH PROJECTIONS AND TARGETS FOR PERFORMANCE INDICATORS ARE BASED:

- A. Economic gains will be distributed to the working population to permit increased purchasing power.
- B. GODR does not reduce its financial support for health and family planning below 1986 levels unless alternative forms of financing are instituted.
- C. GODR will improve the management and coordination of services provided through its primary health care system.
- D. International donor agencies, who support the LAC Accelerated Immunization Program will continue funding, as planned.
- E. CARE will increase its Title II program and incorporate child survival interventions, as planned.
- F. The Child Survival project will be implemented in FY-1987, as planned.

52

6	KEY PROJECT/PROGRAM ACCOMPLISHMENTS PLANNED FOR ACTION PLAN PERIOD	QUARTER/YEAR	
	Infant mortality rate reduced from 80/1,000 to 76/1,000 to 74/1,000	4	88
		4	89
	-- 65% of all MCH Title II beneficiaries will be enrolled in a child survival program composed of growth monitoring, diarrheal disease control and ORT, nutrition education, and immunizations.	4	88
	-- 70% of all MCH Title II beneficiaries enrolled in a child survival program.	4	89
	-- 50% of middle to low income mothers with children under five years of age will be participating in a national child survival program.	4	88
	-- 70% of middle to low income mothers with children under five years of age will be participating in a national child survival program.	4	89
	Immunization for childhood diseases will reach the following coverage levels for children under five years of age:		
	-- Polio - 80%	4	88
	DPT III - 80%		
	Measles - 80%		
	BCG - 80%		
	-- Polio - 90%	4	89
	DPT III - 90%		
	Measles - 90%		
	BCG - 90%		
	-- SESPAS will develop and implement a reliable information system to report on the effectiveness of the Child Survival Program.	2	88
	-- A Donor Coordinating Group will be established to minimize institutional conflicts and better direct donor resources.	1	88

53

7. PROJECTS SUPPORTING OBJECTIVE

Title	Number	New (N) Ongoing (O)	Type of Funding	LOP (\$000)	L/G/ LC	OBLIGATIONS			
						Cum. thru FY-86	FY- 1987	FY- 1988	FY- 1989
Applied Nutrition Education Program (OPG)	517-0174	O - 83	DA	495	G	495	-	-	-
Child Survival (OPG)	517-0239	N - 87	DA PL-480	2,750 (1,000)	G LC	-	2,750	-	-
LAC Accelerated Immuniz. PL-480 Title II	598-0643	N - 87	DA	705	G	-	705	-	-
PL-480 Title II - CARE	517-LC-17	O - 87	Continuing PL-480 <u>1/</u>	Continuing	G	-	1,713	3,000	3,000
			PL-480	(200)	LC	(100)	(100)	-	-

1/ AID/W PL-480 Title II account.

54

8. NARRATIVE:

In an effort to meet the objective of reduced infant mortality, the Mission's development strategy focuses on those actions (i.e., increased and diversified agricultural production, private sector industrial development) which are aimed at increasing the standard of living of the average Dominican citizen. Assuming that increased incomes from the projected economic growth are widely shared, there should be greater disposable resources at the family level to purchase food and health care to bring down the rate of infant mortality.

The policy dialogue with the GODR and private sector that best supports diminishing the rates of infant mortality in the long-term are those negotiations that encourage the application of sound economic development practices in the Dominican Republic. In the short-term, however, infant mortality will be reduced by widespread application of child survival interventions and supplementary food assistance targeted at the low income portion of the population. In addition, primary health care, including the prevention and treatment of respiratory diseases, will have to improve as must hospital services for treatment of acute childhood illness. The recommended improvements in the overall health care system are discussed under Objective No. 9.

From 1982 to 1986, AID and PAHO evaluations have documented a deterioration of basic health services throughout the Dominican Republic. A "showcase" immunization program was launched in late 1983 which lasted for approximately three years. However, because of the inadequate reporting procedures used by SESPAS, the results reported for the vaccination campaigns are not considered reliable. During the same period, there was only one attempt, in December of 1985, to distribute ORS via a national campaign. ORS, by and large, is not available at most SESPAS establishments today.

The Mission believes that the most effective way to obtain a significant reduction in infant mortality rates in the short-term is to implement a national child survival program through SESPAS and selected PVOs. The child survival program will incorporate and expand on those elements of the Applied Nutrition Education Program (ANEP) OPG that have proven effective. These include the growth monitoring model, use of educational materials and mass media messages, and training and supervision of health personnel. The Mission's Title II effort implemented by CARE will be incorporated into the larger child survival program. CARE already has 1,200 food distribution centers throughout the country that reach the target population. Their administrative and technical personnel can complement SESPAS staff. The process of retraining SESPAS health promoters to carry out nutrition interventions at the community level has already begun. Constraints to implementing a national child survival program through SESPAS include the lack of programmatic and administrative experience among the directors of key divisions which have shown a notable inability in the past to coordinate activities among themselves and with other organizations, even when headed by experienced supervisors.

USAID resources will assist child survival activities in the Dominican Republic through family planning (\$5 million via Project No. 517-0229), Title II with CARE and SESPAS, immunizations (\$705,000 LAC Accelerated Immunization Program), and the new Child Survival program (\$2,750,000). SESPAS is the principal host country

55

8. NARRATIVE: (Continuation)

Implementor in each case. Because of our concern with SESPAS' capacity to coordinate such a range of programs effectively, we will work at a policy dialogue level to establish a National Council on Child Survival and Primary Health Care that will coordinate with the GODR in the design and implementation of the FY-1987 Child Survival project. The Council will also have the participation of selected PVOs who complement the work of SESPAS or provide services in geographic areas not covered by SESPAS.

The main international donors (i.e., UNICEF, PAHO, UNFPA, BID, Rotary) who fund child survival activities, will also be encouraged to participate in the coordinating mechanism so that we do not overburden SESPAS' implementation capacity or form competitive relationships between SESPAS programs seeking resources from international donors.

The FY-1987 Child Survival OPG, the buy-in to the LAC Accelerated Immunization Program, and PL-480 Title II will be the Mission's vehicles to carry out the desired policy changes and introduce the programmatic improvements needed to reduce infant mortality.

ILLUSTRATIVE BUDGET

The budget for the USAID/DR grant donation to PAHO for the implementation of the Immunization program in the Dominican Republic is found in detail in Annex 1 to Attachment A. Below appears the USAID/DR contribution to the LAC Accelerated Immunization Program by category of expenditure. This budget forms part of the donors' contribution to the immunization program as seen on the following page.

LOP BUDGET (1987-1991)

<u>Category</u>	<u>Amount (US\$000)</u>
1. Biological Supplies	455.4
2. Cold Chain	19.8
3. Training	108.2
4. Social Communication	40.0
5. Operating Costs	1.0
6. Evaluation	22.0
7. Maintenance	58.6
TOTAL	705.0

LOP BUDGET (1987 - 1991)
Planned Expenditures by Year (US\$000)

<u>1987</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>	<u>TOTAL</u>
244.4	150.6	132.0	99.2	78.8	705.0

Cont: See Page 65-A of 65.

S. RESUMEN GENERAL POR FUENTE Y POR AREAS DE ACCION, 1967-1971.

País: REPUBLICA DOMINICANA		(Miles de US\$)													
Area de Accion	Tipo de Costo	FUENTE EXTERNA						FUENTE NACIONAL							
		D	P	S	UNICEF	AID	OTRO	TOTAL	X	GOBIERNO	OTROS	TOTAL	X	TOTAL	
		Reg.	1967	1968	1969	Total									
1.	INV.				0.0	-						0.0			
BIOLÓGICOS	IFUN.				0.0	423.9	455.4					423.9	1121.3		
SUMINISTROS	ITOTAL	4.0	0.0	0.0	0.0	423.9	455.4					423.9	1121.3	0.7	604.5
2.	INV.		37.0	20.0	57.0	194.0	4.3	235.0				1543.5			
CALCINA DE FRÍO	IFUN.		2.0	125.0	30.0	40.0	15.0					85.0			
	ITOTAL	2.0	27.0	145.0	67.0	236.0	19.2	250.0				215.4	0.0		215.4
3.	INV.		4.0	175.2	77.2	160.9	169.2					235.2			
CAPACITACION	IFUN.		25.0	30.0		55.0						55.0			
	ITOTAL	25.0	20.0	75.2	137.2	167.8	169.2	0.0				235.2	0.0		235.2
4.	INV.				0.0							0.0			
COMUNICACION SOCIAL	IFUN.		1100.0		100.0	75.0	40.0					16.0	225.0		
	ITOTAL	0.0	1100.0	0.0	100.0	75.0	40.0	0.0				16.0	225.0	0.5	20.0
5.	INV.		10.0		10.0							10.0			
BÁSICOS OPERATIVOS	IFUN.				0.0		1.0					1.0			
	ITOTAL	0.0	10.0	0.0	10.0	0.0	1.0	0.0				1.0	0.0		9250.0
6.	INV.				0.0							0.0			
SUPERVISION	IFUN.		72.0		72.0							72.0			
	ITOTAL	0.0	72.0	0.0	72.0	0.0	0.0	0.0				72.0	0.5		55.0
7.	INV.		28.5		27.0							57.5			
VIGILANCIA EPIDEMIOLÓGICA	IFUN.		52.0	78.8	170.8							170.8			
	ITOTAL	28.5	52.0	117.8	229.2	0.0	0.0	0.0				170.8			30.0
8.	INV.				0.0							0.0			
INVESTIGACION	IFUN.		75.0		75.0							75.0			
	ITOTAL	0.0	75.0	0.0	75.0	0.0	0.0	0.0				75.0	1.0		9.0
9.	INV.				0.0							0.0			
EVALUACION	IFUN.		15.0	51.0		66.0	15.0	22.0				103.0			
	ITOTAL	15.0	51.0	0.0	66.0	15.0	22.0	0.0				103.0			0.0
10.	INV.		10.0		10.0							10.0			
TRANSPORTE	IFUN.		65.0		65.0	6.7						71.7			
	ITOTAL	0.0	65.0	0.0	65.0	6.7	0.0	44.0				71.7	0.5		152.8
11.	INV.				0.0							0.0			
PANTERMINENTO	IFUN.				0.0	30.0	53.5	60.0				143.5			
	ITOTAL	0.0	0.0	0.0	0.0	30.0	53.5	60.0				143.5	0.3		41.0
TOTAL	IFUN.		32.5	57.0	1122.2	211.7	231.5	113.0	770.0			0.0	1143.5	1.0	0.0
	ITOTAL	42.0	1505.0	1168.3	852.6	592.6	592.0	67.0	492.0	12370.4		0.2	10463.8	175.0	11031.8

58

EP 2.0

Fecha: 23 de mayo de 1986.

De: Lee R. Hougen, Jefe, División de Salud y Población. (2/)

Asunto: Inmunización en República Dominicana

A: Dr. Guillermo Torres, Representante Residente, OPS/OMS ✓
Dra. Haydée de Osorio, Representante Residente, UNICEF ✓
Sr. Carlos Rafael Ramírez, Especialista Sectorial, BID ✓

Adjunto podrán encontrar copia del proyecto "Programa de Inmunización Acelerada en las Américas: 1986-1990". El mismo fue presentado a la AID por la Organización Panamericana de la Salud en Washington, D. C., en colaboración con UNICEF, BID y Rotary International. La contribución de los donantes al proyecto es la siguiente:

AID	\$ 20.50 M
OPS/OMS	4.65
BID	16.60
Rotary International	10.70
UNICEF	5.00
TOTAL	\$ 47.55 M

Espero reunirme con ustedes en la AID, el próximo miércoles 28 a las 3:00 p.m. para hablar sobre este proyecto y otros programas de ayuda a la República Dominicana.

Agradecería trajeran a dicha reunión los datos sobre inmunización en República Dominicana disponibles en sus oficinas.

Anexo : Citado

*Dr. Hougen
05/23/86
P.R.*

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05/23/86 -- ID-0364h

U. S. AID MISSION TO DOMINICAN REPUBLIC

AMERICAN EMBASSY, P. O Box 2220-L
SANTO DOMINGO, DOMINICAN REPUBLIC

FOR U. S. CORRESPONDENTS:
U. S. AID MISSION
APO MIAMI 34041-0008

Fecha: 23 de mayo de 1986.

De: Lee K. Hougen, Jefe, División de Salud y Población 

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Dra. Haydée de Osorio, Representante Residente, UNICEF
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Anexo : Citado

CHILD SURVIVAL: ACCELERATED IMMUNIZATION PROGRAM IN THE AMERICAS
1986-1990

A Proposal to the U.S. Agency for International Development

CONTENTS

SUMMARY	1
1. INTRODUCTION	5
2. BACKGROUND	
2.1 Nature and Magnitude of the Problem	6
2.2 Progress to Date	7
2.3 Rationale	14
2.4 Sustainability	17
2.5 Strengthening Primary Health Care.	19
3. PROGRAM DESCRIPTION	
3.1 Goal, Purpose and Outcomes	20
3.2 Strategy	21
3.2.1 Priority Countries for Action	22
3.2.2 National Plans of Action	24
3.2.3 Country Specific Actions	27
3.2.4 Regional Activities	30
3.3 Program Beneficiaries.	39
3.4 Budget and Financial Plan	39
3.5 Implementation, Management and Coordination.	57
3.6 Timetable	67
3.7 Evaluation	67
3.7.1 Plan for AID-Financed Project	67
3.7.2 Financial Management.	70
3.7.3 Program Evaluation and Reports.	71
4. TECHNICAL ANALYSIS	74
5. ECONOMIC ANALYSIS	82

ANNEXES

- A. Plan of Action
- B. Resolution of the Directing Council
- C. Estimated Total External Funding by Donor Agencies
- D. Format for Timetable of National Annual Work Plan
- E. Timetable of Project Implementation
- F. Log Frame
- G. Breakdown of Personnel Post Costs

LIST OF TABLES

- 1. Number of Polio Cases in the Americas by Country, 1975-1984
- 2. Percentage Change in Mean Number of Cases of Poliomyelitis by Stages. Post-EPI Implementation
- 3. Coverages with Three or More Doses of Polio Vaccine in the Americas, 1978-1984
- 4. Vaccination Coverage in Children Under One Year, by Vaccine Type in the Region of the Americas, 1984
- 5. Risk Status of Poliomyelitis in the Americas, 1984
- 6. Proposed AID Budget
- 7. Proposed Budget for All Donor Agencies
- 8. Proposed Location of Subregional Advisors

LIST OF FIGURES

- 1. Annual Reported Incidence of Poliomyelitis, 1969-1984
- 2. Annual Number of Reported Cases of Poliomyelitis, 1969-1984
- 3. Organizational Chart for the Program

ABBREVIATIONS

AID	U.S. Agency for International Development
EPI	Expanded Program on Immunization
ICC	Interagency Coordinating Committee
IDB	Inter-American Development Bank
PAHO	Pan American Health Organization
TAG	Technical Advisory Group
TOPV	Trivalent Oral Polio Vaccine
DPT	Diphtheria-Pertussis-Tetanus Vaccine
TT	Tetanus Toxoid Vaccine

(ii)

DEFINITIONS

Diphtheria

A major child killer of the past in temperate countries, the mortality and morbidity of diphtheria is the least well documented of the six diseases in developing countries today. Although typically manifested as an acute infection of the throat, diphtheria toxin can affect the heart or brain of infants and young children. Vaccination against diphtheria over the past 50 years has eliminated the disease in many developed countries. Skin infections with *C. diphtheriae* toxin can affect the heart or brain of infants and young children. Vaccination against diphtheria over the past 50 years has eliminated the disease in many developed countries. Skin infections with *C. diphtheriae* in cuts and abrasions may protect many children in developing countries from the severe infection.

DPT:

This vaccine contains toxoids of Corynebacterium diphtheria, Clostridium tetani and killed Bordetella pertussis bacteria. It protects against Diphtheria, Tetanus and Whooping Cough, and a minimum of three doses is required.

EPI:

Initiated by a 1974 World Health Assembly Resolution and endorsed by a PAHO Directing Council resolution in 1977, this program has the goal of providing immunization services for all children of the world by 1990. Objectives include reduced mortality and morbidity from poliomyelitis, diphtheria, whooping cough, tetanus, measles, tuberculosis; increased national capability to deliver immunizations through comprehensive health services; and increased regional capability for vaccine production and quality control.

ICC:

Established in July 1985 to ensure coordination of all international agency inputs for the polio eradication program, agencies represented are AID, UNICEF, IDB, Rotary International the Task Force for Child Survival, and PAHO.

Measles:

A highly contagious viral disease which over 90 percent of the unprotected under-5 population contract in some countries. A relatively mild disease in developed countries, measles is a major cause of childhood mortality in many developing countries, particularly in Africa and Central America. Poor nutritional status seems to be the main factor leading to the most severe consequences of measles. The common practice of withholding food during a child's illness exacerbates the condition. Death is caused by pneumonia, diarrhea or in a small number of cases, encephalitis, in association with the disease. Maternal antibodies transferred through the placenta protect the infant during the first months of life. If measles vaccine is given to the infant before nine months of age, these antibodies may prevent the vaccine from producing immunity in the child. But if the child is vaccinated too late, the period of greatest danger to the child will be past.

Pertussis (Whooping Cough): Second to measles as a cause of morbidity and mortality among vaccine-preventable diseases in some developing countries. The World Health Organization estimates that up to 80 percent of unimmunized children will contract it. Pertussis, an acute bacterial infection affecting the respiratory tract, is very contagious in the first week or two of infection. The spasmodic coughing or "whooping" that characterizes the disease is readily recognized and lasts one to two months. Pertussis is more severe in children under 5 months of age and may lead to death from pneumonia or other conditions. In very young children, there is no characteristic whoop so the disease may be difficult to recognize. Immunity requires three vaccinations which may begin as early as 2 months of age.

Poliomyelitis: A viral disease spread by contact with excreta, poliomyelitis infection is universal but most persons have no symptoms. In a small minority of cases, poliomyelitis leads to varying degrees of paralysis and sometimes death. The older the child at age of infection, the more likely the infection will lead to severe consequences. The use of poliomyelitis vaccines in the last 20 years in developed countries has markedly reduced the incidence of the disease; however its relative infrequency has led to laxity and occasional outbreaks among the unimmunized. In developing countries, the incidence of paralytic poliomyelitis appears to have been seriously underestimated.

The Region: North, Central and South America, and the Caribbean.

TAG: A group of technical experts appointed by the PAHO Director to advise PAHO on the acceleration of EPI in the Americas and on efforts to eradicate the indigenous transmission of wild poliovirus from the Region

Task Force for Child Survival: Consists of representatives of WHO, UNICEF, The World Bank, UNDP and Rockefeller Foundation for the purpose of coordinating efforts to support activities directed to child survival. Its Executive Director is Dr. William Foege.

Tetanus: Caused by a toxin of a bacterium which enters the body through broken skin, neonatal tetanus is often caused by infection from the cut umbilical cord. Pregnant women who receive two tetanus toxoid immunizations within three years of delivery pass immunity which protects the newborn during the first months of life. Tetanus bacteria reside in soil so, unlike smallpox, there is no hope of eliminating the reservoir of harmful organisms. Instead, protection comes only through immunization against the disease or through improved hygiene.

TOPV: Trivalent oral polio virus vaccine which is a mixture of live attenuated strains of all three polio types I, II and III. TOPV is administered orally. At least three doses of oral polio vaccine are needed for primary immunization.

TT: Tetanus toxoid is a formaldehyde-inactivated filtrate of an anaerobic of Clostridium tetanii. This vaccine is used in the adult population, particularly those living in areas at risk of tetanus. In addition, it is recommended for women of childbearing age, or pregnant women for the protection of their offspring against neonatal tetanus. Two doses are required.

**Tuberculosis
(TB)**

TB is a bacterial disease spread by coughing and the sputum of infected persons. The disease takes many forms in children, infecting the bones, lungs or brain. Often it may not be recognized as the same disease that affects adults. TB is particularly common where many persons share the same crowded living quarters. In some cities in developing countries, one percent of the adults may be in the active infective stage of the disease. Beyond infancy, improved housing, clothing, diet, early detection and uninterrupted treatment are all necessary to effectively control TB. That these measures are difficult to achieve in many developing countries explains the importance of immunization as a means to protect those not infected by TB.

CHILD SURVIVAL: ACCELERATED IMMUNIZATION PROGRAM

Summary

Building self-sustaining immunization programs within health delivery systems is an important step toward the attainment of child survival. By providing immunization to infants, the Expanded Program on Immunization (EPI) will contribute directly to the broader goal of child survival by reducing morbidity and mortality due to the childhood diseases that are preventable by adequate immunization.

Member states of the Pan American Health Organization (PAHO) have set the goal of totally interrupting the indigenous transmission of wild poliovirus thereby eradicating poliomyelitis from the Americas by 1990. Not counting loss of income due to paralysis nor loss of life, the cost of acute care and rehabilitation of poliomyelitis to the Region is approximately US\$40 million annually.

The eradication of poliomyelitis from the Americas will promote the development of the EPI in the region through improvements in surveillance and supervision systems, vaccine delivery systems and laboratory services. It is also expected that training programs will result in improved health staff performance. In particular, the interruption of transmission of wild poliovirus will assure that no child residing in the Americas will suffer from paralytic polio due to the wild virus. In the effort to eradicate poliomyelitis through immunization, the EPI will also deliver DPT and measles vaccines as well as tetanus toxoid vaccine to women of childbearing age for the prevention of neonatal tetanus. Hence, the eradication of poliomyelitis will be the wedge by which sustainable immunization programs may be achieved while contributing directly to improved child survival.

Despite progress achieved through implementation of the Expanded Program on Immunization over the past few years, 17 countries in the region have reported cases of poliomyelitis during the past three years. Another 15 countries are at high risk of an outbreak of poliomyelitis due to immunization coverage of less than 80% of children under one year of age.

A Plan of Action to interrupt indigenous transmission of poliovirus from the Americas was reviewed and endorsed by the Directing Council of PAHO (Annex B), a Technical Advisory Group constituted by world experts in this field and by an Interagency Coordinating Committee of potential donors which includes participants from AID, IDB, Rotary International, the Task Force for Child Survival, and UNICEF. Administrator McPherson of AID addressed the Ministers of Health attending PAHO's Directing Council Meeting in September 1985 and declared his support for activities to eradicate poliomyelitis from the Region by 1990.

The Plan of Action (Annex A) documents the dramatic reduction in poliomyelitis achieved in the Region due to increased coverage with polio vaccine since 1978 and proposes that eradication of this disease from the Americas is a feasible goal for 1990. Key strategies recommended to achieve this goal are: fiscal planning to enable the mobilization of national resources and sustain coverage of recurrent costs, achievement and maintenance of 80% coverage for each country, surveillance to detect and control outbreaks, strengthened diagnostic services through laboratory support, information dissemination, a certification protocol to declare the countries and the Region free of indigenous transmission, and ongoing evaluation of all program activities. The total cost of these activities is estimated at US\$120 million, of which approximately one-third will be provided by external donors.

The total external input is estimated at US\$47,550 million and is expected to come from the donor agencies that will be supporting the acceleration effort (see Table 7--page 38, and Annex C).

The project activities to be financed by the various donors were defined taking into consideration the comments made by the representatives of these agencies during the First Meeting of the Inter-Agency Coordinating Committee, held in July, 1985. In spite of the fact that no commitments were made at the Meeting, representatives indicated some of the areas which traditionally their agencies have supported in other projects.

Another point of consideration was the novelty of the terms of reference for the contributions of the donors, particularly AID and IDB, which will entail a considerable amount of processes in the financial management of the project.

Considering the above, and in order to facilitate the planning and financial management and the participation of the IDB, it was decided that its contribution would be requested for two entire components of the project, in this case the consultants (in-country and short-term) and the training.

