RURAL HEALTH PROJECTS IN BRAZIL

Consultants' Report

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The present report on Rural Health Projects in Minas Gerais and Pernambuco, Brazil is based on work conducted by consultants Dr. Eugene Boostrom and Alfred Davidson in Rio de Janeiro, Belo Horizonte, Montes Claros, Recife and Caruaru during two weeks from 13 June to 26 June, 1976. The current study and status report is one of several provided under loan 512-6-089. The authority and terms of reference for the present study are contained in Brasilia cable 3338, dated April 19, 1976, which was subsequently used as the basis for the terms of reference furnished to the consultants as guideline for their mission.

The terms of reference were stated as follows in a letter from APHA to each of the consultants 4/30/76:

"To review progress of the AID Health Delivery Systems loan, and specifically to:

1) review the Minas Gerais 1976 financial plan as well as the evaluation model
2) review the revised Pernambuco financial plan and final evaluation model and
3) review the PAPPE comparative evaluation and updated 1976 financial plan."
Findings and Conclusions

General Conclusion:

The project is well conceived and viable. At the time of the visit (June 1976), development of needed infrastructure through training and the establishment of health posts and of coordinating mechanisms is proceeding without undue complications. Technical assistance and international training, as well as administrative procedures and arrangements, have been delayed for a variety of reasons and this will retard accomplishment of the scheduled coverage for 1976 and 1977 which was projected in the implementation plan of 1975. Evaluation plans must be revised and are scheduled for completion in September, 1976. (See APPENDIX I and APPENDIX II)

Specific Conclusion:

A. The conditions of the loan will not be fully met by the end of 1977 in the following respects:

1. PAHO will not have contracted the number of advisors agreed to with the GOB (See APPENDIX III)

2. Coverage of 70 percent will not be attained in the two geographical regions. Minas Gerais is still in the planning stage, with less than 200 trained auxiliary workers. Pernambuco has met midwife training goals, but is delayed in organization, supervision, training and coverage resulting therefrom. Both projects need at least one more year beyond December 1977 to complete training of personnel for coverage under terms of the agreement.
3. PAPPE has not prepared the 1976 financial plan or the plan of comparative evaluation. International Training and International Fellowship requirements will not be met in 1976.

**Conclusion:** The project will probably be one year short of completion at termination of the loan in the programmed areas, but in both Minas Gerais and Pernambuco indications are that the program will be continued (with fewer resources and slower expansion of coverage) with State and national funds.

4. Central Planning (PAPPE) has provided technical assistance to the projects and exercises advisory and monitoring functions. They do not appear to have financial data from the States which would be needed for exercising a coordinating function, although the problem is somewhat alleviated by frequent site visits of PAPPE staff. PAPPE has been unable to proceed with international training, for various reasons, but has provided excellent technical assistance in planning to the two projects.

B. Montes Claros (Pirapora)

There is significant evidence of careful preliminary planning through surveys of the Municipios prepared by the State and Montes Claros management group. A regional survey has been made of the health services and other data available in the area, and a plan has been drawn up that will require certain conditions before implementation. In April a coordination meeting achieved agreement in principal from all agencies to coordinate under the Montes Claros project. Subsequent
meetings have been held, but details have not been worked out. Further agreement on details will be required before full implementation can be achieved.

The administrative coordinating group in Montes Claros is enthusiastic and able, but even when full coordination is agreed upon by all agencies in the area, the administrative machinery has not been put together to assure effective implementation. It appears that an effective delegation of necessary implementation authority should be given to the Director of the Montes Claros project by the coordinating council's member agencies and that he in turn should have a full time professional administrator to assist him and the council in the management aspects of the program (personnel, logistics, finance, etc.).

A most encouraging aspect of the program is the agreement with the local university to utilize both medical students and faculty to provide supervised physician services.

The plan for coverage of the Pirapora program area, if implemented according to its own planned schedule, would lead to 70 percent geographic coverage (accessibility) by December 1977, but there is no likelihood that the entire region will have 70 percent coverage by December 19, 1977. The present conclusion of the consultants is that implementation has been slow in development in the above respects and that adequate logistical and support systems
are unlikely to be sufficiently developed by December 1977, even in the Pirapora area.

C. Pernambuco (Caruarú)

The team of consultants found that rate of development of the program in this region has accelerated greatly since the AID/W team visit of March 1976. The Pernambuco project at that time was criticized as being too preoccupied with coordination of the various groups and levels contributing to the project, to the exclusion of extending "coverage". While the problem of coordination remains serious and will continue for some time, other major activities of the project, particularly training of midwives, asistentes and short term professional training, have accelerated remarkably. The consultants are of the opinion that target coverage in the Caruarú area will be reached within terms of the loan at least with respect to trained midwives and numbers of posts projected for 1976 and very likely for 1977.