This grant proposal to AID totals \$20,600,000 for a five year project. Over half of this amount is accounted for by costs due to mobilization, promotion and operations research. Other costs include personnel, laboratory support, evaluations, cold chain, information dissemination and meetings.

over support

The grant is to be managed by PAHO's EPI office in Washington, D.C. AID grant funds will enable PAHO headquarters staffing to be reinforced with additional management and technical personnel to provide technical assistance and ensure adequate monitoring, supervision, coordination and liaison with donor agencies. Eleven epidemiologists resident in countries having major problems will support national Ministry of Health staff. The resident epidemiologists will be funded by IDB.

Each country will be requested to assign a member of their EPI office within the Ministry of Health (MOH) to be in charge of the polio eradication effort. The national polio eradication manager will coordinate all eradication activities within the EPI. The manager would work under the supervision of the national EPI manager and have responsibility for implementation of the National Plan of Action. This national polio eradication manager may be the same person in charge of EPI.

CP: staff

At the subregional level, seven PAHO epidemiologists/technical officers will serve as advisors on an international basis to provide support and supervisory assistance to the in-country personnel. AID will fund two subregional advisors.

PAHO/Washington will be responsible for reviewing national work plans, monitoring their implementation, centrally procuring commodities based on field requests, deploying technical assistance, operational research, evaluations, reports to AID and financial accountability. In addition to project-specific evaluations, program evaluation will include national coverage surveys, country program reviews, plus a review of regional level activities such as laboratory diagnostic services.

Technical Advisory Group and Inter-Agency Coordinating Committee meetings will be convened by PAHO at least twice annually to review progress and provide continuing guidance.

The project is being undertaken in a phased manner, starting with those countries at highest risk as determined by the classification of countries according to risk of poliomyelitis outbreaks (Table 5--page 22).

The project is aimed primarily at countries which are reporting cases of poliomyelitis or have reported cases within the last three years. Considering the weaknesses in the surveillance systems it will be necessary to ascertain the rates of underreporting as well as a confirmation of absence in those countries not reporting polio. The national polio eradication manager and the country epidemiologist with the support of the PAHO subregional advisor will prepare the National Plans of Action in collaboration with the Ministries of Finance. These Plans will be operational and will indicate activities to be undertaken. The Plans will include fiscal analysis including recurrent costs.

Country-specific annual work plans will be then prepared indicating all activities to be implemented. Gradually the countries will enter a program of training or retraining aimed at sustaining increased vaccination coverage coupled with a program to improve the disease surveillance system. Once countries have taken the necessary steps to interrupt the transmission of wild poliovirus, the project will then focus on those countries which have not reported cases of paralytic polio within the previous three years in order to assure that control measures remain at the same level or are improved.

The National Plans of Action, the country-specific annual work plans, PAHO annual project work plans and quarterly progress reports will be provided to AID. Planning is already underway at the country level. AID and other donor agency field staff will be invited to participate in this process. Preliminary meetings have been held by PAHO with MOH EPI office directors and their support has been obtained. Meetings are underway with other donor agencies to formalize funding support. The tentative start-up date is January 30, 1986.

1. INTRODUCTION

This proposal identifies specific AID inputs which will complement other donor agency resources in an overall five-year Plan of Action to interrupt wild poliovirus transmission in the Americas by 1990. This Plan was revised in July 1985 by a specially appointed PAHO/EPI Technical Advisory Group, and was approved by the PAHO Member Countries (including the U.S.A.) at the 31st PAHO Directing Council in September 1985 (Annexes A and B).

The Plan has a goal of improving the health and productivity of the population in the Americas through the prevention of immunizable diseases and has the following purpose:

To strengthen and accelerate the Expanded Program on Immunization in the Region and its objective of improved child survival, including the interruption of indigenous transmission of wild polioviruses and thus, the eradication of poliomyelitis in the American Region by the year 1990. ✓

One of the major outcomes of the effort will be setting up a surveillance system at regional and national levels, so that all suspected cases of poliomyelitis are immediately investigated, and appropriate control measures to stop transmission are rapidly implemented. This surveillance system will be the basis for measuring the impact of the overall Expanded Program on Immunization.

Section 2 of this proposal describes the nature of the polio problem and operational constraints against further expansion of coverage with polio vaccine in the Region; it provides the rationale for project design. Section 3 describes the activities and contains information on budget and implementation arrangements. Section 3 also contains the evaluation plan and a proposed schedule of reports to be submitted to AID. Sections 4 and 5 contain the technical and economic analysis of the project, respectively.

2. BACKGROUND

2.1 Nature and Magnitude of the Problem

The problem addressed in this project is the presence and transmission of the wild poliovirus and the crippling effects of poliomyelitis on the individuals, families, and nations of the Americas which can be prevented by adequate immunization. Despite the tremendous progress achieved through the implementation of the EPI over the past few years, there are still 17 countries that have reported cases of polio during the past three years. Of the remaining countries that have reported no polio cases during the same period, 15 are classified as high-risk due to the fact that less than 80% of the children under one year of age have been covered by the immunization program.

In view of the continuing presence of this problem, the member states of the Pan American Health Organization have set the target of totally interrupting the indigenous transmission of wild poliovirus, thereby eradicating poliomyelitis from the Americas by 1990. The aggregate cost of immunizing all children under five years of age in the Region against polio during the first year, and immunizing the children less than one year of age born in subsequent years is roughly \$120 million over the next five years. Approximately one-third of the funds are required from external sources. Specifically, external resources are needed to strengthen national immunization programs in order to overcome the following operational problems:

- Insufficiency of vaccine quality control in the countries of the Region to meet the demand;
- Inadequacy of laboratory infrastructure available in the Region for isolation and characterization of wild and vaccine poliovirus;
- Need for expansion of cold chain facilities, including resources and personnel for repair and equipment maintenance;
- Insufficiency of funds for adequate and timely staff mobilization to manage and supervise program and disease control activities;

Morbidity Trends

It is impressive to evaluate the number of reported cases at different stages of implementation of EPI: the first (1978-1980) representing the training period and early implementation, the second (1981-1983) representing the build-up of the program, and the third, the most recent year, 1984 (Table 2). By 1983 all subregions had shown major reductions in the number of cases reported annually from pre-EPI days, ranging from 34% in Caribbean to 91% in Temperate South America. Overall, there was a 74% reduction in the number of cases reported in the Americas. In 1984, the Caribbean and Temperate South America reported no poliomyelitis activity. Tropical South America reported a 93% reduction in cases, and overall in the Americas, there was an 88% reduction in numbers of cases.

Table 2
Mean Number of Cases of Poliomyelitis Reported Annually in the Americas by Stages Pre- and Post-EPI Implementation (with total for 1984) and Percentage Change from Pre-EPI, by Sub-region

Sub-Region	Pre-EPI	Stage 1		Stage 2		Stage 3	
	Implementation 1969-1977 Mean No.	Post-EPI 1978-1980 Mean No.	%	Post-EPI 1981-1983 Mean No.	%	Total No.	%
<u>North America</u>	20	8	-40	9	-55	8	-60
<u>Middle America</u>							
Continental*	1,062	1,140	+7	473	-55	312	-71
Caribbean	29	1	-97	19	-34	0	-100
<u>South America</u>							
Tropical	3,011	2,465	-18	599	-80	205	-93
Temperate	151	22	-85	14	-91	0	-100
TOTAL	4,274	3,651	-15	1,115	-74	525	-88

* Includes Haiti and Dominican Republic.

72

Vaccination Coverage

Table 3 presents the reported coverage of the less than one year old population with three or more doses of polio vaccine during the period 1978-1984, since the adoption of the EPI in the Americas. During this period, the proportion of countries reporting coverages has increased from 68% in 1978 to 95% in 1983 (Canada and the United States of America do not report coverages for the less than one year old population). Overall, the proportion of less than one year olds with three or more doses of polio vaccine in the Americas has increased from 35% in 1978 to greater than 75% in 1984. During the period 1978-1983, 19 countries demonstrated increasing trends of coverage.

Vaccination coverage for all the EPI vaccines has improved considerably since the EPI was launched in 1977. In 1978, 10% of children under 1 year of age lived in countries where immunization coverage was at least 50% for this age group. By 1984, the proportion of children completely immunized had risen considerably, to over 55% for DPT and Measles. Table 4 shows 1984 vaccination coverages in children under one year of age by type of vaccine.

The impact of the high coverage with polio vaccine can be seen in Figure 1, which shows the annual reported incidence of poliomyelitis in the Region of the Americas during the period 1969-1984, and in Figure 2, which shows the number of cases reported each year during the same period.

Table 3

Coverages With Three or More Doses of Polio Vaccine in the Americas, 1978-1984

Subregion and Country	% coverage by year of the less than one year old population						
	1978	1979	1980	1981	1982	1983	1984
North America							
Bermuda	...	...	39	...	68	53	48
Canada	...	...	...	...	...	...	...
United States	...	...	...	...	...	...	...
Caribbean							
Anguilla	77	48	86	81	86	99	73
Antigua and Barbuda	53	...	36	47	90	99	93
Bahamas	99	27	35	40	67	65	62
Barbados	56	60	99	54	63	62	77
British Virgin Is.	..	14	95	70	94	75	85
Cayman Islands	31	52	47	63	91	90	90
Cuba*	99	97	99	82	82	95	99
Dominica	20	31	53	97	73	92	82
Dominican Republic	28	35	46	42	37	22	99
Grenada	...	6	32	41	61	72	75
Haiti	1	3	2	3	7	6	12
Jamaica	...	...	34	37	68	47	56
Montserrat	63	5	38	55	95	95	82
Saint Lucia	32	...	58	65	81	80	84
St. Kitts/Nevis	...	25	76	71	93	91	97
St. Vincent	5	...	26	33	99	84	90
Trinidad and Tobago	45	28	38	55	59	61	66
Turks and Caicos	...	21	44	27	80	79	70
Continental Mid America							
Belize	45	42	21	51	52	61	54
Costa Rica	58	44	67	85	78	54	81
El Salvador*	..	57	42	38	42	48	44
Guatemala*	..	62	43	42	45	44	37
Honduras	7	25	32	37	53	70	84
Mexico	...	11	43	85	85	74	91
Nicaragua	18	...	99	52	50	30	73
Panama	41	57	45	50	61	60	70
Tropical South America							
Bolivia	3	12	14	15	15	11	57
Brazil*	34	49	99	99	99	99	89
Colombia	17	19	16	22	27	42	60
Ecuador	10	16	14	19	36	34	36
Guyana	31	37	42	37	73	59	41
Paraguay	2	5	14	26	39	47	59
Peru	21	19	16	20	23	18	26
Suriname	...	20	24	22	53	83	79
Venezuela	83	88	95	75	77	67	59
Temperate South America							
Argentina	..	5	31	38	94	94	64
Chile	98	97	91	93	98	93	87
Uruguay	52	58	59	58	72	74	83
Total**	34	34	59	69	74	72	78

* Second instead of third dose data.

** Includes only countries with available data.

... Data not available.

74

Figure 1

Annual reported incidence rate of poliomyelitis and other EPI diseases
(per 100,000 population),
Region of the Americas, 1969-1984

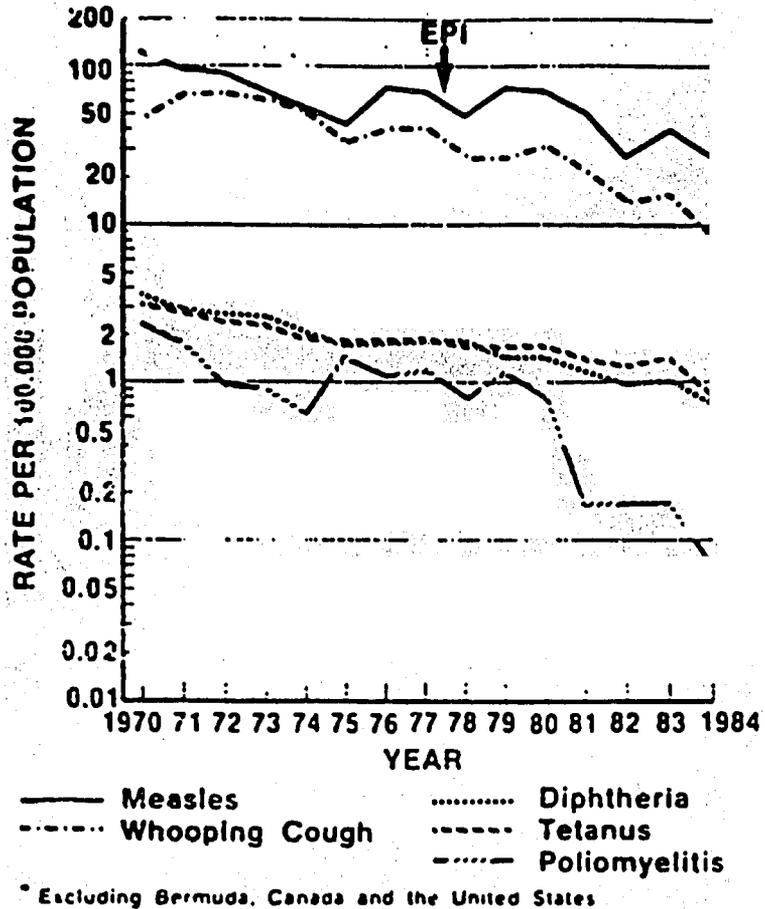


Figure 2

Annual number of reported cases of poliomyelitis

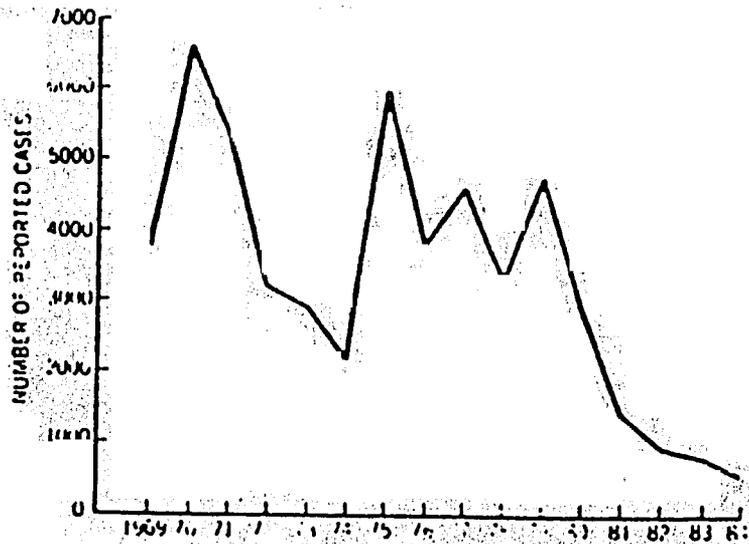


Table 4

Vaccination Coverage in Children under 1 year by Vaccine Type and Dose
in the Region of the Americas, 1984

Subregion and Country	Population Under 1 Year	DPT 3rd Dose	Polio 3rd Dose	Measles	BCG
<u>NORTH AMERICA</u>	4,420,000				
Bermuda	800	40	41	42	---
Canada	403,000	---	---	---	---
United States	3,700,000	---	---	---	---
<u>CARIBBEAN</u>	672,970				
Anguilla	200	69	73	72	75
Antigua & Barbuda	2,100	94	92	73	---
Bahamas	6,200	62	62	66	---
British Virgin Islands	300	85	85	89	---
Cayman Islands	600	90	90	75	64
Cuba	168,000	88	99	80	94
Dominica	2,500	84	82	85	84
Dominican Republic	197,000	20	99	19	43
Grenada	4,000	76	75	31	---
Haiti	200,000	12	12	13	58
Jamaica	59,000	57	56	60	48
Montserrat	300	84	82	---	81
St. Kitts/Nevis	1,800	97	97	85	---
St. Lucia	4,300	83	84	60	80
St. Vincent & Grenadines	3,500	86	90	92	32
Trinidad & Tobago	23,000	65	66	10	---
Turks & Caicos	170	60	70	44	99
<u>CONTINENTAL MID AMERICA</u>	3,522,992				
Belize	5,700	54	54	44	82
Costa Rica	68,000	82	81	83	---
El Salvador	200,000	44	44	41	21
Guatemala	294,000	54	53	27	37
Honduras	169,000	48	84	51	47
Mexico	2,622,000	26	91	30	24
Nicaragua	133,000	32	73	30	24
Panama	60,000	70	70	72	79
<u>TROPICAL SOUTH AMERICA</u>	6,103,429				
Bolivia	243,252	24	56	17	24
Brazil	3,845,000	67	99	80	79
Colombia	798,000	60	60	52	67
Ecuador	347,000	36	36	40	79
Guyana	25,000	43	41	33	49
Paraguay	122,000	58	59	53	70
Peru	672,000	26	26	32	59
Suriname	11,000	80	79	83	---
Venezuela	557,7000	27	59	25	23
<u>TEMPERATE SOUTH AMERICA</u>	938,880				
Argentina	602,000	66	64	90	72
Chile	285,000	84	86	77	87
Uruguay	57,000	57	83	17	---
<u>TOTAL FOR ALL SUBREGIONS (EXCEPT NORTH AMERICA)</u>	15,658,271	49	78	53	57

--- Data not available.

This impressive, rapid reduction in the disease burden resulting from increased coverages with the polio vaccine has paved the way for the decision to interrupt transmission of wild poliovirus in the American Hemisphere by 1990.

In September 1985, all PAHO Member Countries formally endorsed the Plan of Action for interruption of wild poliovirus transmission by approving Resolution No. 22 (Annex B) at the 31st Meeting of the PAHO Directing Council. Included in this Resolution was a request that the PAHO Director take immediate steps to assure the necessary technical and financial support to put the Plan into action. The AID Administrator, Mr. Peter McPherson, endorsed the goal of eradicating poliomyelitis from the Americas by 1990 in his Address to the PAHO Directing Council Meeting the 27th of September 1985. Several of the international donor agencies had pledged their support to the achievement of this goal on the 14th of May, 1985, when the PAHO Director first announced this goal.

2.3 Rationale

The success of the campaign to eradicate smallpox from the world, achieved in 1977, led public health officials to focus on the question of what other diseases might be potential candidates for eradication. Before serious consideration can be given to the global eradication of a disease, however, one of the most important requirements is to show that it can be eliminated from large geographic areas.

The observations documented in Section 2.2 above reported that cases in 1984 were at an all time low, indicating that the timing is propitious and that interruption of indigenous transmission of wild poliovirus in the Americas is now feasible.

Factors which favor the regional interruption of wild poliovirus are: (1) infection is limited to a human host and transmitted person to person; (2) paralytic polio is usually serious and recognizable; (3) there are no long term carrier states; (4) though the period of infectivity is not accurately known, cases are probably most infectious during the first few days before and after the onset of symptoms; (5) following the disease or immunization with polio vaccine, immunity is conferred for life, and a patient is not subject to

reinfection; (6) the seasonality of polio is such that one can experience fade-outs at the low point in the yearly cycle of the wild virus; (7) There exist two types of vaccines, TOPV and inactivated polio vaccine which have proven to be very effective in providing immunity and controlling outbreaks. The conclusions of the International Symposium on Poliomyelitis Control* indicated that both are effective against the disease and that political will and financial and administrative matters are the necessary ingredients for the achievement of worldwide control or its eradication.

Furthermore, the high costs of medical care for the acute stage and long-term rehabilitation -- as well as the incalculable costs of human suffering and lost productivity -- make polio eradication a cost-effective measure in any terms. In the Americas, the savings in medical costs alone are estimated to be almost twice the projected cost of the acceleration of the program (approximately US\$120 million with approximately US\$42,000 from external donors over five years) from now to the year 2000. (See Item 5, Economic Analysis).

The calculations of cost and benefit (in the form of reduced expenditures for treatment and rehabilitation) are based on estimates of the average cost per person vaccinated or per person treated, as they must be for total costs and benefits to be correctly estimated. However, the average cost of vaccination is almost certain to depend on the coverage achieved: as coverage approaches 100 percent, immunization is extended to people who are more difficult to reach geographically or more difficult to persuade more must be spent per person vaccinated. The marginal cost of immunization rises, perhaps sharply, as coverage expands. If coverage reaches enough of the population to cause high average costs but not enough to interrupt transmission, there is a further reason to expand coverage to break the chain of transmission and ensure eradication. That is, once adequate coverage has been achieved, marginal -- and therefore average -- costs can decline, offsetting some or all of the increased expenditure required by the higher coverage. That part of the cost due to the difficulty of reaching remote or dispersed populations cannot of course be avoided, since their immunity must be maintained. It

* Proceedings of the International Symposium on Poliomyelitis Control Reviews of Infectious Diseases, Vol. 6, Supplement 2, May-June 1984.

should be possible to eliminate the extra cost required to locate and vaccinate older children and adults, including the costs of persuading those people to accept vaccination. Once it is necessary only to vaccinate each year the infants born that year, both logistic and educational costs can and should decrease. It is therefore wasteful to approach eradication paying the high cost of high but still inadequate coverage, if an extra effort can achieve eradication and thereby lower the costs of maintaining immunity.

Polio vaccination differs in many aspects from other EPI vaccinations, permitting use of special strategies already demonstrated to produce a rapid impact on poliomyelitis activity as seen in Brazil, Colombia, Dominican Republic, and Bolivia. In addition, the paralytic forms of the disease are easy to recognize, thereby permitting an early identification of its presence and facilitating rapid implementation of control measures. Once transmission is stopped in the Hemisphere, the possibilities of reintroduction of the disease into the region of the Americas is limited to importation from other regions in the world where transmission of wild poliovirus has not ceased. In addition, from an epidemiological standpoint, poliovirus has no extra human reservoir nor does infection persist in infected individuals. Given this criteria and a population with high levels of coverage with polio vaccine, and therefore a reduced pool of susceptibles, the possibility of reintroduction is further reduced since poliovirus must initiate new infections or fade out. Should reintroduction of the wild poliovirus occur, effective measures can be rapidly organized at a lower cost to control possible spread.

The experience of the United States of America and Canada in the past decade illustrates this point. In both countries, wild poliovirus transmission ceased in the early 1970's. Only on one occasion has wild poliovirus been introduced which resulted in the occurrence of paralytic cases. Although both countries have continuing antipolio vaccination programs, there are areas where immunization coverage is not optimal and where, if the virus were constantly present, outbreaks would be expected. They have not occurred, however. If similar conditions were achieved in all countries of the Americas, cases would cease, even in those population groups which are especially difficult to reach with vaccination programs.

To assure the interruption of transmission, it will be necessary to maintain immunization levels of over 80% in children under one year of age, as stated in the Plan of Action. This coverage level should be sustained over the years, until such time as global eradication is achieved.

It is therefore proposed that whenever the existing routine services are not able to achieve this level of coverage, special acceleration efforts be made, either in the fashion of national immunization days or weeks, mass-media campaigns to increase the demand by the population, or both. These acceleration efforts should include the other EPI vaccines.

The different approaches will be decided upon as the national workplans are elaborated, taking into consideration the history and achievements of the immunization program in each specific country.

Until global eradication of polio has been achieved, control measures such as vaccination and surveillance must be maintained beyond 1990 to protect the susceptibles from the threat of importations. The eradication of indigenous transmission of wild poliovirus in the American Region deserves immediate Hemispheric action. The necessary elements to ensure program success are assured by the strong political commitment coupled with ongoing immunization programs presently shown by the countries and several multilateral, bilateral and non-governmental organizations towards immunization in particular and child survival in general.

2.4 Sustainability

To achieve the interruption of transmission of wild polio virus from the Americas, the project has to assure that a number of immunization activities and procedures are improved and/or maintained at current levels. The key to

achieving the interruption of the transmission of wild polio virus is to ensure that national immunization programs are self reliant in all aspects related to delivery of immunization, disease surveillance and control, and provision of reliable laboratory diagnostic services for analyzing specimens from all suspect cases. In addition, all programs must have staff well trained in management and training skills in order to carry out the program in the future. Though not directly related to infrastructure improvement or maintenance, but equally important, is the mobilization of the community to not only demand immunization services but also assist health authorities in the delivery of immunization services.

In order to ensure that national immunization programs are sustainable this project will specifically provide inputs directed at improving the following components of each national immunization program:

- Improving the capability of national laboratories to provide reliable diagnostic services through the provision of new equipment, and newer methods for polio virus isolation and characterization.
- Provision of cold chain equipment to assure that national cold chains are improved and/or extended to those areas currently deficient or lacking appropriate equipment to permit immunization services to be available routinely.
- Enhance surveillance activities for prompt detection of all suspect cases of poliomyelitis as well as the other EPI diseases in order that immediate control measures be implemented and that routine surveillance information is used to improve program decision-making.
- Improve the supervision of the program by instituting a routine system of supervisory visits which will allow that adjustments to annual work plans are made and that future plans include new approaches or corrections to program implementation.
- Improve health education activities aimed at generating a greater demand for immunization services by changing the health attitudes of the community in order to lead to a sustained demand by the consumer.

- Increase program performance by carrying out operational research. It is through operational research that solutions to operational problems will be found that will ensure that immunization programs meet their targets and sustain their operational capacity into the future.
- Training of managers at the various levels of the health system on planning, management, implementation and evaluation of immunization programs as well as in the various disciplines outlined above.

With the expected increased vaccination coverage and consequent reduction of EPI diseases among the population, the health services should realize a net savings from not treating children suffering the EPI diseases. These cost savings as a result of reduced disease burden can be used to support other EPI activities and child survival interventions.

More importantly, any cost savings realized from reduced disease burden can be used in the future to cover recurrent immunizations program costs.

With the infrastructure support to be provided by this project and the resulting cost savings from reduced diseases burden to the health services as well as from increased cost effectiveness this project will directly contribute to the efforts of all governments in sustaining their immunization programs beyond the scope of the project.

2.5 Strengthening Primary Health Care

The development of a strong primary health care system requires that first priority be given to building institutional capacity, therefore attention should be given to programs and activities which best serve this end. Health interventions of proven effectiveness have the best chance of becoming established and of effecting improvements in health.

Achievement of the polio eradication goal will require the acceleration of immunization programs. Program acceleration will in turn entail an improved

organizational and management structure, extending from the national level through each lower level of government and to all existing health establishments, and will also involve village-level participation. It will require the establishment of a distribution system for a few manageable biologic agents and supplies, as well as a well organized information system to measure program progress and success in controlling disease.

Personnel will be trained at all levels, not only in the technical aspects related to the epidemiology and control of diseases, but also in problem-solving and other managerial skills relevant to the delivery of other preventive and curative measures at the primary health care level.

In addition, the effort to eradicate a disease draws on support from other sectors within a country, and mobilizes in-country resources not generally used by the health sector. This process makes the health sector aware of the existence and availability of other resources that can be used for further health interventions either simultaneously or at a later date.

Pursuit of the goals set forth in this Proposal will improve the existing infrastructure and thus help strengthen immunization programs throughout the Region. It will result in better trained health personnel and a vastly improved surveillance system, within a strengthened structural and managerial framework which will facilitate the institutionalization of primary health care.

3. PROGRAM DESCRIPTION

3.1 Goal, Purpose and Outcomes

The goal of the project is to improve the health and productivity of the population of the Americas through the prevention of immunizable diseases.

The purpose of the project is:

- To strengthen and accelerate the Expanded Program on Immunization in the Region, and its objective of improved child survival; including

the interruption of indigenous transmission of wild poliovirus and thus, the eradication of poliomyelitis in the American Region by the year 1990.

The program outcomes will include the following elements:

- Regional strategy and Plan of Action developed for the eradication of polio by 1990 from the Americas.
- National Plan of Action developed with resources and constraints identified and targets determined.
- Functioning, effective epidemiological surveillance and outbreak control mechanisms in place at regional and national levels.
- Strengthened National Immunization programs and improved polio control activities.
- Strengthened Ministry of Health institutional capacity in planning, implementation, monitoring and evaluation of immunization services in general and poliomyelitis in particular.
- Access to laboratory facilities by all countries for identification of polio virus type.
- Improved strategies and alternatives for increasing immunization services and polio control activities tested in pilot areas.
- Interruption of indigenous transmission of wild poliovirus and eradication of poliomyelitis in the American Region by the year 1990;

3.2 Strategy

Regional vs. National Effort. In order to insure the provision of the necessary components lacking at the national level, a regional effort directed towards eradication is indicated. In many of the countries in the Region, the health infrastructure has not developed to the extent necessary to eradicate a

84

disease without international assistance. The Regional level strategy will provide resources to countries as deficiencies are identified. Were the project to be undertaken at the national level alone, the risk of reinfection of neighboring countries through overland migration of difficult access populations would be great, and would impede the attainment of the eradication goal. Through the simultaneous implementation of eradication activities in all countries of the Region, once transmission has been interrupted, the risk of reinfection will be markedly reduced, allowing the countries with less developed infrastructures to continue their development in the absence of a major threat of reintroduction.

The project will begin with the identification of high-risk countries. A major focus is the development of comprehensive national plans to achieve the objective of polio eradication by 1990. AID-funded inputs will facilitate implementation in the various countries. In addition, regional level activities will be undertaken to support country level activities.

3.2.1 Priority Countries for Action

The first step consists of classifying countries according to poliomyelitis activity and vaccination coverage as shown in Table 5. The program will focus on the countries in Groups I and II-A.

Table 5

Risk Status of Poliomyelitis in the Americas, 1984

GROUP I: Polio-infected countries. Those countries reporting indigenous cases due to transmission of wild poliovirus within the previous three years

Argentina	El Salvador*	Mexico*
Bolivia*	French Guiana	Paraguay*
Brazil*	Guatemala**	Peru*
Colombia	Haiti**	Suriname
Dominican Republic	Honduras*	Venezuela
Ecuador*	Jamaica*	

* Countries where in-country technical advisors not funded by AID may be placed.

** Countries where AID-funded advisors may be placed.

GROUP II: Polio-free countries. Those countries reporting no indigenous cases due to transmission of wild poliovirus within the previous three years. This group will be subdivided into the following two categories:

Group II-A: Higher-risk countries. Those countries which have had vaccination coverages of less than 80% of children under one year of age in any of the previous three years.

Anguilla	British Virgin Islands	Nicaragua
Bahamas	Costa Rica	Panama
Barbados	Dominica	Trinidad and Tobago
Belize	Grenada	Turks and Caicos Is.
Bermuda	Guyana	Uruguay

Group II-B: Lower-risk countries. Those countries which have maintained vaccination coverages of greater than or equal to 80% of children under one year of age in each of the previous three years.

Antigua & Barbuda	Guadeloupe	St. Lucia
Canada	Martinique	St. Kitts-Nevis
Cayman Islands	Montserrat	St. Vincent & Grenadines
Chile	Netherlands Antilles	United States of America
Cuba	Puerto Rico	U.S. Virgin Islands

Although Group I and Group II-A countries may most urgently require intervention, so that on-going transmission can be stopped and prevented from recurring, eradication of poliomyelitis in the Region requires that all Member Countries achieve and maintain at least 80% coverage of children below one year of age.

3.2.2 National Plans of Action

The political commitments were declared when the Resolution on this subject was approved by PAHO Member Countries during the Directing Council Meeting in September 1985.

Member Countries have pledged to increase their financial and manpower commitment to national EPI programs and, specifically, to allocate highest priority to interrupt wild poliovirus transmission.

With technical assistance from PAHO, and with the direct involvement of AID missions and other collaborating (donor) agencies, detailed National Plans of Action will be prepared with the national EPI and other Ministry of Health (MOH) and Ministry of Finance counterparts in each country. The national plan within each country will be a blueprint for planners and immunization program managers to follow. These Plans will define the nature and magnitude of the problems in each component of the immunization programs and will address the following areas of problems and components:

- Programming and evaluation;
- supervision;
- coordination;
- vaccination coverage and disease reduction targets;
- strategies for attaining the targets;
- fiscal planning for the mobilization of national resources, including recurrent costs;
- improvements in national laboratories;
- training activities
- disease surveillance and outbreak control measures;
- information systems and dissemination;
- cold chain;
- vaccine needs for the five year period;
- administration, resources and financing;
- detailed budget with commitments of government and external agencies.

DESPAS
CONTEXT

These areas of activities are based on problems already identified in the various national programs which are outlined in the Official Report* generated by the First Regional Meetings of EPI Program Managers, held in Quito, Ecuador in May 1981 and Kingston, Jamaica in September 1981. These problems have been further detected in program reviews performed in every Latin American country within the last four years.

These Plans of Action covering the next five years will serve as the framework for the elaboration of annual work plans which will also contain Timetables of quarterly activities which can then be monitored by national authorities with participation of donor agencies (see Annex D).

The activities related to polio will be an integral part of the National Plans of Action for the Expanded Program on Immunization and will be addressed in the components of the Plan as outlined above. As can be seen in Annex D, the detailed implementation steps will be specified with the respective timetable and budgetary and donor resource identification. This timetable constitutes the framework for the management plan to be monitored by the national and donor agencies involved. Periodic cost-analysis will be performed on a country-by-country basis using the WHO-EPI Costing Guidelines** which outline key concepts in program costing, how costing information may be applied to improve program performance, allocation of resources, and adaptation and selection of more cost-effective strategies.

In countries where they are available, AID Health Officers will be directly involved in all stages of preparation of national plans of action, annual work plans, the monitoring and evaluation processes. For these countries where AID Health Officers are not available, the Health and Nutrition Division of the Bureau for Latin America and the Caribbean should play this role.

* Immunization and Primary Health Care: Problems and Solutions, PAHO Scientific Publication No. 417, 1981.

**WHO Document EPI/GEN/79/5.

In May 1986, PAHO is convening a Regional Meeting on EPI in Washington, D.C., in which Governments will send official representatives with the first draft of proposed national plans of action and workplans to be implemented. Subsequently, it will be asked that other Ministries, particularly Finance and Planning participate in the preparation of the work plan.

Finally, when work plans are finalized at the national level, a Letter of Agreement should be signed between the Government and donor agencies, and all commitments. external and national should be specified.

Additional agreements between member countries and donor agencies are expected to support and complement these National Plans once PAHO and MOH staff have reached consensus on the Plans. Bilateral agreements with USAID and governments will cover costs not included in this proposal to AID, and are anticipated to provide resources over and above the US\$20,600,000 proposed here.

The national plans of action and annual work plans will also outline evaluation activities using a combination of coverage surveys, program reviews and other epidemiological studies as warranted.

Each country will prepare a financial plan as a part of the Plan of Action. These financial plans will identify capital, recurrent, and manpower

costs associated with the eradication effort. Recurrent costs associated with maintenance of the immunization program in the post-eradication era will be projected beyond 1990 to the year 2000 to permit the governments to include necessary outlays into their national budgets.

3.2.3 Country Specific Actions

Ongoing PAHO/EPI activities will be intensified and accelerated. Areas of direct support to Member Countries which are expected to receive assistance through this grant are described below.

Supervision, Surveillance and Outbreak Control

Surveillance will be both active and passive. All potential sources of notification of suspected cases of poliomyelitis in the countries will be contacted and incorporated into the surveillance activities.

The AID grant funds will enable that:

- PAHO can ensure the availability of expert international personnel to help strengthen epidemiological surveillance in the Region.
- Each suspected case will be investigated immediately. Detailed standardized case investigation forms will be designed and implemented.
- PAHO can provide investigation teams which will be mobilized within 24 to 48 hours of notification of a case to participate in the investigation of an outbreak, the search for additional (secondary) cases, and implementation of control measures. Thorough investigations into the source of the cases will be conducted and rapid analysis will be done with utilization of microcomputers.
- PAHO can ensure that adequate laboratory services are available to all countries through regional level activities, to facilitate surveillance and outbreak control activities at the country level.

A chronic need in national EPI programs is mobility of personnel, which is often constrained by transport fuel and per diem expenses for national counterparts. In limited cases, vehicles will be provided, along with necessary local currency funding, to ensure ongoing supervision and evaluation of program operations at regional and local levels and rapid outbreak investigation and control. Mobilization support will also be critical for national immunization days or special campaigns where such actions are indicated.

Promotion

In order to ensure completion of immunization schedules, reduce dropout rates and encourage community participation, special efforts will be made in the area of health education and motivation using effective communication techniques. Support will be provided in the development and testing of alternative media and messages, as well as its production. Costs of broadcasting time and mass media production will be supported.

Operations Research

Countries will undertake operations research activities aimed at increasing polio vaccine coverage. This could include studies of operational constraints, of dropout rates and community attitudes. The Technical Advisory Group will assist in prioritizing research issues and will provide technical guidance on their execution.

EPI Vaccines and Cold Chain

Countries are expected to order vaccine supplies as needed on a routine basis. To ensure quality control and procurement at the world market price, all vaccines will be purchased through the PAHO EPI Revolving Fund. The vaccine provided by Rotary International will also be purchased through this mechanism. Orders will be placed through the Revolving Fund and after shipment, PAHO will start the billing process directly with Rotary International.

PAHO created the EPI Revolving Fund to assist countries in the Region with these vaccine purchases. The Fund combines vaccine requirements from participating members in order to obtain good quality vaccine at low prices. The establishment of this Fund has allowed member countries to count on the ready availability of vaccines.

The Revolving Fund received strong support from the United States through a contribution of US\$1,686,600. Current capitalization is approximately US\$4.5 million.

Cold chain deficiencies will be identified as a component of the development of National Plans of Action, and the Plans will reflect the needs to be fulfilled. Depending upon the situation in each country, the project will fund refrigerators, freezers, spare parts, tool kits, and vaccine carriers.

Information Dissemination

Countries will be encouraged to include a section on poliomyelitis in their national epidemiological bulletin, with distribution to all health care workers in the network.

In order to facilitate the analysis of epidemiological and program data (coverage, morbidity and mortality, operational research, administrative and financial), personal computers and accompanying software will be provided to the various countries with funds from AID. These computers will permit project managers to obtain information for routine evaluation of program progress. This will in turn lead to more informed decisions. Because the computers will facilitate the analysis of information, program managers will be able to provide timely feedback to field staff on program problems and progress.

Evaluation

Coverage surveys and program reviews will be conducted as described in section 3.7 below. In addition, AID project evaluations will be conducted at mid-term and in 1990. Two consultants will be funded for four weeks each, including fees, travel and per diem for this purpose.

The above country level activities are expected to receive AID assistance through PAHO. In addition, training and in-country PAHO personnel will be funded through other donor support.

3.2.4 Regional Activities

In order to facilitate and coordinate technical and funding assistance for the development and implementation of National Plans of Action, the following activities will be undertaken.

Personnel

The Regional EPI Office of PAHO will add technical and administrative staff to coordinate all activities. One project administrative officer and one epidemiologist are to be funded through the AID grant. Short-term expert consultants will also be available and will be funded by PAHO and other donors. Sub-regional advisors will be located in 7 countries. Advisors located in Haiti and Guatemala are to be covered under this grant and will be responsible for the Dominican Republic, El Salvador, Guatemala, Haiti, Honduras, and Panama.

Terms of Reference for AID-funded personnel

a) Two Epidemiologists to serve in Guatemala and Haiti. ^{DR}

Duties and responsibilities:

1. Promote sound immunization practices within extended primary health care systems, in close coordination with all components of the Maternal and Child Health Program (HPM) and other related programs in the Organization.
2. Promote the implementation of the Plan of Action for the eradication of the indigenous transmission of wild poliovirus in the Americas by 1990.
3. Develop and update operational plans for EPI, including norms, objectives, strategies, and operational methodologies within primary health care systems; develops accelerated strategies for those countries where poliomyelitis is endemic.

4. Assist countries under his/her responsibility in the following areas of technical cooperation: preparation of training materials; implementation of training programs on the operation, administration and surveillance components of immunization programs; and operational research relevant to program adaptation and implementation.
5. Assist countries in the organization of national surveillance systems for prompt detection of suspected cases of poliomyelitis, immediate case investigation, and institution of control measures.
6. Assist the regional program to develop and update standards and procedures for multidisciplinary evaluation of immunization programs which will emphasize effectiveness (e.g., coverage and impact on disease reduction); assist regional program to develop a methodology for certification of poliomyelitis eradication, and collaborate in all aspects of information dissemination.
7. Collaborate and coordinate with national and international organizations in making optimal use of technical, administrative and economic resources available in the Americas for the achievement of the overall goals of the EPI and, in particular, the eradication of the indigenous transmission of wild poliovirus in the Americas by 1990.

Qualifications:

1. University degree in one of the health professions with a Master's degree in Public Health.
2. At least 5 years' experience at senior level of national program for disease control in general, and immunization in particular. At least 1 year of experience working in an administrative capacity within an international health-related program or institution.
3. Excellent knowledge of Spanish (for post in Guatemala)/French (for post in Haiti), with working knowledge of English.

b) Medical Officer/Epidemiologist to serve in Washington, D.C.

Duties and responsibilities:

1. Assist the Regional EPI in the identification of problems hampering program implementation and accomplishment of the EPI goal, with particular regard to the goal of eradicating the indigenous

transmission of wild poliovirus in the Americas by 1990. This task will require analysis of all issues pertaining to the program, including immunization strategies employed; cold chain equipment and procedures; delivery of vaccines and related supplies; training of personnel in all aspect of program implementation; the system for reporting immunizations administered; the organization of epidemiological surveillance systems for the EPI diseases, in particular to be able to detect, investigate and control all cases of paralytic poliomyelitis occurring in the Region; intra- and extra-sectorial coordination, and coordination at institutional level; social mobilization for immunization programs.

2. Prepare and coordinate international training programs in the operational and administrative aspects of immunization programs, and in special surveillance activities for poliomyelitis control, such as case identification and diagnosis; case investigation and active case finding; case and outbreak control; laboratory support for case diagnosis.
3. Assist member countries in all aspects of program evaluation, including the development of methodologies for process and impact evaluation, as well as for the certification of interruption of the indigenous transmission of wild poliovirus in the Americas by 1990.
4. Collaborate and coordinate with national and international agencies and organizations supporting the Regional Polio Plan of Action, such as UNICEF, AID, IDB, and Rotary International, in order to make optimal use of the technical, administrative and economic resources available in the Americas for this initiative.
5. Assist the Regional EPI in maintaining an active information system for morbidity of the EPI diseases and vaccination coverages in member countries.
6. Participate in meetings, internal or external, as required.
7. Collaborate with other units, within or outside HPM, in order to achieve effective coordination of progrom activities and appropriate utilization of resources.

Qualifications:

1. Medical degree from a recognized medical school, with a post-graduate degree in public health or epidemiology.
2. At least 5 years' experience at the national level in disease control programs and the implementation of immunization programs in developing countries. At least 3 years' experience at the international level in disease control programs, preferably in the implementation of technical cooperation for immunization programs and the control of poliomyelitis in particular.
3. Excellent knowledge of English and Spanish.

c) Administrative Officer, to serve in Washington, D.C.

Duties and responsibilities:

1. Analyze and monitor EPI expenditures from both regular and extrabudgetary funds; serve as liaison with funding agencies (principally AID, IDB, UNICEF and Rotary International) to assure funds are disbursed in accordance with established criteria; prepare periodic financial reports in accordance with requirements of funding agencies.
2. Develop internal financial management procedures with country offices for handling and reporting extrabudgetary resources.
3. In close collaboration with government officials, analyze the administrative process of ongoing projects and make recommendations concerning improvements in management of resources. (Work to be performed through periodic site visits and monitoring at Headquarters).
4. Participate with technical officer or alone in on-site multipartite (government, funding agencies and PAHO) reviews of extrabudgetary projects.
5. Maintain administrative liaison with Personnel, Budget and Finance, Procurement, and other units as necessary; collaborating with Procurement in all matters related to orders for supplies and equipment.
6. Process nominations of consultants or advisors; make travel arrangements for consultants and staff duty travel. Assist in preparation of personal services contracts, with responsibility for their administrative processing.

7. collaborate with other units both within and outside HPM in order to achieve effective coordination of program activities and appropriate utilization of resources.

Qualifications:

1. University degree in economics or in financial or business administration.
2. At least 5 years' experience working in an administrative capacity within a health related program or institution at the national level, or at least 3 years of such experience at the international level.

Development of Regional Laboratory Network

The development of the laboratory support will entail inputs such as equipment, reagents and supplies, which will be financed by AID grant funds. In addition, training of personnel, production of manuals and technical assistance will be supported by IDB and PAHO funds.

In keeping with the general PAHO policy of developing networks of national institutions for technical cooperation among developing countries, a regional laboratory network will be formed. The development of the network of laboratories will involve strengthening the necessary logistics system for both the transport of specimens and the distribution of necessary supplies such as reagents. A continual supply of standardized reagents for the serologic, virus isolation, and genetic characterization studies will be ensured. The Centers for Disease Control (CDC) in Atlanta, with PAHO's support, will be requested to assist in the development of the laboratory networks and to certify laboratories as reference centers. CDC will assist in the improvement of diagnostic capabilities of the laboratories in the Region and in activities of quality control and proficiency. This assistance will be mostly in terms of consultants, who will be financed by PAHO.

The reference laboratories will assist countries in the development of in-country virology support. The reference laboratories will confirm the results of the country laboratories. A regional laboratory supervisory system will guarantee consistent, high quality testing and reliability of results. For countries without laboratories, reference laboratories will be identified for their assistance.

As part of the development of the laboratory network, a manual will be produced by PAHO covering: tests to be performed on all suspected cases, testing procedures, appropriate specimens, methods of collection of specimens, shipping procedures, handling of specimens, quality control procedures, data collection and data processing. This manual will be ready by February 1986 and will be distributed to all participating laboratories.

Training needs will be addressed at the various levels through the development of a workshop for participating laboratory personnel in the network. The first course will be held by February 1986, following the identification of the laboratories.

In addition to the laboratory studies related to surveillance, there is a need to develop further laboratory support for potency testing of vaccines for quality control. The laboratories equipped for poliovirus isolation studies will be used as reference centers for testing of vaccine potency and quality control, as similar techniques and materials are needed.

The network of laboratories will be comprised of laboratories available at national level and will involve at least 15 countries. Such a network should be able to provide assistance on a regional basis, in close collaboration with the Centers for Disease Control, Atlanta, as well as with other components of the Program. In order to establish this network it is anticipated that technical assistance should be provided to these national laboratories in terms of technical expertise as well as training of personnel and provision of some key items of equipment, supplies and reagents. This will assure the upgrading of these facilities and guarantee the necessary laboratory support to the surveillance activities.

Site visits are presently being made in the various countries to assess laboratories and determine the exact needs for this upgrading. From the preliminary data already available, a tentative distribution of the resources earmarked for Laboratory will be as follows:

a) Equipment:

Centrifuges	US\$150,000
Ultracentrifuges	130,000
Safety cabinets	105,000
Ultra low freezers	84,000
Microscopes	48,000
Spectrophotometers	
pH meters	51,000
Lamimar flow hoods	48,000
Sub-total	<u>US\$616,000</u>

b) Supplies:

Plasticware, glassware,
filters, TC flasks
(10,000/lab/year
x 5 years)

Sub-total US\$750,000

c) Reagents:

TC media, antisera,
antigen, chemicals
(4,000/lab/year
x 5 years)

Sub-total US\$300,000

TOTAL US\$1,666,000

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Vaccine Stockpile

Manufacturers will be requested to have 5 million doses of Trivalent Oral Poliomyelitis Vaccine (TOPV) for regional use in case of emergency. PAHO will oversee the inventory of these emergency stocks and allocate distribution when needed.