The coordination and supervision of the various levels of health care, and particularly of informal health care in the rural areas, remains a problem. While the State health infrastructure is fairly well organized, supervision of rural health workers outside the formal structure is just beginning. Training for supervision and technical assistance in community participation are major requirements for the project; this will take some time and will probably extend beyond the present life of the loan project.
In one other major respect the Pernambuco project requires assistance. The traditional State administration is not geared to manage a coordinated health program at different levels with varied programs. Technical assistance in establishing proper coordination and supervisory management is necessary. The informal method of meetings, personal relationship and goodwill does not fully substitute for more formal methods of coordination such as formal agreements, instructions, operational manuals and the establishment of written procedures.

D. Some Other General Conclusions

1. Both financial and program baseline data for even such recent years as 1974 and 1975 are lacking. This makes cost comparison and progress comparison before and after the project difficult.

2. Interest in the project appears widespread in other States of Brazil (States of Rio, Minas Gerais and Paraíba) and indeed in the whole country. It is important that data and information (financial and program) be collected and reported consistently.

3. Financial Plans:

Montes Claros - The financial plan of Montes Claros reflects the 1975 implementation plan and therefore is unrealistic in terms of present conditions of the project. Modifications will have to be made to reflect the unfilled requirement for international training and technical assistance, as well as delays in establishment of posts. These delays will have to
be considered in the revised plan. Also at the time of the review all contributing agencies had not made their allocations.

Pernambuco Project - As in Montes Claros, some modification is necessary in international training and technical assistance, although domestic training goals appear within reach.

No Financial Plan for PAPPE was available at the time of the consultants' visit. The Plan when prepared will be comparatively uncomplicated, including primarily staff salaries, technical monitoring and coordination.

E. Course of Action by PAPPE Between June and September, 1976

"PAPPE representatives (including regional coordinators and the evaluation expert) will visit Minas Gerais and Pernambuco in order to reach agreement by all parties on modifications of the 1975 implementation plans. This should be accomplished by late September of 1976. The revised implementation plans will indicate how much time is expected to be required in order for each State project to achieve the objectives of the loan agreement.

The plans should include descriptions and requirement schedules for resources (personnel, commodities, etc.) needed for their accomplishment. They should also provide estimates of interim attainments of objectives (probably for periods ending December, 1976, June, 1977 and December 1977). Implementation plans should be coordinated with evaluation plans which will permit interim evaluations
(including an evaluation in December, 1977 indicating achievements at the end of the loan-financed period of the project) which will facilitate comparisons of progress made in various aspects of the two projects, and possibly also among various areas within each project. Cost reporting systems should be installed which will produce data required for cost comparisons, and project records should make it possible to establish the cost and resource composition of activities particularly of those which might be considered for inclusion in other State rural health services systems. This will establish a cost system which can be used as a basis for comparison when replicated elsewhere in Brazil."
Recommendations

1. Project objectives for loan funded activities should be immediately agreed upon by all parties at all levels, taking into consideration the shortened time frame, the administrative problems in PAPPE and PAHO and uneven progress to date in implementation. The completion date for all activities specified under the loan should be determined, including those that will require time beyond December, 1977.

2. The 1975 implementation plans should be revised to provide for attainment of 70 percent coverage of the entire populations for which the project as first designed was intended to provide services, extending the plans as far forward in time as is expected to be necessary for the achievement of such coverage. Intermediate objectives, including 70 percent coverage of the population of a more limited geographic area, should be specified for December 1977, and implementation plans should provide for the measurement of the attainment of intermediate objectives at that time.

3. Objectives should emphasize project's strengths and original main intentions, i.e., population coverage with basic services.

4. Project evaluation under loan should focus on initial implementation areas (Pirapora and Caruarú), rather than on total regions initially expected to be covered.
5. Evaluation should focus on coverage (defined in terms of geographical accessibility, population contacted, population receiving one or more of a specified set of services, or some combination of such measures; geographical accessibility would be easiest to attain and to measure) and use the same measures of coverage in both states, using data from the last six months of 1977 (by which time the project should be well implemented in the initial areas).

6. Evaluation should be based on data which will continue to be gathered, analyzed and used routinely by health care system workers, to make future comparisons feasible and easy. Disruption of health care and information systems and distraction of health workers by special studies and evaluation activities should be discouraged.

7. Quality of services, if evaluated, should be evaluated in terms of compliance with pre-established norms agreed upon by trainers, supervisors, and possibly trainees.