Information Dissemination

At the Regional level, the PAHO EPI Newsletter (which now reaches approximately 10,000 readers in the Region) will contain a section on poliomyelitis in all issues. This section will include information on the current epidemiology of polio in the Region; the number of cases reported in the interval since the previous issue, by week of reporting and by country; individual case studies of outbreaks and investigations; issues related to the eradication effort; and topics of interest in polio research. The section on polio activities in the Region will be distributed monthly. It is expected that EPI Newsletter circulation will increase so that all health facilities in the region will receive copies. Information should also be disseminated through other PAHO publications.

Periodic reviews of the literature on poliomyelitis will be distributed by PAHO throughout the Region.

Information Exchange Meetings

To maintain momentum and to facilitate communication in the Region, meetings of EPI program managers and/or polio eradication managers for Latin America and English-speaking Caribbean countries financed by AID grant funds will be held as often as necessary to discuss progress made and problems encountered. These meetings will serve as a forum for mutual assistance and information dissemination and will be attended by technical experts to aid in the resolution of problems encountered. The meetings will consist of country presentations, discussions related to issues raised during the country presentations, and presentations of updates in the field. Outputs of the meetings will include recommendations of the working groups to the countries

on strategies to resolve the problems encountered. Findings and recommendations of the meetings will be published and disseminated in the Region.

Identification of Operational Research Needs

Recognizing that questions remain to be addressed in the field of poliomyelitis eradication and others will likely arise as the effort proceeds, both in technical and operational areas, support for operational research will be provided. Needs identified by the TAG will be implemented within the first two years of the project. It is also recognized that questions will continue to arise as some problems are solved and others appear in their place. Participation in addressing operational research needs will be encouraged by all member nations (see 4.5).

Certification Protocol

The certification of eradication of indigenous transmission of wild poliovirus for the Americas will be accomplished when the following conditions have been met: (1) Three years have lapsed without identification of indigenous cases of poliomyelitis due to wild poliovirus, in the presence of adequate surveillance; (2) Extensive case search by an international investigation team does not identify any cases having onset in the three years preceding the visit; and (3) In the case of an importation, there are no secondary cases identified within one month of the date of onset of the illness in the imported case.

An international certification commission will convene to develop a protocol for determining whether countries can be certified free of wild poliovirus transmission. This commission will review findings of studies conducted and the need to include other criteria to detect wild poliovirus. In addition, the commission will make site visits to the various countries to review each program, and to determine if that country has met the established criteria. Funding for this activity will be provided by AID, PAHO, and other donors involved.

3.3 Program Beneficiaries

The primary program beneficiaries will be children under one year of age in the Region. Of the 16 million children in the Region less than one year of age, those who will directly benefit from the project include 11 million (97%) in Group I countries, and about 400,000 (0.03%) in Group II-A countries (Table 5). Secondary beneficiaries include communities and national governments who will be spared the cost of lost productivity and rehabilitative care. The health sector will benefit from cost savings due to medical care. Regionally and globally, benefits will be available in terms of strengthened delivery systems and laboratory facilities which can be deployed for other priority health problems. It is intended that the health professional and donor community will use lessons learned from the polio eradication program of the Americas, to mount polio eradication efforts in other regions of the world.

3.4 Budget and Financial Plan

Table 6 shows a detailed breakdown of the proposed AID contributions, with projected annual sub-totals through 1990. Excluding contingency funds, mobilization, promotion and operations research comprise over half the budget.

Procurement of equipment, supplies and any vehicles needed will be from US sources or collaborating countries within the Region.

Payment provisions and reporting requirements for the AID contribution are expected to be similar to those arranged for other comparable grants between the two agencies.

The proposed contributions by the five collaborating (donor) agencies for functional components of the program appear in Table 7, PAHO will contribute US\$4,650,000 to the project.

Recurrent costs beyond 1990 for maintaining the program are expected to be covered by in-country health sector budgets.

Table 6
Proposed AID Budget* In Thousands of US Dollars**

ITEM	1986	1987	1988	1989	1990	Total
A. PERSONNEL ***						
Project Adm. Officer (Washington)	96	86	85	96	95	458
Epidemiologist (Washington)	96	86	85	96	95	458
Epidemiologist (Haiti)	96	86	85	96	95	458
Epidemiologist (Guatemala)	96	86	85	96	95	458
Subtotal	384	344	340	384	380	1,832
B. MEETINGS						
TAG Meetings (2 per year)	40	42	44	47	49	222
Program Project Managers Meeting (1 Meeting per year)	60	63	66	69	73	331
Subtotal	100	105	110	116	122	553

* The budget is shown for U.S. Fiscal Years which cover the period October 1 through September 30. For example 1986 covers the period 1 October, 1985 through 30 September, 1986.

** These figures are adjusted for inflation using a compound inflationary factor of 5% per annum.

*** All personnel are in new posts. Per diem and travel for these personnel will be paid under supervision and surveillance (see item G). Cost of each post includes:

- 1) Salary
 - Post adjustment
 - Dependent allowances
- 2) Pension Fund
 - Insurances
 - Terminal payments
- 3) Recruitment and installation
 - allowances
 - Education grant

C. LABORATORIES

Equipment, Supplies, and Installations (15 countries)	250	525	551	340	-	1,666
Subtotal	250	525	551	340	-	1,666

D. INFORMATION DISSEMINATION

Computer Services (hardware and software for 20 countries)	30	32	33	35	37	167
Subtotal	30	32	33	35	37	167

E. EVALUATION

Coverage Surveys (40,000 each country x 27)	120	240	320	240	160	1,080
Program Reviews (10,000 each country x 45)	60	90	100	100	100	450
AID Project Evaluation (Salary, per diem, travel for 2 persons, 1988 10 countries 1990 15 countries)	-	-	30	-	50	80
Subtotal	180	330	450	340	310	1,610

F. PROMOTION

Development, production and broadcasting costs (15 countries)	700	850	700	600	500	3,350
Subtotal	700	850	700	600	500	3,350

G. SUPERVISION, SURVEILLANCE AND OUTBREAK CONTROL

1) Inter-country personnel (Airfare, local travel & per diem)						
- 2 PAHO/Washington staff *	30	35	40	45	50	200
- 2 Sub-regional staff.*	16	20	25	30	35	126
2) New vehicles (20x \$9000)	180	-	-	-	-	180
Fuel and maintenance.	421.2	421.2	421.2	421.2	421.2	2,106
Per diem (20 countries)	328	328	328	328	328	1,640
Subtotal	975.2	804.2	814.2	824.2	834.2	4,252

* AID funded posts.

H. INTERNATIONAL CERTIFICATION COMMISSION

Development of Protocol International team of 4 investigators (travel and per diem)	6.8	6.8	-	-	5.4	19
	-	39	60	89	163	351
Subtotal	6.8	45.8	60	89	168.4	370

I. COLD CHAIN

Refrigerators, Cold rooms, spare parts, tool kits	100	500	100	100	106	1,006
Subtotal	200	500	100	100	106	1,006

J. OPERATIONAL RESEARCH

2 countries yearly	500	525	551	290	305	2,171
Subtotal	500	525	551	290	305	2,171

TOTAL	3,326	4,114	3,778.2	3,160.2	2,824.6	17,203
CONTINGENCY	156	203	219	192	212	982
OVERHEAD	440	573	660	538	430	2,641
GRAND TOTAL	3,922	4,837	4,588.2	3,848.2	3,404.6	20,600

A detailed cost breakdown, by year and source of funding, is contained on the following pages.

SUMMARY OF EXPENDITURES BY YEAR AND SOURCE OF FUNDS

REGION/YEAR	1986	1987	1988	1989	1990	TOTAL
LAC REGIONAL	1690.10	2194.65	2323.20	1857.95	1782.75	9848.65
CA REGIONAL	1099.30	1314.75	1195.40	1110.65	857.25	5577.35
BILATERAL ATTRIB	1132.60	1327.60	1069.60	879.60	764.60	5174.00
TOTAL	3922.00	4837.00	4588.20	3848.20	3404.60	20600.00

Attributions, by year and source of funding, 1986-1990

LAC REGIONAL
(Figures in thousands of dollars)

ITEM/YEAR	1986	1987	1988	1989	1990	Total
A. PERSONNEL						
Proj Admin Ofc DC	76.80	68.80	68.00	76.80	76.00	366.40
Epidemiologist DC	67.20	60.20	59.50	67.20	66.50	320.60
Epidemiologist HAI	96.00	86.00	85.00	96.00	95.00	458.00
Subtotal	240.00	215.00	212.50	240.00	237.50	1145.00
B. MEETINGS						
TAG (2/year)	40.00	42.00	44.00	47.00	49.00	222.00
Managers (1/yr)	51.00	53.55	56.10	58.65	62.05	281.35
Subtotal	91.00	95.55	100.10	105.65	111.05	503.35
C. LABORATORIES						
Subtotal	200.00	420.00	440.80	272.00	0.00	1332.80
	200.00	420.00	440.80	272.00	0.00	1332.80
D. INFORMATION DISSEM						
Computer Svcs	10.00	12.00	13.00	15.00	17.00	67.00
Subtotal	10.00	12.00	13.00	15.00	17.00	67.00
E. EVALUATION						
Surveys (16)	40.00	80.00	100.00	60.00	40.00	320.00
Prog Reviews (20)	30.00	60.00	60.00	70.00	70.00	290.00
AID Project Eval	0.00	0.00	30.00	0.00	50.00	80.00
Subtotal	70.00	140.00	190.00	130.00	160.00	690.00
F. PROMOTION						
Subtotal	250.00	300.00	250.00	200.00	200.00	1200.00
	250.00	300.00	250.00	200.00	200.00	1200.00
G. SUP/SURV/CONT						
1. Inter-country	38.00	45.00	52.50	60.00	67.50	263.00
2. Vehicles (5)	45.00	0.00	0.00	0.00	0.00	45.00
Fuel	105.30	105.30	105.30	105.30	105.30	526.50
Per diem	100.00	100.00	100.00	100.00	100.00	500.00
Subtotal	288.30	250.30	257.80	265.30	272.80	1334.50
H. CERTIFICATION						
Subtotal	6.80	45.80	60.00	89.00	168.40	370.00
	6.80	45.80	60.00	89.00	168.40	370.00
I. COLD CHAIN						
Subtotal	15.00	15.00	15.00	15.00	15.00	75.00
	15.00	15.00	15.00	15.00	15.00	75.00
J. OPER RESEARCH						
Subtotal	165.00	240.00	268.00	92.00	195.00	960.00
	165.00	240.00	268.00	92.00	195.00	960.00
TOTAL						
	1336.10	1733.65	1807.20	1423.95	1376.75	7677.65
CONTINGENCY						
	156.00	203.00	219.00	192.00	212.00	982.00
OVERHEAD						
	198.00	258.00	297.00	242.00	194.00	1189.00
GRAND TOTAL						
	1690.10	2194.65	2323.20	1857.95	1782.75	9848.65

CA Regional
(Belize, Costa Rica, Panama, Honduras, El Salvador, Guatemala)
(Figures in thousands of dollars)

ITEM/YEAR	1986	1987	1988	1989	1990	Total
A. PERSONNEL						
Proj Admin Ofc DC	19.20	17.20	17.00	19.20	19.00	91.60
Epidemiologist DC	28.80	25.80	25.50	28.80	28.50	137.40
Epidemiologist GUT	96.00	86.00	85.00	96.00	95.00	458.00
Subtotal	144.00	129.00	127.50	144.00	142.50	687.00
B. MEETINGS						
Managers (1/yr)	9.00	9.45	9.90	10.35	10.95	49.65
Subtotal	9.00	9.45	9.90	10.35	10.95	49.65
C. LABORATORIES						
Subtotal	50.00	105.00	110.20	68.00	0.00	333.20
	50.00	105.00	110.20	68.00	0.00	333.20
D. INFORMATION DISSEM						
Computer Svcs	10.00	10.00	10.00	10.00	10.00	50.00
Subtotal	10.00	10.00	10.00	10.00	10.00	50.00
E. EVALUATION						
Surveys (11)	40.00	80.00	120.00	120.00	80.00	440.00
Prog Reviews (16)	30.00	30.00	40.00	30.00	30.00	160.00
Subtotal	70.00	110.00	160.00	150.00	110.00	600.00
F. PROMOTION						
Subtotal	200.00	250.00	200.00	200.00	150.00	1000.00
	200.00	250.00	200.00	200.00	150.00	1000.00
G. SUP/SURV/CONT						
1. Inter-country	8.00	10.00	12.50	15.00	17.50	63.00
2. Vehicles	45.00	0.00	0.00	0.00	0.00	45.00
Fuel	105.30	105.30	105.30	105.30	105.30	526.50
Per diem	100.00	100.00	100.00	100.00	100.00	500.00
Subtotal	258.30	215.30	217.80	220.30	222.80	1134.50
I. COLD CHAIN						
Subtotal	65.00	185.00	35.00	35.00	31.00	351.00
	65.00	185.00	35.00	35.00	31.00	351.00
J. OPER RESEARCH						
Subtotal	165.00	135.00	133.00	117.00	55.00	605.00
	165.00	135.00	133.00	117.00	55.00	605.00
TOTAL	971.30	1148.75	1003.40	954.65	732.25	4810.35
OVERHEAD	128.00	166.00	192.00	156.00	125.00	767.00
GRAND TOTAL	1099.30	1314.75	1195.40	1110.65	857.25	5577.35

BILATERAL ATTRIBUTION
 (Peru, Ecuador, Bolivia, Dominican Republic, Haiti, Jamaica)
 (Figures in thousands of dollars)

ITEM/YEAR	1986	1987	1988	1989	1990	Total
D. INFORMATION DISSEM						
Computer Svcs	10.00	10.00	10.00	10.00	10.00	50.00
Subtotal	10.00	10.00	10.00	10.00	10.00	50.00
E. EVALUATION						
Subtotal	40.00	80.00	100.00	60.00	40.00	320.00
	40.00	80.00	100.00	60.00	40.00	320.00
F. PROMOTION						
Subtotal	250.00	300.00	250.00	200.00	150.00	1150.00
	250.00	300.00	250.00	200.00	150.00	1150.00
G. SUP/SURV/CONT						
2. Vehicles (10)	90.00	0.00	0.00	0.00	0.00	90.00
Fuel	210.60	210.60	210.60	210.60	210.60	1053.00
Per diem	128.00	128.00	128.00	128.00	128.00	640.00
Subtotal	428.60	338.60	338.60	338.60	338.60	1783.00
I. COLD CHAIN						
Subtotal	120.00	300.00	50.00	50.00	60.00	580.00
	120.00	300.00	50.00	50.00	60.00	580.00
J. OPER RESEARCH						
Subtotal	170.00	150.00	150.00	81.00	55.00	606.00
	170.00	150.00	150.00	81.00	55.00	606.00
TOTAL						
	1018.60	1178.60	898.60	739.60	653.60	4489.00
OVERHEAD						
	114.00	149.00	171.00	140.00	111.00	685.00
GRANDTOTAL						
	1132.60	1327.60	1069.60	879.60	764.60	5174.00

Illustrative

Bilateral Attributions, by year and country, 1986-1990

BOLIVIA (Figures in thousands of dollars)

ITEM/YEAR	1986	1987	1988	1989	1990	Total
D. COMPUTER SVCS	10.00	0.00	0.00	0.00	0.00	10.00
E. EVALUATION	10.00	15.00	20.00	10.00	10.00	65.00
F. PROMOTION	40.00	50.00	40.00	30.00	24.00	184.00
G. SUP/SURV/CONT						
Vehicles (2)	18.00	0.00	0.00	0.00	0.00	18.00
Fuel	42.12	42.12	42.12	42.12	42.12	210.60
Per diem	25.60	25.60	25.60	25.60	25.60	128.00
I. COLD CHAIN	20.00	50.00	8.00	8.00	10.00	96.00
J. OPER RESEARCH	28.33	25.00	25.00	13.50	9.17	101.00
TOTAL	194.05	207.72	160.72	129.22	120.89	812.60

DOMINICAN REPUBLIC (Figures in thousands of dollars)

ITEM/YEAR	1986	1987	1988	1989	1990	Total
D. COMPUTER SVCS	0.00	10.00	0.00	0.00	0.00	10.00
E. EVALUATION	6.00	13.00	16.00	10.00	6.00	51.00
F. PROMOTION	40.00	50.00	40.00	30.00	24.00	184.00
G. SUP/SURV/CONT						
Vehicles (1)	9.00	0.00	0.00	0.00	0.00	9.00
Fuel	21.06	21.06	21.06	21.06	21.06	105.30
Per diem	25.60	25.60	25.60	25.60	25.60	128.00
I. COLD CHAIN	20.00	50.00	8.00	8.00	10.00	96.00
J. OPER RESEARCH	28.33	25.00	25.00	13.50	9.17	101.00
TOTAL	149.99	194.66	135.66	108.16	95.83	684.30

Illustrative

HAITI (Figures in thousands of dollars)

ITEM/YEAR	1986	1987	1988	1989	1990	Total
D. COMPUTER SVCS	0.00	0.00	0.00	0.00	10.00	10.00
E. EVALUATION	6.00	13.00	16.00	10.00	6.00	51.00
F. PROMOTION	40.00	50.00	40.00	30.00	24.00	184.00
G. SUP/SURV/CONT						
Vehicles (1)	9.00	0.00	0.00	0.00	0.00	9.00
Fuel	21.06	21.06	21.06	21.06	21.06	105.30
Per diem	25.60	25.60	25.60	25.60	25.60	128.00
I. COLD CHAIN	20.00	50.00	10.00	10.00	10.00	100.00
J. OPER RESEARCH	28.34	25.00	25.00	13.50	9.16	101.00
TOTAL	150.00	184.66	137.66	110.16	105.82	688.30

JAMAICA (Figures in thousands of dollars)

ITEM/YEAR	1986	1987	1988	1989	1990	Total
D. COMPUTER SVCS	0.00	0.00	0.00	0.00	0.00	0.00
E. EVALUATION	6.00	13.00	16.00	10.00	6.00	51.00
F. PROMOTION	40.00	50.00	40.00	30.00	24.00	184.00
G. SUP/SURV/CONT						
Vehicles (1)	9.00	0.00	0.00	0.00	0.00	9.00
Fuel	21.06	21.06	21.06	21.06	21.06	105.30
Per diem	0.00	0.00	0.00	0.00	0.00	0.00
I. COLD CHAIN	20.00	50.00	8.00	8.00	10.00	96.00
J. OPER RESEARCH	28.34	25.00	25.00	13.50	9.16	101.00
TOTAL	124.40	159.06	110.06	82.56	70.22	546.30

ILLUSTRATIVE

ECUADOR (Figures in thousands of dollars)

ITEM/YEAR	1986	1987	1988	1989	1990	Total
D. COMPUTER SVCS	0.00	0.00	10.00	0.00	0.00	10.00
E. EVALUATION	6.00	13.00	16.00	10.00	6.00	51.00
F. PROMOTION	40.00	50.00	40.00	30.00	24.00	184.00
G. SUP/SURV/CONT						
Vehicles (2)	18.00	0.00	0.00	0.00	0.00	18.00
Fuel	42.12	42.12	42.12	42.12	42.12	210.60
Per diem	25.60	25.60	25.60	25.60	25.60	128.00
I. COLD CHAIN	20.00	50.00	8.00	8.00	10.00	96.00
J. OPER RESEARCH	28.33	25.00	25.00	13.50	9.17	101.00
TOTAL	180.05	205.72	166.72	129.22	116.89	798.60

PERU (Figures in thousands of dollars)

ITEM/YEAR	1986	1987	1988	1989	1990	Total
D. COMPUTER SVCS	0.00	0.00	0.00	10.00	0.00	10.00
E. EVALUATION	6.00	13.00	16.00	10.00	6.00	51.00
F. PROMOTION	50.00	50.00	50.00	50.00	30.00	230.00
G. SUP/SURV/CONT						
Vehicles (3)	27.00	0.00	0.00	0.00	0.00	27.00
Fuel	63.18	63.18	63.18	63.18	63.18	315.90
Per diem	25.60	25.60	25.60	25.60	25.60	128.00
I. COLD CHAIN	20.00	50.00	8.00	8.00	10.00	96.00
J. OPER RESEARCH	28.33	25.00	25.00	13.50	9.17	101.00
TOTAL	220.11	226.78	187.78	180.28	143.95	958.90

Summary of funding, by year, 1986-1990

1986

ITEM	LAC Reg.	CA Reg.	Bilat. Attrib.	Total
A. PERSONNEL				
Proj Adm Ofcr DC	76.80	19.20	0.00	96.00
Epidemiologist DC	67.20	28.80	0.00	96.00
Epidemiologist HAI	96.00	0.00	0.00	96.00
Epidemiologist GUT	0.00	96.00	0.00	96.00
B. MEETINGS				
TAG	40.00	0.00	0.00	40.00
Managers	51.00	9.00	0.00	60.00
C. LABS				
	200.00	50.00	0.00	250.00
D. INFORMATION DISSEM				
	10.00	10.00	10.00	30.00
E. EVALUATION				
Surveys	40.00	40.00	40.00	120.00
Prog Reviews	30.00	30.00	0.00	60.00
AID Eval	0.00	0.00	0.00	0.00
F. PROMOTION				
	250.00	200.00	250.00	700.00
G. SUP/SURV/CONT				
Inter-country	38.00	8.00	0.00	46.00
Vehicles	45.00	45.00	90.00	180.00
Fuel	105.30	105.30	210.60	421.20
Per diem	100.00	100.00	128.00	328.00
H. CERTIFICATION				
	6.80	0.00	0.00	6.80
I. COLD CHAIN				
	15.00	65.00	120.00	200.00
J. OPER RESEARCH				
	165.00	165.00	170.00	500.00
CONTINGENCY				
	156.00	0.00	0.00	156.00
OVERHEAD				
	198.00	128.00	114.00	440.00
TOTAL				
	1690.10	1099.30	1132.60	3922.00

1981

ITEM	LAC Reg.	CA Reg.	Stat. Attrib.	Total
A. PERSONNEL				
Proj Adm Ofcr DC	68.80	17.20	0.00	86.00
Epidemiologist DC	60.20	25.80	0.00	86.00
Epidemiologist HAI	86.00	0.00	0.00	86.00
Epidemiologist GUT	0.00	86.00	0.00	86.00
B. MEETINGS				
TAG	42.00	0.00	0.00	42.00
Managers	53.55	9.45	0.00	63.00
C. LABS				
	420.00	105.00	0.00	525.00
D. INFORMATION DISSEM				
	12.00	10.00	10.00	32.00
E. EVALUATION				
Surveys	80.00	80.00	80.00	240.00
Prog Reviews	60.00	30.00	0.00	90.00
AID Eval	0.00	0.00	0.00	0.00
F. PROMOTION				
	300.00	250.00	100.00	650.00
G. SUP/SURV/CONT				
Inter-country	45.00	10.00	0.00	55.00
Vehicles	0.00	0.00	0.00	0.00
Fuel	105.30	105.30	210.60	421.20
Per diem	100.00	100.00	128.00	328.00
H. CERTIFICATION				
	45.80	0.00	0.00	45.80
I. COLD CHAIN				
	15.00	185.00	300.00	500.00
J. OPER RESEARCH				
	240.00	135.00	150.00	525.00
CONFRINGENCY				
	203.00	0.00	0.00	203.00
OVERHEAD				
	258.00	166.00	149.00	573.00
TOTAL	2194.65	1314.75	1327.60	4837.00

114

1988

ITEM	LAC Reg.	CA Reg.	Bilat. Attrib.	Total
A. PERSONNEL				
Proj Adm Ofcr DC	68.00	17.00	0.00	85.00
Epidemiologist DC	59.50	25.50	0.00	85.00
Epidemiologist HAI	85.00	0.00	0.00	85.00
Epidemiologist GUT	0.00	85.00	0.00	85.00
B. MEETINGS				
TAG	44.00	0.00	0.00	44.00
Managers	56.10	9.90	0.00	66.00
C. LABS				
	440.80	110.20	0.00	551.00
D. INFORMATION DISSEM				
	13.00	10.00	10.00	33.00
E. EVALUATION				
Surveys	100.00	120.00	100.00	320.00
Prog Reviews	60.00	40.00	0.00	100.00
AID Eval	30.00	0.00	0.00	30.00
F. PROMOTION				
	250.00	200.00	250.00	700.00
G. SUP/SURV/CONT				
Inter-country	52.50	12.50	0.00	65.00
Vehicles	0.00	0.00	0.00	0.00
Fuel	105.30	105.30	210.60	421.20
Per diem	100.00	100.00	128.00	328.00
H. CERTIFICATION				
	60.00	0.00	0.00	60.00
I. COLD CHAIN				
	15.00	35.00	50.00	100.00
J. OPER RESEARCH				
	268.00	133.00	150.00	551.00
CONTINGENCY				
	219.00	0.00	0.00	219.00
OVERHEAD				
	297.00	192.00	171.00	660.00
TOTAL				
	2323.20	1195.40	1069.60	4588.20

115

1989

ITEM	LAC Reg.	CA Reg.	Bilat. Attrib.	Total
A. PERSONNEL				
Proj Adm Ofcr DC	76.80	19.20	0.00	96.00
Epidemiologist DC	67.20	28.80	0.00	96.00
Epidemiologist HAI	96.00	0.00	0.00	96.00
Epidemiologist GUT	0.00	96.00	0.00	96.00
B. MEETINGS				
TAG	47.00	0.00	0.00	47.00
Managers	58.65	10.35	0.00	69.00
C. LABS				
	272.00	68.00	0.00	340.00
D. INFORMATION DISSEM				
	15.00	10.00	10.00	35.00
E. EVALUATION				
Surveys	60.00	120.00	60.00	240.00
Prog Reviews	70.00	30.00	0.00	100.00
AID Eval	0.00	0.00	0.00	0.00
F. PROMOTION				
	200.00	200.00	200.00	600.00
G. SUP/SURV/CONT				
Inter-country	60.00	15.00	0.00	75.00
Vehicles	0.00	0.00	0.00	0.00
Fuel	105.30	105.30	210.60	421.20
Per diem	100.00	100.00	128.00	328.00
H. CERTIFICATION				
	89.00	0.00	0.00	89.00
I. COLD CHAIN				
	15.00	35.00	50.00	100.00
J. OPER RESEARCH				
	92.00	117.00	81.00	290.00
CONTINGENCY				
	192.00	0.00	0.00	192.00
OVERHEAD				
	242.00	156.00	140.00	538.00
TOTAL	1857.95	1110.65	879.60	3848.20

1990

ITEM	LAC Reg.	CA Reg.	Bilat. Attrib.	Total
A. PERSONNEL				
Proj Adm Ofcr DC	76.00	19.00	0.00	95.00
Epidemiologist DC	66.50	28.50	0.00	95.00
Epidemiologist HAI	95.00	0.00	0.00	95.00
Epidemiologist GUT	0.00	95.00	0.00	95.00
B. MEETINGS				
TAG	49.00	0.00	0.00	49.00
Managers	62.05	10.95	0.00	73.00
C. LABS				
	0.00	0.00	0.00	0.00
D. INFORMATION DISSEM				
	17.00	10.00	10.00	37.00
E. EVALUATION				
Surveys	40.00	80.00	40.00	160.00
Prog Reviews	70.00	30.00	0.00	100.00
AID Eval	50.00	0.00	0.00	50.00
F. PROMOTION				
	200.00	150.00	150.00	500.00
G. SUP/SURV/CONT				
Inter-country	67.50	17.50	0.00	85.00
Vehicles	0.00	0.00	0.00	0.00
Fuel	105.30	105.30	210.60	421.20
Per diem	100.00	100.00	128.00	328.00
H. CERTIFICATION				
	168.40	0.00	0.00	168.40
I. COLD CHAIN				
	15.00	31.00	60.00	106.00
J. OPER RESEARCH				
	195.00	55.00	55.00	305.00
CONTINGENCY				
	212.00	0.00	0.00	212.00
OVERHEAD				
	194.00	125.00	111.00	430.00
TOTAL	1782.75	857.25	764.60	3404.60

Table 7

Tentative Budget by Donor Agency and Component
(In Thousands of Dollars)
1986-1990

ITEM	USAID	PAHO	IDB	UNICEF	ROTARY	TOTAL
<u>Personnel</u>						
Inter-Country	1,832	1,900				3,732
In-Country			1,650			1,650
Consultants			1,750			1,750
<u>Training</u>			2,100			2,100
<u>Meetings</u>	553	250				803
<u>Laboratories</u>	1,666	200				1,866
<u>Information</u>	167	350				517
<u>Evaluation</u>	1,610	600				2,210
<u>Promotion</u>	3,350			750		4,100
<u>Supervision & surveillance</u>	4,252			1,750		6,002
<u>Certification</u>	370					370
<u>Cold Chain</u>	1,006	500		2,000		3,506
<u>Research</u>	2,171	200				2,371
<u>Vaccine</u>					10,700	10,700
<u>Contingency</u>	982			500		1,482
<u>Overhead</u>	2,641	650*	1,100	*	**	4,391
TOTAL	20,600	4,650	6,600	5,000	10,700	47,550

* Overhead costs associated with UNICEF's contribution will be covered by PAHO.

** Overhead costs associated with vaccine procurement will be covered according to regulations of the Revolving Fund.

118

3.5 Implementation, Management and Coordination

The implementation of the project will be multi-pronged focusing on those countries classified as Polio-Infected, followed by those countries classified as higher and lower risk.

In those countries classified as polio-infected, staffing of in-country technical advisors as well as inter-country advisors will be the first order of priority. Following this, the development of national plans of action and country annual work plans will be developed by all countries in order that training and infrastructure needs are identified. The first draft of the national plans of action will be discussed in Washington, D.C. at annual meeting of EPI program managers in May of 1986 (see 3.2.2). The development of the national plans of action and annual work plans will be prepared with the participation of PAHO, AID, IDB, UNICEF, and Rotary International.

The national plans of action and annual work plans developed by the countries will simultaneously call for among others (see 3.2.2), the following activities to be undertaken commencing in the first year of the project:

- Accelerated vaccination programs to increase coverages and control disease transmission in those countries with coverages of less than 80% and/or are reporting polio cases due to the wild virus.
- Improvements and extension of the cold chain.
- Training in:
 - Epidemiology and disease surveillance and control (especially poliomyelitis);
 - Laboratory Virology;
 - Cold Chain;
 - Supervision.
- Increase surveillance and supervision activities for stopping the transmission of wild polio virus.
- Development and production of health educational material.
- Mass media campaigns to increase awareness and demand for immunization.

As mentioned previously, those countries classified as polio-infected will receive higher priority in the implementation of the activities listed in their work plans. The planned activities will be carried out during the life of the project. In some countries certain activities will be implemented with greater acceleration and intensity owing to the nature of the polio problem and/or to rapidly increase infrastructure support for improving program performance.

To support activities of each country, PAHO will provide administrative support for procuring the necessary vehicles and cold chain equipment, as well as providing the funds necessary for fuel and per diem.

Independently of the staffing of country programs and preparation of the national plans of action and annual work plans, PAHO will undertake the review of national laboratories in order to quickly establish a network of regional laboratories for providing diagnostic services to the countries for analysis of suspect polio specimens. The review will outline those labs are in good position to support the countries of the region as well as determining the necessities for training and upgrading of lab equipment.

During the course of the first year of the project and thereafter, operational research in one or two areas will be initiated. The TAG will advise which areas of research are of high priority for implementation of the project. In addition, PAHO will begin work on the development of a certification protocol for determining if countries are polio free. In the second year of the project and subsequent years, a certification commission will begin to visit those countries which are classified or will be classified as lower risk countries and which are shown to have good surveillance systems.

The overall implementation of the project in each country may be revised as a result of program reviews. In addition, changes to national annual work plans and PAHO's annual work plans will be made as a result of these reviews.

To guide the implementation of the project and assist PAHO in the management of the project, PAHO will convene AID-funded annual meetings of national immunization program managers for preparing their national plans of

120

action and yearly work plans. At these meetings PAHO will provide technical assistance to countries which request it. In addition, information from program reviews, coverage surveys, and special studies for each country will be used in the formulation of these plans.

To assist in the implementation and management of country activities, PAHO will make available its technical staff or provide consultants. In those countries classified as polio-infected, PAHO will place in-country technical advisors to assist the national immunization manager.

Once national plans of action and annual work plans have been formulated for each country, budgets will be prepared in order that the financial resources for each country's plan are identified. PAHO will establish a special fund for managing project funds, from which annual disbursements will be made to each country based on annual work plans. Project funds will be disbursed according to the fiscal calendar shown in item 3.4. Funds for each country will be provided through the normal budgetary and accounting procedures which PAHO has in place for transferring normal program funds. At the country level, all funds will be managed by the PAHO field offices.

On the Regional level, PAHO will convene a Technical Advisory Group (TAG) for advising PAHO on implementation of the project (see Annexes). To assist the countries in determining the mix of appropriate inputs of human, technical and financial resources for supporting the implementation of the project, the Inter-Agency Coordinating Committee (ICC) will assure donor agencies coordination at national and international levels.

One of the more important management tools for managing the implementation of the project will be the program reviews to be held in each country at least twice during the course of the project, as well as the mid-term evaluation of the project by PAHO-AID.

The overall Regional implementation, monitoring, and logistical support to the project will be managed and provided by PAHO/EPI staff, both central level and inter-country staff. For this purpose the AID-funded project will enable the establishment of two new inter-country technical advisors, as well as two new administrative/epidemiological posts at the central level for meeting the

121

increased administrative demands expected from this country (see section 3.5). PAHO will also provide increased technical support for developing the regional network of laboratory and another epidemiologist for supporting field activities in the countries.

Finally, to support the countries in the procurement of vaccines, equipment and other supplies, and providing technical services to the countries PAHO will use its established administrative mechanisms and procedures.

In order to assure that all countries have sufficient polio vaccine for control of outbreaks, PAHO will establish a reserve stock. This, as well as the other EPI vaccines, will be procured through the EPI Revolving Fund. This Fund establishes annual contracts with approved vaccine suppliers based on competitive bidding. Cold chain equipment and syringes can also be procured via the Fund in a similar fashion.

For the provision of technical services, PAHO has a variety of contracts for hiring additional personnel. PAHO's personnel department will be administratively responsible for managing this using the PAHO/WHO procedures which are well established. The EPI office in Washington will provide the terms of reference for each contract for the provision of technical services (see Timetable, Annex E).

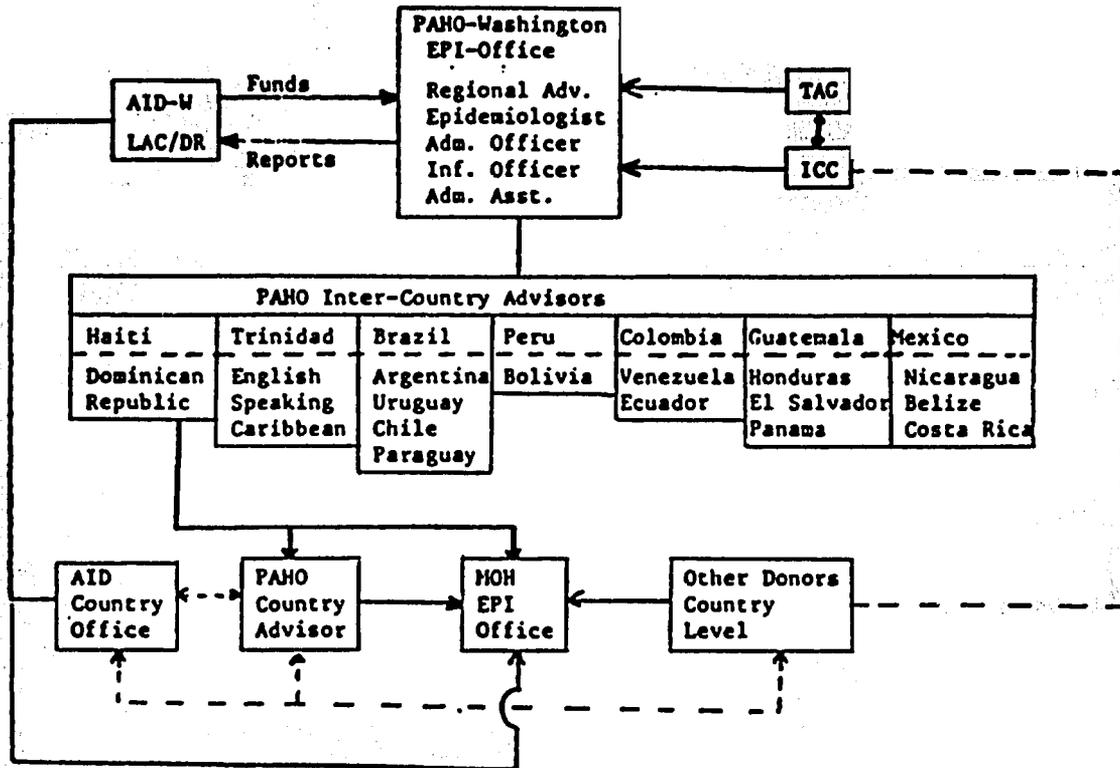
Figure 3 contains an overview of the relationships among PAHO, AID and organizational elements of the project. The elements are:

- PAHO's EPI Office in Washington, D.C. to coordinate and manage the program region-wide.
- A Technical Advisory Group.
- An Inter-Agency Coordinating Committee representing donors.
- National EPI offices in the Ministries of Health.
- AID-Washington Office
- AID-Country Offices
- PAHO Inter-Country Advisors
- PAHO Country Advisors
- Other Donors - Country Level

122

Figure 3

Organizational Chart



3.5.1 Coordination

Because of the multi-donor funding of this program, and because the success of the eradication effort depends upon the participation of every country in the Region, the coordination is a key element of the project. Activities at the international, national, and regional levels will be undertaken throughout the life of the project as follows:

a. PAHO/Washington, D.C.

The Regional EPI office will coordinate all activities related to the eradication effort. All reports and requests for assistance from the field will go through the EPI office, which will in turn coordinate assistance as needed from other units within PAHO. This is critical to ensure a consistent, coordinated effort in the regional activities.

Technical cooperation in all areas of program operations will be available through PAHO to its member countries. Assistance of expert consultants from outside the organization will be coordinated by PAHO and provided as needs arise and may include epidemiologists, virologists, laboratory technicians, cold chain specialists, mass media experts in health education, economists and financial management experts.

In addition to the country and sub-regional level personnel, additional support personnel will be available to the EPI program office at the Regional level. This will include support of virologists (with extensive laboratory skills) to assist in the development of the laboratory network in the region (including training, supervision, supplies and quality control). The AID-financed administrative officer will assist in the planning, management and implementation of the project, including its budgetary and financial aspects. The AID-financed epidemiologist will assist in the coordination of activities related to epidemiological surveillance, outbreak investigation, immunization strategy design, and provision of supervisory assistance to the sub-regional advisors. Increase in data collection and processing will require additional statistical support staff to be funded by PAHO.

b. Technical Advisory Group (TAG)

To assist in guiding the activities of the eradication effort, a Technical Advisory Group (TAG) has been formed, composed of experts in the field of immunizations and polio. The TAG is composed of a core of five individuals, and will call on additional experts as needed to address special problem areas. At least one member of the TAG is a member of the EPI Global Advisory Group (GAG), in order to provide the necessary coordination with global EPI activities. The TAG Chairman or another representative of the group will participate in coordinating meetings with any other agencies or organizations involved in the same effort.

The role of the TAG is to advise on technical components of the program. Strategies to achieve required vaccine coverages, recommendations for vaccination schedules and the choice of vaccines will be reviewed on an annual basis. The TAG will assist in the identification of research

124

needs, oversee the progress of the studies under way, and review protocols and results. The TAG will meet semi-annually to review progress and problems encountered. Recommendations of the TAG will be published and distributed throughout the Region. The PAHO EPI program office will serve as Secretariat to the TAG. The first meeting of the TAG was held in July 1985, to review the Plan of Action that subsequently was approved by the PAHO Directing Council in September 1985 (Annexes A and B). Members of the ICC (see following section) will participate at the TAG meeting. An AID representative will be assured continuing presence at all TAG meetings.

c. Interagency Coordinating Committee (ICC)

To ensure the coordination of all international agency inputs, an Interagency Coordinating Committee with representation from the international agencies (e.g. PAHO, UNICEF, Rotary, AID, IDB, and the Task Force for Child Survival) will participate in the eradication effort. This Committee will meet as frequently as necessary (quarterly or semi-annually or annually) to review progress and the needs for additional assistance. The Coordinating Committee will secure interagency participation in the individual country planning stage to guarantee the coordination of donor inputs into the countries. The first meeting of the Coordinating Committee was held in July 1985 to review the Regional Plan of Action and identify the types of assistance each of the agencies could provide in the effort. The PAHO EPI program office serves as Secretariat to the Coordinating Committee.

A member of the TAG will participate in the ICC meetings in order to advise ICC members of progress to date and problems encountered in the eradication effort. In addition, the TAG member will identify problem areas which may require reallocation of resources or new inputs in order to achieve the eradication of the transmission of wild poliovirus.

d. Country and Sub-Regional Level

Countries will be requested to appoint an individual in charge of the polio eradication effort as a member of the national central-level EPI unit. This person will be supervised by the national EPI program manager

125

(or may be the same individual), and will have full responsibility for all components of the polio eradication effort, drawing upon resources made available to the EPI unit.

Within each country, all activities in the eradication effort will be under the guidance of the national EPI office to strengthen implementation of the activities and facilitate achievement of the overall EPI objectives. This office will oversee the eradication activities at all levels, ensure that coordination with laboratories is a high priority, that training needs are identified, and that courses addressing these needs are organized. This office will serve as the focal point for identification of all external cooperation and coordination of multilateral and bilateral assistance.

The MOH-led task force or coordinating group will meet periodically (approximately quarterly) throughout the life of the project to develop National Plans of Action, annual work plans and to review findings of evaluations, Program Reviews, Coverage Surveys, results of special studies and other monitoring activities. This group will include representatives of donor agencies such as USAID, as well as representatives of key health and non-health implementing agencies in the public and private sectors. Donor agency representatives will participate in program reviews, coverage and morbidity surveys and evaluations. Widespread dissemination of information regarding the project is also expected to be undertaken through local newsletters and distribution of reports of program reviews and surveys.

It is anticipated that IDB funds will enable the placement of eleven epidemiologists/technical advisors in countries classified as Group I. These advisors will preferably be nationals and will assist the Ministries of Health with the planning and implementation of the eradication effort activities. The country level personnel will work closely with counterparts in the MOH for the eradication effort. This personnel is in the process of being identified.

126

Countries were selected for placement of the 11 epidemiologists/technical advisors based on the magnitude of the problems which have impeded the development of sustainable immunization services, the number of polio cases reported with the last three years and the relatively low vaccination coverages.

At the sub-regional level (inter-country), seven epidemiologist posts are needed (of which five are already available and funded by PAHO, and two to be funded by AID), to serve as technical advisors on an international basis and to provide support and supervisory assistance to the inter-country personnel: (Table 8). They will: assist and cooperate in assessing needs for special intervention in the countries under their jurisdiction, participate on the polio investigation teams' certification visits, train personnel at all levels, procure vaccines, in design of cold chain systems, preparation of manual for improving supervisory and surveillance system, and in general provide direct technical cooperation when needed.

Table 8

PROPOSED LOCATION OF SUBREGIONAL ADVISORS

<u>Location of Advisor</u>	<u>Countries in Subregion</u>
GUATEMALA *	Guatemala El Salvador Panama Honduras
MEXICO	Mexico Nicaragua Belize Costa Rica
HAITI *	Haiti Dominican Republic
COLOMBIA	Colombia Venezuela Ecuador
PERU	Peru Bolivia
BRAZIL	Brazil Argentina Uruguay Chile Paraguay
TRINIDAD & TOBAGO (CAREC)	English-speaking Caribbean and Suriname

* AID funded

821

3.6 Timetable (see Annex E)

The following is a preliminary timetable of activities:

- TAG Meetings 7/85 and semi-annually thereafter
- ICC Meetings 7/85, 10/85, and annually thereafter
- Country classification 1985
- National Plans of Action Developed 1985, 1986 and revisions thereafter
- Personnel hired 1985, 1986
- Cold Chain needs inventoried 1985, 1986
- Program Reviews 1986, continued to 1990
- Information Dissemination 1985, continued to 1990
- Certification Commission 1985, 1989, 1990
- Training Manual 1986 and thereafter
- Stockpile of TOPV Vaccine 1986 and thereafter
- Research Priorities Established 1986, and annually thereafter
- Training local personnel 1986, continued to 1990
- Operational Research 1986, continued to 1990
- Equipment Procured and Installed 1986, 1987
- Surveillance and outbreak control mechanisms in place 1986, continued to 1990
- Promotion Campaigns 1986, continued to 1990
- Coverage Surveys 1986, continued to 1990

3.7 Evaluation

3.7.1 Plan for AID Financed Project

The main elements of the evaluation of the multi-donor program for the eradication of poliomyelitis will be coverage surveys, program reviews, laboratory evaluations, TAG meetings and disease reports from countries. In addition to these, the AID financed project will be evaluated by a team of experts at mid-term in 1988 and at the end of the project in 1990. This team will draw information on baseline conditions and progress towards the

achievement of program goal and project purpose from reports on coverage surveys, program reviews and other elements of the multi-donor program evaluation. They will collect additional detailed information on AID financed inputs and outcomes.

3.7.1.1 Evaluative Elements

For the AID financed project, these include baseline information; targets and indicators; planning assumptions and causal factors.

- (i) Baseline. A summary of existing baseline information on poliomyelitis morbidity and mortality and coverage with polio vaccine is given in Section 2.1 of this proposal. The baseline on program activities will be provided in each National Plan of Action.
- (ii) Targets and Indicators. (See Annex F, Log Frame)

Goal (see Log Frame, page 1).

Purpose (see Log Frame, page 1).

AID Financed Outcomes

- a. Functioning, effective epidemiological surveillance and outbreak control mechanisms in place at regional and national levels (see Log Frame, page 3).
- b. Strengthened national immunization programs and improved polio control activities (see Log Frame, page 4).
- c. Strengthened MOH institutional capacity in planning, implementing, monitoring and evaluating immunization services in general, and poliomyelitis in particular (see Log Frame, page 4).
- d. All countries of the region have access to laboratory facilities for identification of poliovirus type (see Log Frame, page 5).
- e. Improved polio immunization services tested in pilot areas (see Log Frame, page 5).

AID Inputs (see Log Frame, page 7).

- (iii) Assumptions and Causal Factors. External factors outside the scope of the project design, but important to the success of the project are listed under the column heading of "Important Assumptions" in the Log Frame. See page numbers listed above for assumptions underlying AID financed outcomes, inputs, purpose and goal. For a description of project strategies, technologies selected and the level and type of resource inputs which may be important causal factors in achieving project targets, see section 3.2 and section 4 of this proposal.