8. Competence of trainees to correctly perform tasks/functions which their work will require should be measured during or after training.

9. Long term technical assistance required from PAHO is urgently needed ASAP in the following areas (See APPENDIX III):
   a. Paramedical auxiliary training and supervision (for all basic levels of system).
   b. Community development (integrated, with emphasis on health).
c. Administrative system upgrading/organizational development at local, regional and State levels.

d. Development of support and logistic/supply systems for/of rural health services systems.

10. Evaluation of administration and of organizational development aspects of each State project should consist of a formal administrative case study, written by an administrative expert with appropriate experience who is not otherwise involved in the project, based on observations during the last six months of 1977.

11. A system of periodic financial reporting should be established. The system should include either monthly or quarterly expenditure data based on major program activities (e.g., training, construction, technical assistance) and classified by source of funds.

12. Continuing monitoring of the loan should be carried out by USAID/Brazil and should include site visits (including Rio) at least quarterly. AID/W should provide assistance to the mission for technical and administrative monitoring quarterly.

13. Unit costs of activities and sub-activities should be determined (e.g., costs of training a midwife, home visits by auxiliaries) for purposes of project cost evaluation and comparison. It is recommended that cost analysts be added to the PAPPE staff to establish a unit cost
system and carry out current studies of comparative costs.

14. PAPPE should set up a system of information exchange and the exchange of personnel between the Minas Gerais project and the Pernambuco project.
Activities List

1976
12 June  Boostrom arrive Rio

13 June  AM  Davidson arrive Rio
         PM  Review documents
         Eve  Meet with J. Davison and M. Van Doren for
               briefing and scheduling

14 June  AM & PM  Meetings at PAPPE to discuss contributing
           agencies roles and project status
         Eve  Fly to Belo Horizonte

15 June  AM  Meeting with Secretary of Health of Minas Gerais
         Meeting with Minas Gerais Project Coordinator
         PM  Drive to Montes Claros

16 June  AM  Meeting with Regional project personnel located
         in Montes Claros
         PM  Meeting with medical school's project coordinator
              and project staff

17 June  AM  Drive to Pirapora and meet with staff on site
         PM  Visit Pirapora (IESP) hospital and health center

18 June  All day - Drive to Belo Horizonte
19 June AM Fly to Recife
PM & Eve Meet with Drs. Audifax and Pinedo

20 June AM & Eve Review documents

21 June AM Drive to Granata health center to inspect facility, observe midwife training and interview trainers and midwives
PM Drive to Caruaru
Meet with regional staff of project at regional headquarters

22 June AM Attend opening of two health centers with Secretary of Health for Pernambuco
PM Attend graduation of three classes of students (midwives, nursing auxiliaries and assistants) with Secretary of Health

23 June AM Fly to Recife
PM Outline report and draft conclusions and recommendations

24 June AM Meet with PAPPE Superintendent and staff, PAHO
PM coordinator, and USAID representative and USAID project manager and controller to review and discuss consultants' findings and recommendations

25 June AM Work on revision of draft conclusions and recommendations
PAPPE/AID WRAP-UP MEETINGS
JUNE 24 AND 25, 1976

AGENDA

June 24
9.00-12.00

A. Overview/impression general project activities (Davidson)

1. Montes Claros/Pirapora test model
   a. in-country TA and training activities
   b. PAHO TA component
   c. auxiliary unit construction plans

2. Caruaru
   a. progress made in mid-wife identification
   b. effect of training activities to date
   c. other project activities

3. Progress made toward integrating health services in each state
   a. Soares/Jose Carlos presentation on identification of financial resources inputs

4. Evaluation of State to PAPPE technical and financial reporting
   a. progress reports - sufficient to meet PAPPE monitoring requirements?
   b. financial plans - comments on substance and value as a planning document

13.00-16.00

B. Evaluation and information (Boostrom)

1. Overview of each states evaluation models
   a. progress made in meeting evaluation requirements
   b. applicability of designed information system in meeting continuing evaluation needs

2. Value of each state model for central level replication process

3. Other topics
16.00-17.00

C. PAPPE central level evaluation (Dr. Hamilton)

1. Presentation of work done to date
2. When will PAPPE evaluation model be presented to AID for approval?
3. Other Observations

June 25
9.00-10.00

D. PAHO (Dr. Arestivo)

1. PAHO progress regarding staffing of TA.
2. Training activities
   a. central level
   b. States
   c. revised chronogram for training (1976, 1977, 1978)