3.7.1.2 Arrangements for Evaluation of the AID Financed Project

A team of experts representing the fields of epidemiology, immunology, economics and evaluation will conduct a mid-term and final evaluation of the AID financed project. An estimated 6 to 8 weeks will be spent in selected countries and at PAHO headquarters to collect the following information:

Progress in reaching the program goal and project purpose targets based on a review of the following sources of information:

- (i) Disease reports in the form of weekly telexes sent by each country on the status of polio cases and of other immunizable diseases.
- (ii) Coverage surveys completed on polio and other immunizations.

Progress in reaching AID financed project output targets based on:

- (i) Program reviews completed.
- (ii) Annual evaluations of the laboratory network.
- (iii) Technical Advisory Group meetings reports.
- (iv) Reports of annual meetings of the EPI and polio eradication program managers from participating countries.

- (v) Visits to selected country program operation sites, laboratories and operational research sites.
 - (vi) Short-term and long-term consultant reports.
 - (vii) Other as deemed necessary by AID, PAHO and collaborating countries at the time.
- c. AID Inputs. Review of grant agreements, schedule of obligations and reimbursements.

The evaluation team will work closely with staff of PAHO and collaborating countries and institutions. The scope of work will include identification of constraints, deviations from planned targets, revised targets and schedules, recommendations for overcoming problems and a timetable for implementing the recommendations, as they relate to the AID financed project. The team will be jointly selected by PAHO and AID.

3.7.1.3 Schedule

The mid-term evaluation will be conducted during calendar year 1988. The final evaluation will be conducted during calendar year 1991.

3.7.1.4 Budget (see Table 6, item E)

3.7.2 Financial Management

The financial records, including documentation to support entries on accounting records and to substantiate charges within the agreement, shall be maintained in accordance with PAHO's usual accounting procedures, which shall follow generally accepted accounting practices and be consistent with the Organization's financial rules, regulations and accounting manual procedures. PAHO will maintain all such financial records for at least three years after final disbursement of funds under the agreement.

All procurement by PAHO of supplies and equipment with funds provided under this agreement shall be carried out in accordance with PAHO's established purchasing procedures and will be consistent with generally accepted business procurement practices.

PAHO confirms that this program will be included within the scheduled reviews performed by its Internal Audit Department and that the project records and accounts will be subject to audit along with all other financial transactions of the Organization by the Organization's External Auditors (The Comptroller and Auditor General of the United Kingdom and Northern Ireland). PAHO will furnish copies of all relevant audit reports to AID along with such other related information as may be requested by AID with respect to questions arising from such audit reports. Special or joint audit reviews on any particular aspect of the program may be carried out by mutual agreement of PAHO and AID.

Funds provided by AID to PAHO under this agreement shall be disbursed in accordance with the payment provisions established by AID for financing under a Letter of Credit (LOC or FRLC).

PAHO will prepare and submit to AID all financial reports or statements as may be required by AID on a periodic basis.

3.7.3 Program Evaluation and Reports

Recognizing the critical nature of evaluation for monitoring success and detecting and resolving problems, there will be increased emphasis on the EPI evaluation component. The key components of program evaluation will be coverage surveys, program reviews, laboratory evaluation, TAG meetings and disease reports from countries.

Because of lack of adequate information, program reviews and/or coverage surveys will be carried out prior to the elaboration of National Plans of

Action where necessary. Project inputs can thus be carefully matched to the actual status of each national EPI program, and to the local polio situation. Coverage surveys and national EPI program reviews will be repeated, as needed, to monitor and evaluate the progress of the eradication effort. International observers will participate in all country program reviews and reports of findings will be widely distributed.

Coverage surveys on vaccination will be performed in most countries. Included in the coverage surveys will be questions on reasons for compliance and non-compliance. Results of these surveys will be used as a basis for modifications of strategies to optimize the efficacy of interventions.

Program reviews: The Pan American Health Organization (PAHO) has designed a methodology for carrying out multidisciplinary reviews of the Expanded Program on Immunization in the Americas. These reviews aim to identify the principal problems which are impeding program progress; to study possible solutions, expressed in the form of recommendations; and to design a plan of action to implement these recommendations. Another important aspect of the methodology is that the team is formed of national officials of the corresponding Ministry of Health, with multidisciplinary representation. AID and other donor agencies will be invited to participate in program reviews.

The review covers:

- a) A study of current EPI operations at all levels of the health system.
- b) Identification of the accomplishments and limitations of the EPI.
- c) Design of recommendations for surmounting the problems; and
- d) Development of a timetable for implementing the recommendations.

Sources of data include:

- Review of immunization data available at the central level;
- Field visits to the administrative (State Health Service) and operational (health establishment) levels.

- Studies in the Ministry of Health of administrative activities of the EPI and related entities (including maternal and child health, epidemiology, information systems, programming, and the cold chain) by means of interviews with the persons in charge of these activities.

In the study of EPI operations, the following areas are emphasized as being of critical importance to immunization:

- The cold chain: equipment and procedures for the preservation of biologicals;
- the system for delivery of vaccines and other supplies;
- the system for reporting immunizations administered;
- training of EPI personnel;
- immunization strategies employed;
- the promotion of immunization and community participation;
- the epidemiological surveillance system; and
- coordination among health institutions.

Laboratories

In addition to evaluations of country program operations, the laboratory network will be evaluated annually to guarantee that the high level of support needed is met. Part of the laboratory evaluation process will include a retesting of original specimens by the reference laboratories, as well as reference specimens sent by the reference laboratories to the country laboratories for testing.

Disease Reports

Weekly telexes will be sent to PAHO by each country, on the status of polio cases. The analysis of data will be supported by computer hardware and software provided under this project. Other local costs will be covered in national budgets.

Technical Advisory Group

TAG meetings will be used to review the overall strategy and technical feasibility of program activities from time to time.

Reports to AID

- A. National Plans of Action. Copies will be provided to AID as they are developed. All Group I and II-A countries are expected to have National Plans by December 1986.
- B. Annual Country Work Plans will be provided by PAHO covering the entire regional Plan of Action.
- C. Quarterly Progress Reports. PAHO will submit quarterly progress reports and each will contain:
 - regional, sub-regional and country level activities, achievements and constraints.
 - any modifications in the Regional or National Plans of Action.
 - Financial statement on expenditures.
 - Proposed work plan for the following quarter.
- D. Final Report. This will contain coverage rates, cases reported, outcomes and beneficiaries reached. Financial data will be provided, and achievements, lessons learned and future plans will be described.

4. TECHNICAL ANALYSIS

Poliomyelitis is an acute viral infection with severity ranging from inapparent infection to a non-paralytic febrile illness, to an aseptic meningitis, to paralytic disease and possible death. Symptoms include fever, malaise, headache, nausea and vomiting, excruciating muscle pain and spasms, and stiffness of neck and back with or without flaccid paralysis, the hallmark of the disease. The infectious agents are the poliovirus types 1, 2 and 3, with all types causing paralysis.

4.1 Surveillance and Information Systems

Because national health information systems are often incomplete or poorly developed, sample surveys will be conducted periodically in order to assess TOPV and other EPI vaccine coverage. Such surveys have already been carried out in several countries of the Region.

In view of the relatively small number of cases being reported annually in the Region, every suspected case is expected to be investigated immediately. This is one of the most critical components of the eradication effort. Case investigation will be carried out according to the definitions set out in a manual following PAHO guidelines. For operational purposes, the following provisional definitions are proposed:

- Suspected poliomyelitis case. Any acute onset of paralysis in a person less than 15 years of age.
- Probable poliomyelitis case. Any acute onset of flaccid paralysis without sensory loss or other identified cause.
- Confirmed poliomyelitis case. Any probable case with laboratory confirmation or linkage to another probable or confirmed case or presence of residual paralysis 60 days after onset.

Case identification and reporting will include weekly calls to all facilities that might see acute or convalescent cases as part of the surveillance mechanism. The types of facilities to be called include: all acute care hospitals (public and private, general and specialized) and rehabilitation centers. Once suspected cases are identified, thorough community investigations for additional cases will be conducted. Each country will send PAHO weekly reports by telex of probable and confirmed cases of poliomyelitis.

In the event of an outbreak, all countries in the Region will be notified immediately by telex from PAHO/Washington, so that traveller's advisories can be issued.

PAHO will make experts available in the field of surveillance. In Group I countries these personnel will be made available to assist countries in developing or improving surveillance activities, and to review case records of other diseases included in the differential diagnosis of poliomyelitis, such as Guillain-Barré Syndrome (GBS) and transverse myelitis.

PAHO personnel will be available to assist in confirming the validity of the reports. These personnel will also be available to assist in performing

evaluations of facilities that are likely to see polio cases, following up diagnosed cases of GBS (to verify that the distinction between GBS and polio was clearly present), and instituting the reward mechanism for cases found.

4.2 Outbreak Investigation and Control

For operational purposes, the definition of an outbreak is the occurrence of one probable or confirmed case of poliomyelitis. Upon identification of a probable or confirmed case, the Ministry of Health should make an official announcement alerting all health personnel and the general population to the situation in order to increase public awareness of the need for immunization, and the need to report all suspected cases promptly. The PAHO country office should also be notified immediately.

PAHO investigation teams will be available to assist in investigations of outbreaks, search for additional cases and implementation of control measures.

Adequate stocks of TOPV must be available to the countries to mount control measures immediately. The control measures will aim to provide TOPV to all persons at risk; in Group I countries this will usually be children less than 5 years of age. Due to the rapid, wide and silent spread of the poliovirus, immunization is recommended not just of the surrounding neighborhood, but also of a wider area.

Part of outbreak investigation and control will be the rapid identification of poliovirus type. Upon identification of a probable case, specimens will be collected immediately and sent to the nearest laboratory for virus isolation studies. In addition, the probable epidemiological classification of the case will be determined within 24-48 hours of notification. In the event of a probable vaccine-associated case, immediate control measures will not be required.

Reports on all outbreaks and case importations will be published and disseminated. When intra-regional importation has occurred, the country of origin of the case will be notified and an investigation team will be available to assist in the investigation.

4.3 Training

This component, which is anticipated to be funded by the IDB grant, will put major emphasis on training personnel in the additional areas of program operations critical for success of the program. To assist in this endeavor, PAHO/EPI will prepare a manual on the technical basis of poliomyelitis eradication for distribution to all member countries. This manual will serve as a prototype for countries to produce country-specific manuals adapted to local circumstances. PAHO will provide technical assistance to the countries for the adaptation of the manual and for its production and distribution, as well as for the planning and execution of training courses as needed.

Within each country, systematic manpower training will be carried out on national, regional (mid-level) and local levels. On the national and regional levels, a core group of EPI trainers, or "multipliers" will be trained. Modular training materials, whose successful use has been widely demonstrated in the Region in recent years, will be prepared and adapted. Major areas of training will include:

- Epidemiology of polio (and other EPI diseases);
- laboratory skills in polio identification;
- vaccine use, conservation and programming of local vaccine needs;
- outbreak investigation and polio control measures.

The project will train approximately 4,000 workers in the health sector in various components of the immunization programs. The bulk of the training will consist of short-term in-service training workshops conducted in each country for trainers of health personnel at all levels of the health system, particularly those involved in MCH and child survival activities as well as those involved with disease control, which are crucial for the immunization programs in general, and polio eradication program in particular.

The following list illustrates the content of training activities:

Preparation and dissemination of materials for training in epidemiologic surveillance and methods of control;

- Preparation of materials for orientation courses to update virologists in selected countries;
- Planning, coordinating and conducting national and international training programs in the laboratory diagnosis of poliomyelitis and non-polio enterovirus at both conventional and molecular levels;
- Training for supervisors and health workers in cold chain operations and preventive maintenance.
- Training/retraining of laboratory personnel for performing poliovirus isolation and characterization studies;
- Development and execution of a continuing education program or in-service training for each category of health worker involved in EPI in general and polio eradication in particular regarding technical and operational aspects of the program.
- Training of international response teams in outbreak investigation and methods of control.

The projected timetable of training activities is as follows:

<u>Training</u> (No. of courses and seminars)	<u>1986</u>	<u>1987</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>Total</u>
Cold Chain	8	10	10	8	6	42
Epidemiology and Surveillance	8	10	12	8	6	44
Laboratory	8	10	11	8	6	43
Maintenance	8	10	11	8	6	42
Planning/Evaluation	<u>8</u>	<u>10</u>	<u>10</u>	<u>8</u>	<u>6</u>	<u>42</u>
TOTAL	40	50	54	40	30	213

Training workshops will be conducted at various target countries directly at regional and local levels as well as in collaboration with national training institutions.

Training expenses will include production and reproduction of materials; local organization of workshops; mobilization of personnel and trainers. All training expenses will be paid in local currency.

140

4.4 Laboratories

Support to surveillance activities

A major component of surveillance activities will be laboratory studies of probable cases of poliomyelitis. For all probable cases, specimens will be collected for isolation studies. Oligonucleotide mapping or other testing of the isolates will be performed to identify the origin of the virus. The more sophisticated laboratories in the network will provide this reference service to the Region. The close participation of the laboratories in the epidemiological evaluation process is imperative. If clinically and epidemiologically compatible cases of poliomyelitis are identified but isolation studies are either negative or yield a non-polio enterovirus, original specimens and the non-polio enterovirus isolate will be sent to reference laboratories for further study.

Laboratory evaluations

All countries should have access to laboratory facilities for poliomyelitis studies and PAHO/EPI will assist for the necessary laboratory support. A team of internationally recognized virologists, under the auspices of PAHO, is presently evaluating laboratory facilities available in the Region to identify those to be included in a Regional network. This process will be completed by January 1986. In addition, a network of laboratory personnel available to participate in the investigation team assessments will be developed, thereby permitting a laboratory person to be a member of all teams.

Virus isolation and serological capabilities to perform poliovirus and other enterovirus laboratory studies will be identified. It is expected that six or seven laboratories in the Region will be certified as reference laboratories. They will be selected from the WHO collaborating centers and from national laboratory networks and will serve as technical resources for assisting countries to develop their own laboratory facilities. Capabilities to perform more sophisticated viral identification studies (nucleic acid hybridization and oligonucleotide mapping) will be developed in two or three reference laboratories.

National immunization days, to be held at least twice a year, will be recommended for countries classified in Group I. National immunization days are recommended for Group I countries for the following reasons: to rapidly increase vaccination coverages so as to protect children from paralytic polio and other diseases; interrupt reduce the transmission of wild poliovirus and for the control of ongoing polio outbreaks. Their success will require intensive planning of the logistics of both supply and demand. The use of the mass media and professional advertising firms to sell the concept of vaccination will be encouraged. Mobilization of all resources, both multilateral and bilateral, and participation of non-governmental sectors in these efforts will be essential for success. This tactic will be viewed as an ad hoc measure, to be gradually replaced by regular immunization services performed routinely by health services.

Advantage will be taken of the national immunization days to administer DPT and measles vaccine as well as tetanus toxoid vaccine for women of childbearing age..

As alluded to earlier, countries classified in Group II will need to maintain coverages of at least 80% of the target population by reinforcing routine immunization services and to maintain high levels of surveillance.

4.7 Vaccines and Cold Chain

All countries will ensure that the vaccines used in the program meet WHO requirements. Vaccine distribution will be a key component of immunization activities. Adequate distribution systems will be essential to ensure that vaccines are available at the delivery points on the scheduled days. Most countries in the Region have developed adequate systems for distribution of vaccines. However, on a country-by-country basis, logistical systems may have to be improved. This may include restructuring the distribution points for vaccines and changing the frequency of distribution of vaccines to improve efficiency.

Cooperation from donor agencies includes the procurement and maintenance of necessary cold chain equipment. To address the recognized problems with

142

cold chain equipment maintenance, countries will be encouraged to design cold chain systems that rely upon low-maintenance equipment and equipment that is energy efficient.

4.8 Community Promotion and Health Education

Intensive mass media campaigns will be undertaken in Group I countries. The design phase of these campaigns will consist of reviewing quantitative studies and qualitative research such as through focus groups and anthropological methods to identify existing attitudes, knowledge and behaviour in communities regarding immunization and poliomyelitis. Priority messages will be developed and carefully pretested. A variety of communication channels including the mass media (radio, T.V., posters) and face-to-face education will be used. Outreach workers from non-health sectors will be recruited and trained to support the effort. Target behaviour consists of participation in immunization days, seeking three or more doses of polio vaccine for children under one year of age and case reporting in conformance with the surveillance and outbreak control protocols of the program.

5. ECONOMIC ANALYSIS

5.1 Prior to the implementation of the EPI in the region of the Americas, an average of over 3,000 cases and approximately 350 deaths from poliomyelitis were reported annually in the Region. Recognizing that there is a serious problem with under-reporting, the true morbidity burden can be safely approximated by multiplying these figures by a factor of at least five*. A 1977 study estimated that the average cost per patient for acute care of poliomyelitis in hospitals was US\$253 in Brazilian hospitals (ranging from US\$100 to US\$800), and that the average cost for rehabilitation was US\$2,400 (ten years). At US\$2,653 per case, the cost to the Region was approximately US\$40 million annually (3,000 cases x 5 x \$2,653 per case treated is \$39.8 million). Though the extent of rehabilitation received by any one patient is

* Estimated maximum underreporting of 80%.

143

not well documented, for purpose of this discussion it will be assumed that all cases receive both acute care and rehabilitation. It takes no account of loss of income due to paralysis, nor the loss of life. If such calculations were made, they would yield staggering figures in net loss to the individuals, to the family and to the economy of the nations in productivity losses and waste of manpower resources.

To interrupt indigenous transmission of wild poliovirus will cost the Region about \$120 million over five years, or \$24 million annually. The saving in medical costs alone over this period would be \$200 million, so there would be a net saving about equal to the cost of the eradication program. The savings will continue after the five-year eradication campaign. From 1990 onward, the cost of keeping children under 1 year of age vaccinated and maintaining the eradication of polio should drop to only \$10 million per year. The \$10 million dollars will cover recurrent costs associated with salaries, maintenance of the cold chain and vehicles, per diem and travel for investigating possible outbreaks, laboratory services for diagnosis of specimens, procurement of vaccine and syringes, health education efforts and material and supplies (i.e. telephone, paper, reports and others). While the saving in medical costs -- compared to the situation that prevailed before the EPI was instituted -- would continue to be about \$40 million annually, leaving a net saving of \$30 million per year.

Savings obtained in the future must be discounted, for comparison to immediate savings. If a discount rate of ten percent is used (so that \$1.00 saved today is worth \$1.10 saved next year), then from 1985 through the end of the century the present discounted value (PDV) of the savings from eradicating polio will be no less than \$213.6 million. This estimate includes savings of \$66.7 million over the five years of the eradication campaign (less than \$80 million because of discounting in 1987-1990), and \$146.9 million in savings over the following decade (this is much less than ten years times \$35 million, because the first year's savings, in 1991, is discounted to only \$21.7 million and subsequent years are discounted still more). This approximation suggests that by the year 2000, the eradication of polio would pay for itself almost twice over in reduced medical costs alone.

144

At present it is estimated, and recent data from Brazil reinforces this estimation, that underreporting of polio in the region may be over five times. This was the assumption utilized in the analysis made and presented in the proposal.

In the absence of a strengthened surveillance system, the real number of cases, and overall impact of the immunization program in the various countries cannot be determined, in spite of the fact that there has been reduction in the number of polio paralytic cases being reported.

On the other hand, the reduction that has been observed partly was possible in view of the acceleration of the EPI in several countries that aimed at polio elimination, such as Brazil, Mexico, Bolivia, Dominican Republic and Colombia.

As coverage declines, the occurrence of outbreaks of greater magnitude is unpredictable, but most likely the disease may return to the levels observed in 1980 or 1981.

The example of Jamaica better illustrates this fact:

After over five years of "reporting" zero cases, and in the absence of reliable surveillance system, probably due to false confidence, levels of coverage declined and a large outbreak occurred in 1982, with over 50 cases, bringing considerable damage to the health of these individuals and considerable economic burden to the country's economy, both in terms of extra emergency costs to control the outbreak as well as in lost revenues due to decline in tourism during the period of the outbreak.

The external funds that will be utilized in this project will ensure that the surveillance system is built up and that supervisory systems are in place to guarantee the sustaining of high levels of coverage and the eventual eradication of the wild poliovirus.

Without these additional resources, it will be very difficult for the countries to organize these needed surveillance systems and it can be assumed the levels of coverage will decline due to the lack of supervisory systems.



PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

EPI-85-102

**ERADICATION OF INDIGENOUS TRANSMISSION
OF WILD POLIOVIRUS IN THE AMERICAS**

**PLAN OF ACTION
July 1985**

1) Introduction	1
2) Strategies and Technical Components	3
3) Organization and Administration	13
4) Funding and Financial Components	16
5) Timetable	18
6) Appendices	20

1. INTRODUCTION

The Expanded Program on Immunization (EPI) has its basis in resolution WHA 27.57, adopted by the World Health Assembly in May 1974. General program policies, including the EPI goal of providing immunization services for all children of the world by 1990 (resolution WHA 30.53, 1977) were endorsed by resolution CD 25.27 of the Pan American Health Organization (PAHO) Directing Council in September 1977.

The long-term objectives of the EPI are to:

- reduce morbidity and mortality from diphtheria, whooping cough, tetanus, measles, tuberculosis and poliomyelitis by providing immunization services against these diseases for every child in the world by 1990 (other selected diseases may be included when and where applicable);
- promote countries' self-reliance in the delivery of immunization services within the context of comprehensive health services; and
- promote regional self-reliance in matters of vaccine production and quality control.

Since the EPI was launched in the Region of the Americas in 1977, immunization coverages have improved considerably. In 1978, less than 10% of the children under one year of age lived in countries where coverage with the EPI vaccines was at least 50%; by 1984, nearly 50% of the children in this age group lived in countries with coverage of at least 50% for DPT vaccine, of over 50% for measles and BCG vaccines, and of over 80% for polio vaccine.

The impact of the high coverages with polio vaccine can be seen in Figure 1, which shows the annual reported incidence of poliomyelitis in the Region of the Americas during the period 1969-1984, and in Figure 2, which shows the absolute number of cases reported each year during the same period.

PREFACE

The Director of the Pan American Health Organization has appointed a Technical Advisory Group (TAG) to advise the Organization on the acceleration of the Expanded Program on Immunization and the eradication of the indigenous transmission of wild poliovirus in the Americas. This group is composed of the following five members:

- Dr. José Manuel Borgoño
Chief, Office of International Affairs
Ministry of Health
Santiago, Chile
- Dr. Donald A. Henderson (Chairman)
Dean, Johns Hopkins University
School of Hygiene and Public Health
Baltimore, Maryland
- Dr. Alan Hinman
Director, Division of Immunization
Centers for Disease Control
Atlanta, Georgia
- Dr. Jesús Kumate Rodríguez
Vice Secretary of Health Services
Secretariat of Health
Mexico D.F., Mexico
- Dr. Joao Baptista Risi, Jr.
Secretary, National Secretariat of Basic
Health Actions, Ministry of Health
Brasília, Brazil

The Technical Advisory Group held its first meeting in Washington, D.C. on 11-12 July 1985 to discuss and revise the Plan of Action for the eradication of indigenous transmission of wild poliovirus in the Americas. The proposed Plan of Action is contained in the following pages.

Figure 1. Annual reported incidence of poliomyelitis (per 100,000 population), Region of the Americas, 1969-1984

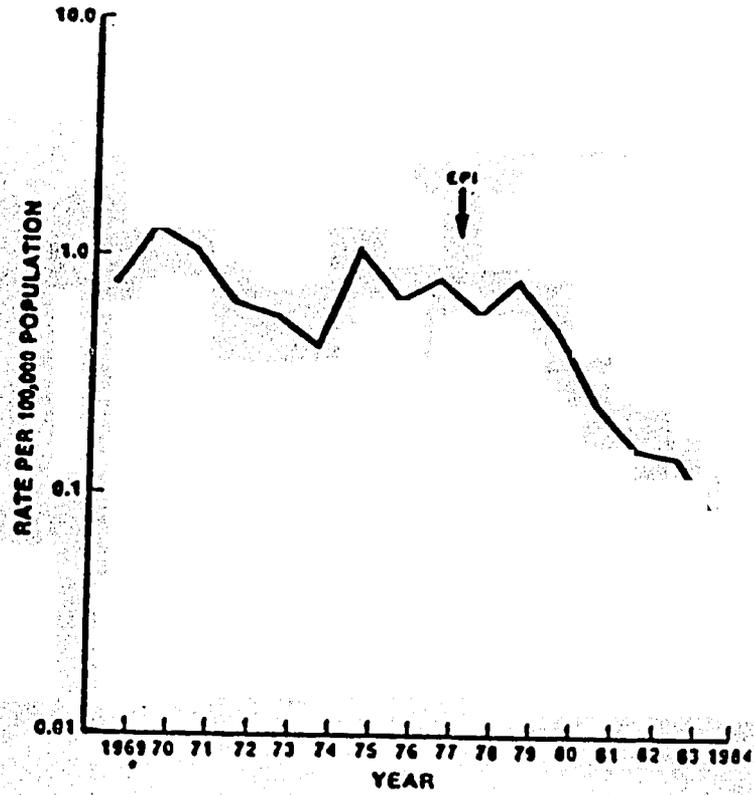


Figure 2. Annual number of reported cases of poliomyelitis, Region of the Americas, 1969-1984

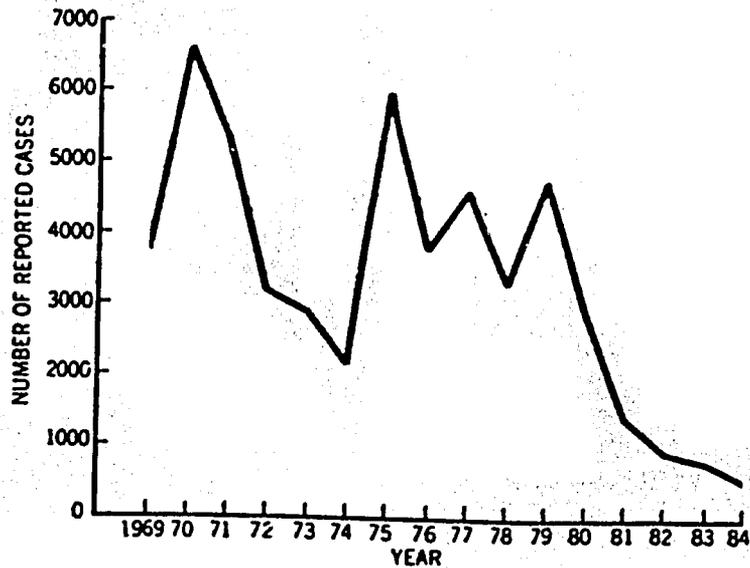


Table 1 gives a breakdown of the annual number of reported cases by country between 1975 and 1984. In 1978, 11 countries in the Region reported no cases of poliomyelitis. By 1984, 19 countries had reported no cases of poliomyelitis, almost double the number of countries reporting no cases only six years earlier.

This impressive, rapid reduction in the disease burden resulting from increased coverages with the polio vaccine has paved the way for the decision to eradicate transmission of wild poliovirus in the American Hemisphere by 1990.

In keeping with this, on 14 May 1985 the Director of PAHO announced PAHO's commitment to this goal and called for support from all member countries and other international agencies. At the time of the announcement, many of the member countries and the international agencies gave their endorsements to the achievement of eradication of indigenous transmission of wild poliovirus in the Hemisphere by 1990.

The Director of PAHO emphasized that activities related to the eradication of diseases preventable by immunization must be considered within the context of the EPI, directed at the control of the six priority diseases.

The proposed Plan of Action aims at three primary objectives:

- a) To promote the overall development of the Expanded Program on Immunization in the Region, to speed up the attainment of its objectives.
- b) To eradicate indigenous transmission of wild polioviruses in the American Region by the year 1990.
- c) To set up a surveillance system at regional and national levels, so that all suspected cases of poliomyelitis are immediately investigated and appropriate control measures to stop transmission are rapidly implemented.

The succeeding sections of this document detail the proposed Plan of Action.

2. STRATEGIES AND TECHNICAL COMPONENTS

The primary prerequisite to achieve the stated objectives will be the level of national political commitment, as expressed by:

- . Approval by the PAHO Directing Council in September 1985 of the Resolution to eradicate indigenous transmission of the wild poliovirus from the Americas by 1990;
- . Legislative action by member countries, whenever necessary;
- . Availability and allocation of national resources for the effort.

Table 1. Number of poliomyelitis cases in the Americas, by country, 1975-1984

Country	Mean number of cases/year		Number of cases			
	1975-1977	1978-1980	1981	1982	1983	1984
NORTHERN AMERICA						
Bermuda	-	-	-	-	-	-
Canada	1	4	-	-	-	1
United States	13	20	7	9	12	7
CARIBBEAN						
Anguilla	-	-	-	-	-	-
Antigua and Barbuda	-	-	-	-	-	-
Bahamas	-	-	-	-	-	-
Barbados	-	-	-	-	-	-
British Virgin Is.	-	-	-	-	-	-
Cayman Islands	-	-	-	-	-	-
Cuba	-	-	-	-	-	-
Dominica	-	-	-	-	-	-
Dominican Republic	63	107	72	70	7	-
Grenada	-	-	-	-	-	-
Guadeloupe	-	-	-	-	-	-
Haiti	25	16	35	35	52	63
Jamaica	-	-	-	58	-	-
Martinique	-	-	-	-	-	-
Montserrat	-	-	-	-	-	-
Netherlands Antilles	-	-	-	-	-	-
Puerto Rico	-	-	-	-	-	-
Saint Lucia	-	-	-	-	-	-
St. Martens and St. Bartholomew	-	-	-	-	-	-
St. Kitts-Nevis	-	-	-	-	-	-
St. Vincent and the Grenadines	-	-	-	-	-	-
Trinidad and Tobago	-	-	-	-	-	-
Turks and Caicos Is.	-	-	-	-	-	-
U.S. Virgin Islands	-	-	-	-	-	-
CONTINENTAL MIDDLE AMERICA						
Belize	-	2	-	-	-	-
Costa Rica	-	-	-	-	-	-
El Salvador	38	23	52	16	88	19
Guatemala	39	116	42	136	208	17
Honduras	78	101	18	8	8	76
Mexico	710	966	186	98	232	137
Nicaragua	26	36	46	-	-	-
Panama	-	-	-	-	-	-
TROPICAL SOUTH AMERICA						
Bolivia	138	121	15	10	7	-
Brazil	2,807	1,854	122	69	45	82
Colombia	525	305	576	187	88	18
Ecuador	45	10	11	11	5	-
French Guiana	-	-	-	-	1	-
Guyana	2	-	-	-	-	-
Paraguay	74	20	60	71	11	3
Peru	136	120	149	150	111	102
Suriname	-	-	-	1	-	-
Venezuela	44	34	68	30	-	-
TEMPERATE SOUTH AMERICA						
Argentina	2	22	5	10	26	-
Chile	-	-	-	-	-	-
Uruguay	6	-	-	-	-	-
Total	4,772	3,877	1,464	969	911	525
Number of countries reporting cases	19	18	16	17	15	11
- no cases						

In order to meet the goal of eradication of indigenous transmission of wild poliovirus in the Americas by 1990, it will be necessary to intensify all components of the EPI strategies presently being implemented and to adapt many of the EPI approaches. Other essential elements are coordination of international agencies at the Regional and country levels, and availability of sufficient funds from both national and international sources to cover all activities related to this goal.

The key strategies to be adopted in this effort are:

1. Mobilization of national resources;
2. Achievement and maintenance of vaccine coverages of greater than 80% of the target population;
3. Surveillance activities adequate to detect promptly all cases of poliomyelitis, with thorough investigations and institution of control measures;
4. Laboratory diagnostic services available to all countries, to permit laboratory studies of all probable cases of poliomyelitis reported;
5. Information dissemination within countries and throughout the Region;
6. Identification of research needs with subsequent funding for execution;
7. Development of a certification protocol to declare the countries and the Region free of indigenous transmission; and
8. Evaluation of all ongoing program activities.

For each of the key strategies, a series of technical components are recommended to ensure their success.

2.1 Mobilization of Country Resources

Recognizing the limited resources available within the Ministries of Health in many of the countries, it will be crucial to concentrate efforts on the mobilization of all country resources to complement those available.

To this end, inter-sectorial coordination will be essential to estimate the potential of existing resources and to mobilize the necessary additional resources. The education and agriculture sectors, social security and other organizations will be essential elements in this endeavour.

Finally, communities and community groups will be called on to collaborate and add their resources and talents towards the achievement of the objective. Private voluntary organizations, religious groups, and mass media organizations will also be tapped to assist in promotional activities, distribution of supplies and personnel and participation in vaccination activities. Cooperative strategies will be developed for combined actions of several countries and technical cooperation between countries for purposes of planning, implementation and evaluation of programs, particularly in the areas of outbreak investigation and control, as well as laboratory support.

2.2 Immunization Activities

2.2.1 Classification of countries by level of poliomyelitis activity and vaccination coverage

Countries will initially be classified into the following two groups:

- GROUP I: Polio-infected countries. Those countries reporting indigenous cases due to transmission of wild poliovirus within the previous three years.
- GROUP II: Polio-free countries. Those countries reporting no indigenous cases due to transmission of wild poliovirus within the previous three years. This group will be subdivided into the following two categories:

Group II-A: Higher-risk countries. Those countries which have had vaccination coverages of less than 80% of children under one year of age in any of the previous three years.

Group II-B: Lower-risk countries. Those countries which have maintained vaccination coverages of greater than or equal to 80% of children under one year of age in each of the previous three years.

2.2.2 Vaccination tactics

The vaccination tactics recommended to achieve the goal will vary depending upon each country's level of poliomyelitis activity, existing vaccination coverage and health infrastructure. Trivalent oral poliomyelitis vaccine (TOPV) will be the primary means of achieving eradication of indigenous transmission of wild poliovirus in the Americas. The appropriate role of inactivated poliomyelitis vaccine (IPV) in the polio eradication effort will be reviewed on a continuing basis.

• National immunization days, to be held at least twice a year, will be recommended for countries classified in Group I. Their success will require intensive planning of the logistics of both supply and demand. The use of the mass media and professional advertising firms to sell the concept of vaccination will be encouraged. Mobilization of all resources, both intra- and extra-sectorial, and participation of non-governmental sectors in these efforts will be essential for success. This tactic should be viewed as an ad hoc measure, to be gradually replaced by regular immunization services performed routinely by health services.

Advantage should be taken of the national immunization days to administer DPT and measles vaccine as well.

Countries classified in Group II will need to maintain coverages of at least 80% of the target population by reinforcing routine immunization services and maintaining high levels of surveillance.

2.2.3 Logistical support

All countries should ensure that the vaccines used in the program meet WHO requirements. Vaccine distribution will be a key component of immunization activities. Efficient distribution systems will be essential to ensure that vaccines are available at the delivery points on the scheduled days. To guarantee that immunization activities will not be interrupted, a stockpile of vaccines will be maintained at the Regional level for use in case of emergency. Manufacturers will be requested to have 5 million doses on hand for emergency use at all times. PAHO will oversee the inventory of these emergency stocks and allocate distribution when needed. Countries are expected to order vaccine supplies as needed on a routine basis.

By the time country work plans are prepared, cold chain deficiencies will be identified and the plans will reflect the needs to be fulfilled. Cooperation from donor agencies should include the procurement and maintenance of necessary cold chain equipment. To address the recognized problems with cold chain equipment maintenance, countries will be encouraged to design cold chain systems that rely upon low-maintenance equipment.

2.2.4 Training

There will be a major emphasis on training personnel in the additional components of program operations critical for success. To assist in this endeavor, PAHO will prepare a manual on the technical basis of poliomyelitis eradication for distribution to all member countries. This manual will serve as a prototype for countries to produce country-specific manuals adapted to local circumstances. PAHO will provide technical assistance to the countries for the adaptation of the manual and for its production and distribution, as well as for the planning and execution of training courses as needed.

2.3 Epidemiological Surveillance and Outbreak Control

In view of the relatively small number of cases being reported annually in the Region, it is urged that every suspected case be investigated immediately. This is one of the most critical components of the eradication effort. Case investigation should be carried out according to the definitions set out in the manual referred to in section 2.2.4. For operational purposes, the following provisional definitions are proposed:

- Suspected poliomyelitis case. Any acute onset of paralysis in a person less than 15 years of age.
- Probable poliomyelitis case. Any acute onset of flaccid paralysis without sensory loss or other identified cause.
- Confirmed poliomyelitis case. Any probable case with laboratory confirmation or linkage to another probable or confirmed case or presence of residual paralysis 60 days after onset.

Adequate stocks of TOPV must be available to the countries to mount control measures immediately. The control measures will aim to provide TOPV to all persons at risk; in Group I countries this will usually be children less than 5 years of age. Due to the rapid, wide and silent spread of the poliovirus, immunization is recommended not just of the surrounding neighborhood, but also of a wider area.

Part of outbreak investigation and control will be the rapid identification of poliovirus type. Upon identification of a probable case, specimens will be collected immediately and sent to the nearest laboratory for virus isolation studies. In addition, the probable epidemiological classification of the case will be determined within 24-48 hours of notification. In the event of a probable vaccine-associated case, immediate control measures will not be required.

Reports on all outbreaks and case importations will be published and disseminated. When intra-regional importation has occurred, the country of origin of the case will be notified and an investigation team will be available to assist in the investigation.

2.4 Laboratory Support

2.4.1 Support to surveillance activities

A major component of surveillance activities will be laboratory confirmation of probable cases of poliomyelitis. For all probable cases, specimens will be collected for isolation studies. Oligonucleotide mapping or other testing of the isolates will be performed to attempt confirmation of the origin of the virus. The more sophisticated laboratories in the network will provide this reference service to the Region. The close participation of the laboratories in the epidemiological evaluation process is imperative. If clinically and epidemiologically compatible cases of poliomyelitis are identified but isolation studies are either negative or yield a non-polio enterovirus, original specimens and the non-polio enterovirus isolate will be sent to reference laboratories for further study.

2.4.2 Laboratory evaluations

All countries should have access to laboratory facilities for poliomyelitis studies and PAHO will assist with the necessary laboratory support. A team of internationally recognized virologists, under the auspices of PAHO, will evaluate laboratory facilities available in the Region to identify those to be included in a Regional network. This process will be completed by December 1985. In addition, a network of laboratory personnel available to participate in the investigation team assessments will be developed, thereby permitting a laboratory person to be a member of all teams.

Laboratory and serological capabilities to perform poliovirus and other enterovirus isolation studies will be identified. It is expected that six or seven laboratories in the Region will be certified as reference laboratories.

They will be selected from the WHO collaborating centers and from national laboratory networks and will serve as technical resources for assisting countries to develop their own laboratory facilities.

Capabilities to perform serologic studies will also be identified in the Region, and logistic systems will be strengthened to provide all countries access to the services. Capabilities for complement fixation and neutralization titer assays will be developed. It is expected that most countries will develop capabilities to perform serologic studies on probable cases of poliomyelitis. Capabilities to perform more sophisticated viral identification studies (nucleic acid hybridization and oligonucleotide mapping) will be developed in two or three reference laboratories.

2.4.3 Development of Regional Laboratory Network

In keeping with the general PAHO policy of developing networks of national institutions for technical cooperation among developing countries, a regional laboratory network will be formed. The development of the network of laboratories will involve strengthening the necessary logistics system for both the transport of specimens and the distribution of necessary supplies such as reagents. A continual supply of standardized reagents for the serologic, virus isolation, and genetic characterization studies will be ensured. The CDC in Atlanta will be requested to assist in the development of the laboratory networks and to certify laboratories as reference centers.

For countries without laboratories, reference laboratories will be identified for their assistance. The reference laboratories will assist countries to develop in-country virology support. The reference laboratories will confirm the results of the country laboratories. A regional laboratory supervisory system will guarantee consistent, high quality testing and reliability of results.

As part of the development of the laboratory network, a manual will be produced covering: tests to be performed on all suspected cases, testing procedures, appropriate specimens, methods of collection of specimens, shipping procedures, handling of specimens, quality control procedures, data collection and data processing. This manual will be ready by November 1985 and will be distributed to all participating laboratories.

Training needs will be addressed at the various levels through the development of a workshop for participating laboratory personnel in the network. The first course will be held by February 1986, following the identification of the laboratories.

In addition to the laboratory studies related to surveillance, there is a need to develop further laboratory support for potency testing of vaccines. The laboratories equipped for poliovirus isolation studies will be used as reference centers for testing of vaccine potency, as similar techniques and materials are needed.

2.5 Information Dissemination

2.5.1 Publications

At the Regional level, the PAHO EPI Newsletter will contain a section on poliomyelitis in all issues. This section will include information on the current epidemiology of polio in the Region; the number of cases reported in the interval since the previous issue, by week of reporting and by country; individual case studies of outbreaks and investigations; issues related to the eradication effort; and topics of interest in polio research. Information on polio activities in the Region will be disseminated monthly. It is expected that newsletter circulation will increase so that all health facilities in the Region will receive copies. Information should also be disseminated through other PAHO publications.

Countries will be encouraged to include a section on poliomyelitis in their national epidemiological bulletins, with distribution to all health care workers in the network.

Periodic reviews of the literature on poliomyelitis will be distributed by PAHO throughout the Region.

2.5.2 Information exchange meetings

To maintain momentum and to facilitate communication in the Region, meetings of EPI program managers for Latin American and English speaking Caribbean countries will be held as often as necessary to discuss progress made and problems encountered. These meetings will serve as a forum for mutual assistance and information dissemination and will be attended by technical experts to aid in the resolution of problems encountered. The meetings will consist of country presentations, discussions related to issues raised during the country presentations, and presentations of updates in the field. Outputs of the meetings will include recommendations of the working groups to the countries on strategies to resolve the problems encountered. Findings and recommendations of the meetings should be published and disseminated in the Region.

2.6 Identification of Research Needs

2.6.1 Advisory group review

Recognizing that questions remain to be addressed in the field of poliomyelitis eradication, both in technical and operational areas, support for research will be provided. Research needs identified by the Technical Advisory Group (TAG) will be implemented within the first two years of the project. It is also recognized that questions will continue to arise as some problems are solved and others appear in their place. Participation in addressing research needs will be encouraged by all member nations.

The Technical Advisory Group (See section 3.2) will review ongoing activities and identify areas for research. This will include identification of funding sources for grants, review of protocols and review of research results. The mechanism to initiate research once areas have been identified will be facilitated by PAHO.

2.6.2 Possible areas for research

Some of the issues to be addressed immediately include:

- strategies and tactics to achieve optimal coverages;
- reasons for dropouts and strategies to reduce dropouts;
- optimal surveillance techniques to detect all potential cases, including vaccine-associated ones;
- criteria for certification of eradication of wild poliovirus circulation;
- simpler diagnostic methods; and
- improved inoculation procedures and equipment for injectable vaccine.

2.7 Certification Protocol

The certification of eradication of indigenous transmission of wild poliovirus for the Americas will be accomplished when the following conditions have been met: (1) Three years have elapsed without identification of any indigenous cases of poliomyelitis in the Region, in the presence of adequate surveillance; (2) Extensive case search by international investigation team does not identify any cases having onset in the three years preceding the visit; and (3) In the case of an importation, there are no secondary cases identified within one month of the date of onset of the illness in the imported case.

An international certification commission will review criteria for certification based on findings of studies conducted and the need to include other criteria to detect wild virus. Vaccination activities should continue until such time as global eradication is achieved.

2.8 Evaluation

Recognizing the critical nature of evaluation for monitoring success and detecting and resolving problems, there will be increased emphasis on the EPI evaluation component. International observers will participate in all country evaluations and reports of findings will be widely distributed.

Because of the difficulties inherent in routine information systems, coverage surveys will be performed in most countries. Included in the coverage surveys will be questions on reasons for compliance and non-compliance. Results of these surveys will be used as a basis for modifications of strategies to optimize the efficacy of interventions.

In addition to evaluations of country program operations, the laboratory network will be evaluated annually to guarantee that the high level of support needed is met. Part of the laboratory evaluation process will include a retesting of original specimens by the reference laboratories, as well as reference specimens sent by the reference laboratories to the country laboratories for testing.

3. ORGANIZATION AND ADMINISTRATION

3.1 Country Level

Each country is strongly urged to develop an overall plan for the EPI and to sign a letter of agreement with PAHO and other collaborating agencies. In the agreement, the National Work Plans should identify additional cooperation needed from PAHO and other participating agencies. All participating agencies in a given country should sign the agreement. Those countries that will require long-term technical advisors should approve their placement in the agreement and commit to a prioritization of the effort in terms of resource allocation.

In addition, technical cooperation will be provided for the drafting of country work plans. Full inventories of existing resources will be made, with identification of needs to be complemented in order to maximize inputs into the program activities. Placement of long-term technical advisors will be considered for the countries in Group I.

It is critical that seed funding be available at the time of design of the plans of action and signing of agreements.

At the time of preparation of the national work plans, participation of other international agencies will be encouraged to ensure the necessary level of donor coordination. As each donor agency has its own mandate, the presence of their representatives will ensure that the individual mandates are met and thereby avoid the all too common duplication of efforts that have occurred when there are independent project designs. The National Work Plans will identify the roles of all of the participating agencies in the country's effort.

All resources necessary to achieve the goal of eradication will be identified in the plans of action, with high priority given to the acquisition of these resources.

Countries will be requested to appoint an individual in charge of the polio eradication effort as a member of the central-level EPI unit. This person will be supervised by the national EPI program manager (or may be the same individual), and will have full responsibility for all components of the polio eradication effort, drawing upon resources made available to the EPI unit.

Within each country, all activities in the eradication effort should be under the guidance of the national EPI office to strengthen implementation of the activities and facilitate achievement of the overall EPI objectives. This office will oversee the eradication activities at all levels; ensure that coordination with laboratories is a high priority, that training needs are identified, and that courses addressing these needs are organized. This office will serve as the focal point for identification of all external cooperation and coordination of extra-sectorial assistance.

3.2 External - International Participation

To assist in guiding the activities of the eradication effort a Technical Advisory Group (TAG) will be formed, composed of experts in the field of immunizations and polio (see Annex V for terms of reference). The TAG will be composed of a core of five individuals, and will call on additional experts as needed to address special problem areas. It is important that at least one member of the TAG be a member of the EPI Global Advisory Group (GAG), in order to provide the necessary coordination with global EPI activities. The TAG Chairman or another representative of the group will participate in coordinating meetings with any other agencies or organizations involved in the same effort.

The role of the TAG will be to advise on technical components of the program. Strategies to achieve required vaccine coverages will be reviewed. The recommendations for vaccination schedules and the choice of vaccines will be reviewed on an annual basis. The TAG will assist in the identification of research needs, oversee the progress of the studies under way, and review protocols and results. The TAG will meet as often as necessary (quarterly or semi-annually or annually) to review progress and problems encountered. Recommendations of the TAG will be published and distributed throughout the Region. The PAHO EPI program office will serve as Secretariat to the TAG. The first meeting of the TAG should be held by July 1985, to review this Plan of Action before the Directing Council meeting.