10.00-12.00

E. General comments/observations by PAPPE (Dr. Penido)

13.00-15.00

F. AID representatives meet separately on Davidson/Bostrom continued monitoring of loan

15.00-17.00

G. Discussion of future project monitoring

1. PAPPE inputs
2. PAHO inputs
3. AID inputs
BRAZIL - EVALUATION COMMENTS

Central Level - PAPPE

PAPPE has not yet completed the required plans for centrally coordinated comparative evaluations of the two state projects. PAPPE has prepared, however, a document entitled Basis for the Development of an Evaluation Model which outlines evaluation objectives and general methodologies in each of the following areas:

1. Implementation progress in coverage, productivity, effectiveness and infrastructure development.
2. Behavior and decisions of agencies as they effect project implementation and health services regionalization.
3. Health Delivery System Model and its effects in areas with different degrees of model implementation.
4. Job competence and productivity of health personnel in relation to several combinations of selection and training factors.
5. Community participation in project implementation at the local level.
6. Management aspects of the project and of the health system development under it, including analyses of planning and programming techniques, information gathering and use, and decision making.
7. Changes in selected morbidity and mortality indicators in the project areas.
8. Overall assessment of feasibility and desirability of developing similar health systems in other areas of Brazil, with suggestions as to modifications which might improve results elsewhere, based on all of the evaluation work listed above.

In discussions of the Basis document and of the states' evaluation plans, the consultants and USAID representatives stressed the need to assure that evaluation plans would indicate what information and analyses would show, by December of 1977, what percent of each the target populations had been provided with health service coverage, using the same definitions and indicators of "coverage" in both states. Emphasis was also given to the need to describe and analyze program content, administration and costs in ways which would be maximally useful for those entrusted with decisions regarding expansion, modification and replication elsewhere of the health services developed under the project. The need to show the resource compositions and multiplier effects of various project activities was specifically discussed in relation to estimating probable costs of developing and operating similar health services systems or using components of the projects' systems in other areas or other countries. Measurement of changes in community health status was judged not to be feasible by late 1977, but PAPPE plans to gather simple baseline information, through the information systems to be incorporated in the rural services, and this information will facilitate future comparisons seeking to measure such changes.

PAPPE estimates that by late August 1976 specific plans will be ready
for the measurement of progress in and attainment of population coverage (still to be operationally defined within the context of the project).

By late September of 1976 plans should also have been developed for gathering, analyzing and interpreting information regarding the operational model and actual functioning of the health services to be developed and the processes of developing them. To the extent possible, evaluations will be based on information produced by the information systems to be built into the health services systems, in order to facilitate ongoing evaluation and future comparisons. The evaluation plans to be prepared by October will stress measurement of the attainment of project objectives (themselves being reformulated at present in view of the shortened time frame) by assessment of the status and functioning of the health services systems (internally and in relation to the communities served) in the latter half of 1977. The information systems required for this are to be designed and installed by late 1976 and adjusted as needed during early 1977, so as to be able to produce the bulk of the information necessary for evaluation studies in late 1977.

While PAPPE was technically required by the agreement to have completed the central level evaluation plan some time ago, the consultants and USAID representatives felt that it would be best to allow them to develop the plan according to the schedule discussed above. Although PAPPE, given the recent addition to their staff of a technical assistance worker who is developing the plans, could undoubtedly produce a central plan acceptable to AID much more quickly, the T.A. worker, other PAPPE staff, and the staff of the state projects prefer to develop the central and state plans simultaneously and in close coordination with one another. Given the continuing presence of adequate technical assistance, such efforts will
probably save time (as opposed to developing a central plan and then
need to modify state plans to fit it) and produce a better evaluation
by late 1977. This approach, which has been used in recent months in
both states, has already produced significant advances and improvements
in the states' evaluation plans. Plans for project cost reporting and
cost studies of the development and operation health services will need
to be coordinated with all other aspects of the project's evaluation efforts;
the project's managers seem to understand this and are revising reporting
systems accordingly. Project personnel also seemed receptive to the
consultants' suggestion that administrative care studies of the projects
could provide descriptive, explanatory and diagnostic information for their
use in both project development and project evaluation.

Minas Gerais - Montes Claros Evaluation Plans

Earlier in the project, a classical experimental vs. control
group pretest-post-test design had been suggested for the measurement of
health status changes in the Montes Claros project area. More recently,
however, a more feasible and useful evaluation program has been outlined,
as discussed in the information and evaluation section of the "coverage
extension" paper presented by the Montes Claros group at the April 1976 meetings.