To ensure the coordination of all international agency inputs, an Interagency Coordinating Committee with representation from all of the international agencies (e.g. UNICEF, Rotary, AID, IDB, World Bank, CIDA and the Bellagio Task Force) will participate in the eradication effort. This committee will meet as frequently as necessary (quarterly or semi-annually or annually) to review progress and the needs for additional assistance. The Coordinating Committee will secure interagency participation in the country planning stage to guarantee the coordination of donor inputs into the countries. The first meeting of the Coordinating Committee will be held by September 1985 to review the Regional Plan of Action and identify the types of assistance each of the agencies can provide in the effort. The PAHO EPI program office will serve as Secretariat to the Coordinating Committee.

As a further step to ensure the coordination of interagency assistance, a letter of agreement between the international agencies and PAHO should be signed after discussion of the Plan of Action. This agreement will define the

roles of each participating agency. In this manner, when additional needs are identified, the agencies appropriate to respond will have been pre-identified.

3.3 : Internal - PAHO

The Regional EPI office will coordinate all activities related to the eradication effort. All reports and requests from the field for assistance will go through the EPI office, which will in turn coordinate assistance as needed from other units within PAHO. This is critical to ensure a consistent, coordinated effort in the Regional activities.

Technical cooperation in all areas of program operations will be available through PAHO and its member countries. Assistance of expert consultants from outside the organization will be provided as needs arise and may include epidemiologists, virologists, laboratory technicians, cold chain specialists, mass media experts in health education and economists.

It is estimated that 10 or 11 epidemiologists/technical advisors will need to be placed at the country level in countries classified as Group I. These advisors will preferably be nationals and will assist the Ministries of Health (MOH) with the planning and implementation of the eradication effort activities.

The country level personnel will work closely with counterparts in the MOH for the eradication effort.

At the sub-regional level (inter-country), seven epidemiologist posts are needed (five of which are already available) to serve as technical advisors on an international basis and to provide support and supervisory assistance to the in-country personnel (Appendix II). They will assist and cooperate in assessing needs for special intervention in the countries under their jurisdiction, participating in the investigation teams' classification visits, and providing direct technical cooperation when needed.

In addition to the country and sub-regional level personnel, there is a need for additional support personnel available to the EPI program office at the Regional level. This will include support of virologists (with extensive laboratory skills) to assist in the development of the laboratory network in the region (including training, supervision, supplies and quality control). An additional epidemiologist is also needed to assist in the coordination of activities related to epidemiological surveillance, outbreak investigation, immunization strategy design, and provision of supervisory assistance to the sub-regional advisors. The anticipated increase in data collection and processing will require additional statistical support.

4. FUNDING AND FINANCIAL COMPONENTS

4.1 Levels of Funding

In order to meet the objectives by 1990, it is expected that approximately US\$110 million will be needed. Approximately two-thirds of this amount will be provided by the member nations for their individual efforts and one-third will be sought from international donor agencies. The additional costs related to certification will be of a lower magnitude, and will be calculated as program implementation gets underway. Monies will be available at the time of design of the country plans of action to permit the immediate implementation of activities. Projected external costs of components of the eradication effort are as follows:

<u>Projected Costs</u>	<u>Total US\$</u>
Personnel	\$ 7,100,000
Administration, Information, Documentation	1,100,000
Vaccine	10,773,000
Meetings	950,000
Laboratories	550,000
Training	2,000,000
National Mobilization Activities .	5,250,000
Promotional Activities	3,750,000
Cold Chain	3,000,000
Evaluations	2,000,000
Research	2,000,000
Contingency Funds	<u>6,000,000</u>
Total External Funding	\$44,473,000 -----

A more detailed cost breakdown and preliminary financial analysis are presented in Appendices III and IV.

162

When individual country plans are designed, an economist should participate in costing the program. Cost figures will be identified and will include salaries for additional personnel, transportation costs (including airfares), per diem costs, expected expenditures for investigation of identified suspected cases, vehicles, gasoline, vaccine, cold chain equipment, and laboratory development costs (including costs for reagents, transportation and shipping of specimens). All recurrent and capital expenditures should be taken into account in the program design. Budgets will also include the cost of media time and production of educational materials.

PAHO will coordinate with all participating agencies to procure the necessary funding to guarantee the achievement of this goal, and could serve as the coordinating agency for all of the financial assistance provided to the effort. Assistance from the Bellagio Task Force will be sought to help identify additional funding sources. It is expected that by the time of the Directing Council Meeting in September 1985, commitments to cover estimated needs for at least the first year of the program will already be identified.

It is important to assure that funds which are committed are allocated and available in a short time to permit rapid implementation of the targeted activities.

5.2 Recurrent Costs

To assist the Ministries of Health in improving the financing and budgetary planning of the recurrent costs associated with their immunization programs the project will work to define the recurrent costs for each component. The recurrent costs for each component will be identified in their annual work plans. It is expected that each annual work plan will improve in its definition of what are the recurrent costs and actual costs attached to each recurrent cost item. Therefore, before the end of the project, each Ministry of Health will know the yearly recurrent cost financing that must be submitted to their governments for funding.

In addition, certain recurrent cost items such as production of health educational materials and their promotion can be financed by the community. This has been shown in Colombia during their national vaccination days in 1984 and 1985 where the community provided the means for promoting the national vaccination days. In this respect, community organizations such as Rotary Clubs can have an important role to play in mobilizing the necessary community resources to support some of the recurrent costs associated with immunization programs and health education activities.

One of the outcomes of this project will be to quantify the impact of financing the recurrent costs associated with national immunization programs. This will serve to provide the political leverage necessary for Ministries of Health to better argue with their governments the importance of obtaining the necessary recurrent financing. Moreover, the cost savings attributed to disease reduction will have been shown which should also convince political and financial decision makers of the cost-benefit of financing recurrent immunization costs.

It may be, however, that certain countries at the end of the project may not be in a position to cover all recurrent immunization costs. This will be evident in their annual work plans where the cost associated with recurring activities will not be covered by the said Ministries. In these cases, donors will be asked to cover a portion of the national recurrent costs until such time that these governments are in a position to finance them.

TIMETABLE (TENTATIVE)

ACTIVITY	1985						1986						
	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
1. Identification of Technical Advisory Group	-----												
2. EPI Newsletter section on poliomyelitis	==	==	==	==	==	==	==	==	==	==	==	==	==
3. Country Classification Assessments			-----	-----	-----	-----	-----	-----	-----	-----			
4. Evaluation of Laboratories in Region	-----	-----	-----	-----	-----	-----	-----						
5. Identification of polio investigation teams		-----	-----	-----	-----	-----	-----						
6. Identification and placement of PAHO/EPI Regional Office personnel		-----	-----	-----	-----	-----	-----						
7. Identification and placement of PAHO/EPI Sub-regional advisors		-----	-----	-----	-----	-----	-----						
8. Development of country surveillance systems		-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----
9. TAG meetings		==			==				==				==
10. TAG review of plan of action		==							==				==
11. Interagency Coordinating Committee meetings		==		==					==				==
12. Training of country level investigation teams			==		==		==			==			==
13. Coverage surveys	-----												
14. Letter of Agreement PAHO/International Agencies				==									
15. Identification of Funding sources	-----			-----									
16. Distribution of Spanish translation of Polio Symposium				==									
17. Distribution of PAHO manual for poliomyelitis eradication				==									
18. Design of standardized case investigation form		-----											
19. Approval of Resolution by Directing Council				==									
20. Identification and placement of PAHO/EPI country personnel					-----	-----	-----	-----	-----	-----	-----	-----	-----

15

TIMETABLE (TENTATIVE)

ACTIVITY	1985							1986					
	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
21. Meetings - EPI Managers						--		--					
22. Laboratory manual						--							
23. Identification of research needs (TAG)								--					
24. Laboratory personnel workshop									--				
25. Criteria for certification of eradication										--			

166

APPENDIX I

PRELIMINARY CLASSIFICATION OF COUNTRIES IN THE AMERICAS
ACCORDING TO POLIOMYELITIS ACTIVITY AND VACCINATION COVERAGE.

GROUP I: Polio-infected countries. Those countries reporting indigenous cases due to transmission of wild poliovirus within the previous three years.

Argentina	El Salvador*	Mexico*
Bolivia*	French Guiana	Paraguay*
Brazil*	Guatemala*	Peru*
Colombia	Haiti*	Suriname
Dominican Republic	Honduras*	Venezuela
Ecuador*	Jamaica*	

* Countries where in-country technical advisors may be placed.

GROUP II: Polio-free countries. Those countries reporting no indigenous cases due to transmission of wild poliovirus within the previous three years. This group will be subdivided into the following two categories:

Group II-A: Higher-risk countries. Those countries which have had vaccination coverages of less than 80% of children under one year of age in any of the previous three years.

Anguilla	British Virgin Is.	Nicaragua
Bahamas	Costa Rica	Panama
Barbados	Dominica	Trinidad and Tobago
Belize	Grenada	Turks and Caicos Is.
Bermuda	Guyana	Uruguay

Group II-B: Lower-risk countries. Those countries which have maintained vaccination coverages of greater than or equal to 80% of children under one year of age in each of the previous three years.

Antigua and Barbuda	Martinique	St. Martens and and St. Bartholomew
Canada	Montserrat	St. Vincent and the Grenadines
Cayman Islands	Netherlands Antilles	United States of America
Chile	Puerto Rico	U.S. Virgin Islands
Cuba	Saint Lucia	
Guadeloupe	St. Kitts-Nevis	

APPENDIX II

PROPOSED SUBREGIONALIZATION FOR POLIOMYELITIS
ERADICATION EFFORT AND LOCATION OF SUBREGIONAL ADVISORS

<u>Location of Advisor</u>	<u>Countries in Subregion</u>
Guatemala	Guatemala El Salvador Nicaragua Panama Honduras
Mexico	Mexico Belize Costa Rica
Haiti	Haiti Dominican Republic
Colombia	Colombia Venezuela Ecuador
Peru	Peru Bolivia
Brazil	Brazil Argentina Uruguay Chile Paraguay
Trinidad and Tobago (CAREC)	English-speaking Caribbean and Suriname

TERMS OF REFERENCE OF PAHO EPI TECHNICAL ADVISORY GROUP (TAG)

1. According to the Plan of Action for the eradication of indigenous transmission of wild poliovirus from the Americas by 1990, a Technical Advisory Group (TAG) should be formed to help the PAHO Secretariat with its implementation.
2. To accomplish the above, an outstanding group of consultants will be appointed by the Director, to advise PAHO on the acceleration of the Expanded Program on Immunization in the Americas and on the efforts to eradicate the indigenous transmission of wild poliovirus from the Region by 1990.

The Technical Advisory Group will be composed of five individuals and will be assisted by additional consultants and/or study panels for any specific purposes they may require.
3. The Technical Advisory Group will:
 - a) Advise the PAHO Secretariat with respect to program priorities over the next five years;
 - b) Advise and guide the PAHO Secretariat concerning the optimal strategies and tactics to reach the overall goals of the EPI and the eradication of indigenous transmission of wild poliovirus from the Americas by 1990;
 - c) Monitor the implementation of the Regional Plan of Action to accomplish the above-stated goals;
 - d) Promote understanding and support for the program goals among technical institutions and bilateral, multilateral and private agencies, as well as political leaders; and
 - e) Participate in missions at country level for program reviews and meetings
4. Members of the Technical Advisory Group will be appointed by the Director for a period of one year, with extensions to be arranged at his discretion.
5. At least one member of the TAG should also be a member of the EPI Global Advisory Group (GAG). At least one member of the TAG should also participate in meetings with other agencies and organizations to assure proper coordination and exchange of information.
6. TAG meetings will be convened as required, usually twice a year, and a report on each meeting will be prepared and circulated as appropriate.

RESOLUTION XXII

EXPANDED PROGRAM ON IMMUNIZATION IN THE AMERICAS

THE XXXI MEETING OF THE DIRECTING COUNCIL,

Having considered the Director's report on the Expanded Program on Immunization in the Americas (EPI) and the report of the 95th Meeting of the Executive Committee;

Noting the overall improvement made at national level in the implementation of this program and the impact already achieved in reducing morbidity by poliomyelitis;

Believing that an attempt to eradicate poliomyelitis presents a challenge and a stimulus to the world to mobilize the resources to achieve the objective, and that the support required is available nationally and internationally; and

Recognizing that the realization of this objective will enhance the overall success of the EPI,

RESOLVES:

1. To congratulate the Director on the report presented.
2. To reassure its full commitment to reach the overall goals of the EPI by 1990.
3. To accept the Proposal for Action for the eradication of indigenous transmission of wild poliovirus from the Americas by 1990 and declare the goals established in the Proposal for Action as one of the major objectives of the Organization.
4. To urge Member Governments:
 - a) To take the necessary steps to accelerate their EPI programs to assure the achievement of the overall objectives of the EPI and of the eradication of indigenous transmission of wild poliovirus from the Americas by 1990;
 - b) To make the needed commitment and allocate the necessary resources for program implementation;
 - c) To promote support towards these goals within those technical and financial multilateral agencies of which they are also members.

that: 5. To draw the attention of the Member Governments to the necessity

- a) immunization programs not be implemented at the expense of efforts to develop the infrastructure of health services and their overall promotion, prevention and care activities;
- b) The strategy of campaigns and the tactic of national vaccination days be viewed as ad hoc measures, to be gradually replaced by regular immunization services performed routinely by health services.

6. To request the Director:

- a) To seek the additional political and material support needed for the realization of these goals from multilateral, bilateral and nongovernmental agencies;
- b) To initiate immediate action as outlined in the Proposal for Action to assure the necessary technical and financial support for the eradication of indigenous transmission of wild poliovirus from the Americas by 1990;
- c) To submit a progress report to the 97th Meeting of the Executive Committee and the XXII Pan American Sanitary Conference in 1986.

(Approved at the eleventh plenary session,
27 September 1985)

FORMAT FOR TIMETABLE FOR NATIONAL WORK PLANS

Country _____

Filled Out By: _____ Page _____

1. Targets:
 1.1 Coverage
 1.2 Disease Reduction

Problem	Quantifiable Objective	Activities	Quarters				Financing		Responsibility/ Coordination/ Support
			1	2	3	4	National Commitment	Donor Commitment	

198

NARRATIVE SUMMARY

OBJECTIVELY VERIFIABLE INDICATORS

MEANS OF VERIFICATION

IMPORTANT ASSUMPTIONS

Goal

To improve the health and productivity of the population of the Americas through the prevention of immunizable diseases.

- a. Measurable reductions in morbidity and mortality from immunizable diseases, especially poliomyelitis.
- b. Reduction in productivity losses due to polioyelitis-caused disabilities.
- c. Reduction in rehabilitation costs for poliomyelitis victims.

Reports from Ministry of Health's EPI Office, PAHO and other international health organizations.
Reports from other affected Ministries. Morbidity surveys—lameness surveys.

The improvement in health and productivity will not be offset by other factors such as declining economic conditions, social unrest, etc.

Purposes

To strengthen and accelerate the Expanded Program on Immunization in the Region, and its objective of improved child survival, including the interruption of indigenous transmission of wild poliovirus in the American Region by the year 1990.

- Coverage of 80% or more in all countries by 1990.
- a) The last case of indigenously transmitted wild poliovirus will occur by the end of 1990.
 - b) During 1990 three countries, at most, will be reporting residual indigenous transmission of wild poliovirus; more than half of the reported cases in 1990 will be vaccine-associated.
 - c) By 1994, at least 3 years will have elapsed without identification of indigenous cases of wild poliovirus, in the presence of adequate surveillance.
 - d) In the event of an importation, there will be no secondary cases identified within one month of the date of onset of the illness in the imported case.

Coverage Surveys Reports from Ministry of Health's EPI Office, PAHO and other international health organizations. Morbidity surveys laboratory analysis of specimens of all suspected cases. Between 1990 and 1994 extensive case search by an international investigation team will not identify any cases in the three years preceding the visit.

Current health infrastructure will be strengthened and maintained. Continuing priority given to immunizations and polio eradication by governments in the Region. Adequate

NARRATIVE SUMMARY

OBJECTIVELY VERIFIABLE INDICATORS

MEANS OF VERIFICATION

IMPORTANT ASSUMPTIONS

Project Outputs (cont.)

- | | | | |
|--|--|---|--|
| <p>6) All countries have access to laboratory facilities for identification of poliovirus type.</p> | <p>a) Laboratories available and capable of virus isolation and identification, and vaccine quality control.
 b) At least 6 laboratories identified and certified as reference laboratories in the Region for this purpose.
 c) All procedures.
 d) For Collection transport, specimens and diagnosis of dose according to PAHO approved manual.</p> | <p>In addition to the above, a team of virologists will review and certify laboratory and serological capabilities in the Region and that all suspected cases are being laboratory diagnosed.</p> | <p>a) Timely procurement and delivery of equipment and supplies.
 b) Continuing commitment by reference laboratories to serve other countries.</p> |
| <p>7) Improved strategies and alternatives for immunization services and polio control activities tested in pilot areas.</p> | <p>a) The Technical Advisory Group assists in identification of priority areas for operational research.
 b) At least two projects per year underway on operational _____ aimed at increasing coverage, lowering costs and improving the effectiveness of the immunization programs.</p> | <p>TAG reports and PAHO regional and country annual reports.</p> | <p>a) Continued governmental commitment.
 b) Availability of technical expertise to design, implement and analyze studies.</p> |

Project Input

Governments of Countries
in the Region

- | | | | |
|---|--|--|---|
| <p>1) Adequate funds for EPI operations, including the and funds available. purchase of vaccines not provided by external agencies, with plans for continuing support after 1990.</p> | <p>a) Total of approximately \$75 million (equivalent) obtained from government and other in-country sources. Specific dollar values per country to be estimated during development of National Plans of Action.</p> | <p>a) Annual Ministry of Health budgets
 b) Staffing patterns.
 c) Site visits.
 d) Annual Work Plans.</p> | <p>Adequate official and executive support for the EPI and polio eradication program.</p> |
|---|--|--|---|

194

Project Outputs (cont.)

	<ul style="list-style-type: none"> f) In the event of an outbreak, all countries in the Region notified immediately by telex from PAHO/ Washington and traveller's advisories issued. g) Case identification and reporting includes weekly calls to all acute care hospitals (public and private, general and specialized) and rehabilitation centers. Once suspected cases are identified, thorough community investigations for additional cases are conducted. h) Control measures will provide TOPV to all persons at risk in a wide geographic area; in Group I countries this will cover all children under 5 years of age. i) Specimens collected for isolation studies on all probable cases and genetic characterization of all polio-virus isolates performed to confirm poliomyelitis. 		
<p>4) Strengthened National Immunization programs and improved polio control activities.</p>	<ul style="list-style-type: none"> a) National immunization days held at least twice a year in Group I (polio-infected) countries during the project. b) Coverage rates of at least 80% of the target population maintained in Group II (polio-free) countries. c) Effective cold chains established and maintained in all countries of the Region. d) At least one intensive health education 	<p>Same as above.</p>	<ul style="list-style-type: none"> 1) Uninterrupted supply of vaccines and cold chain supplies. 2) Community participation in immunization days and compliance with 3 dosage schedule of polio vaccination. 3) Locally available social marketing expertise. 4) Adequate maintenance and fuel for vehicles.

NARRATIVE SUMMARY**OBJECTIVELY VERIFIABLE INDICATORS****MEANS OF VERIFICATION****IMPORTANT ASSUMPTIONS****Project Inputs (cont.)**

- | | |
|--|---|
| <ul style="list-style-type: none">2) Adequate personnel staffing of Ministry of Health's EPI and laboratories.3) Adequate facilities for the EPI and polio eradication activities such as offices, training facilities, warehouses, cold storage and laboratories.4) Vehicles, fuel and maintenance for use in the EPI program.5) Training, educational materials and mass media for the EPI and polio eradication program. | <ul style="list-style-type: none">b) Ministry of Finance's signed agreement with estimated counterpart funding requirements in National Plans of Action.c) Bilateral USAID project agreements and other donor agreements to cover in-country costs not included in the PAHO grant. |
|--|---|

NARRATIVE SUMMARY

OBJECTIVELY VERIFIABLE INDICATORS

MEANS OF VERIFICATION

IMPORTANT ASSUMPTIONS

Project Input (cont.)

\$ in '000

Inter-American Development Bank

1) Personnel	1)		1) Consultations occur as scheduled.	Approval of PAHO grant proposal.
--Long-term advisors in 11 countries.		-1,650		
--205 person monthsd of short-term consultants.		-1,750		
2) Training	2)	<u>2,100</u>	2) Long-term advisors in place.	
Subtotal		5,500		
3) Overhead		<u>1,100</u>	3) Trained polio eradication workers.	
TOTAL		16,600	4) PAHO and country reports.	
			5) Evaluation reports.	

UNICEF

1) Promotion	1)	750	1) PAHO and country reports.	Same as above.
2) Supervision and surveillance	2)	1,750	2) Evaluation reports.	
3) Cold Chain	3)	<u>2,000</u>		
Subtotal		4,500		
4) Contingency		<u>500</u>		
TOTAL		\$5,000		

Rotary International

1) Vaccine	1)	\$10,700	Same as above.	Same as above.
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BREAKDOWN OF PERSONNEL POST COSTS

1. Assumptions:

- Staff member is married and he/she has two dependent children.
- Post has class for 1986 class 8
Post has class for 1987 class 9
Post has class for 1988 class 10
Post has class for 1989 class 11
Post has class for 1990 class 12
- To be recruited from outside the U.S.A.

2. Cost Breakdown:

	<u>1986</u>	<u>1987</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>
- Base salary (salary scale)	39,300	40,100	40,900	41,700	42,800
- Post adjustment (class schedule)	16,400	19,000	22,100	25,300	28,900
- Dependents allowance	1,400	1,400	1,400	1,400	1,400
<u>Total entitlements</u>	<u>57,100</u>	<u>60,500</u>	<u>64,400</u>	<u>68,400</u>	<u>73,100</u>
- Pension fund (14.5% of pensionable scale)	10,200	10,500	10,800	11,100	11,400
- Health insurance (2 dependents or more: 3.9%)	2,200	2,300	2,450	2,600	2,800
- Acc. insurance (.67% of total entitlements)	400	400	450	450	500
- Terminal payments (6% of base salary)	2,350	2,400	2,450	2,500	2,550
<u>Sub-total Organization Cost</u>	<u>15,150</u>	<u>15,600</u>	<u>16,150</u>	<u>16,650</u>	<u>17,250</u>
- Education grant	3,000	3,400	3,800	4,200	4,600
- Recruitment or reassignment	3,000				
- Installation allowance	7,500				
- Home leave		6,000		6,500	
- Personal effects	10,000				
<u>TOTAL ORGANIZATION COST</u>	<u>95,750</u>	<u>85,500</u>	<u>84,350</u>	<u>95,750</u>	<u>94,950</u>

UNITED STATES GOVERNMENT

Memorandum

TO : LAC/DK/HAN

DATE: 11/2/89

FROM : LAC/DR/RR, Linda Seville
Room 2252 NS

*Buy In. Please
make the necessary
action.*

SUBJECT: Clearance of Mission-Issued PIO/Ts

1. Attached is a copy of the PIO/T described below:

Country: Dominican Republic

PIO/T No.: 517-0242-3-70045 (Buy-In)

Project/Activity No. & Title: LAC Accelerated
Immunization Project

2. You are requested to clear the PIO/T or take any other action, if necessary, in accordance with ARA/LA Instruction No. 107 dated December 29, 1972.
3. Please indicate your clearance by signing below and returning this memo to LAC/DR/RR by COB, ASAP
4. Please keep attached PIO/T for your files.

John J. Thomas
(Name)

11-2-89
(Date)

NOTE: CM would like to know who the responsible officer in AID/W will be. Please indicate below.

JACK THOMAS

1987
PIO/T

Attachment: a/s



5010-110

179