The information and evaluation system proposed would use routine
service and activity records, special studies of samples of such records,
and community interview surveys to measure effectiveness, efficiency and
costs, to assess community acceptance and use of the system and to improve
decision making within the health services systems. Indicators are listed
for coverage, production of services, human resources development, community
organization and improvement of physical infrastructure. Further development
and refinement of this basic plan should lead to an acceptable state project evaluation.

Pernambuco - Caruaru Evaluation Plans

The plans for evaluation of the Pernambuco project consist thus far of an initial general description (in the last pages of a document entitled Subprograma Extensão da Cobertura - Asistencia Primaria), a more recent document on information flows, and initial and revised lists of suggested indicators for evaluation of the primary care system.

The general description explains that the projects will evaluate the communities' participation in the development and operation of the health services and community acceptance and use of services, using techniques which will involve the communities themselves in the evaluations and provide them with feedback. The program of primary care would be evaluated in terms of attainment of objectives, fulfillment of norms, community participation, and impact on health problems and on other levels of the system.

The discussion of information flows follows a fairly standard pattern and needs to be worked out in more detail in its application to the Pernambuco project. The same document contains an initial list of indicators which would be more suitable for a relatively sophisticated hospital-clinic system in an industrialized country, where rather complex data might be routinely collected and analyzed by specialized personnel who had access to similar data from other systems for purposes of comparison.

The more recent list of indicators (See APPENDIX II), given to the
consultants in Caruarú, is simpler and more useful for comparative project evaluation. The Pernambuco project team, then, is moving toward a useful and feasible evaluation plan, as is the team in Montes Claros, both with assistance and coordination from PAPPE.
BASIS FOR THE DEVELOPMENT OF AN EVALUATION MODEL

PAPPE
CARUARU and
MONTES CLAROS PROJECTS

MAY 1976
PURPOSES:

Development of an evaluation model that will permit:

1. A follow-up of the project development,
2. The appraisal of different types of health delivery systems,
3. Testing of operational models and management procedures,
4. Measuring the impact of the program on the improvement of health levels,
5. The appraisal of different ways and degrees of community participation,
6. Determining the feasibility of the extension of the experiment to other areas of the country.
1. FOLLOW-UP OF THE PROGRAMS

Objective:
Measure the degree of progress in the implementation of the objectives of the programs in relation to:
- Coverage
- Productivity
- Effectiveness
- Development of the infrastructure

Methodology:
Routine information from the programs: indicators, procedures and periodicity similar to those established by the project management.

2. REGIONALIZATION/PARTICIPATING AGENCIES

Objective:
- Study the behaviour of the Participating Agencies in the projects.
- Analyze the impact of the institutional behaviour on the accomplishment of the proposed objectives.

Methodology:
Design with Participating Agencies of a joint research model, oriented towards:
- Construction of an ideal model of behaviour for each institution.
- Follow-up of the decisions that are generated in relation to the projects.
- Analysis of the positive, negative or null effects produced by the Participating Agencies' decisions in the operations of the projects.
3. HEALTH DELIVERY SYSTEM MODEL

Objectives:

Analyze the different degrees of development of the delivery systems, in relation to:
- Coverage
- Productivity
- Effectiveness
- Costs

Study the effects obtained by the increase of the population coverage with primary health care activities as compared to other levels of health care.

Analyze the vertical and horizontal relations of the different levels of care.

Methodology:

Observation of areas with different degrees of development of health delivery systems. The information to be analyzed would be obtained from the routine project reports (records and supervision reports).

4. TRAINING MODEL

Objectives:

Analyze the terminal behaviour and productivity of health personnel in relation to type of recruitment, curriculum contents and adopted educational techniques.

Methodology:

A special design is required for the analysis of areas where different types of health personnel are acting: health auxiliaries, rural teachers, informal system personnel, etc. Information on the characteristics of recruited personnel, curriculum contents and adopted educational techniques should be available in the routine reports.
5. COMMUNITY PARTICIPATION MODEL

Objectives:

Study the different ways of community participation and their effects on:
- Collective health actions (Diffusion, cooperation)
- Program management (identification of problems, definition of priorities, decisions, use of other local resources)
- Coverage of specific activities
- Contents of training activities, behaviour and effectiveness of health personnel

Methodology:

Observation of communities that have completed the initial stages of organization and are in the actual participation stage. In the selection of areas for analysis certain variables should be taken into account such as size of the community, degree of isolation, social organization, etc.

6. MANAGERIAL ASPECTS

Objectives:

Analyze the dynamics of the programming process in relation to the adopted method, the degree of knowledge and participation of health agents and the adjustments introduced during the operational stage.

Study alternate techniques and procedures for the collection, elaboration and analysis of the information.

Test the efficiency of the methods and administrative procedures adopted by the project management.

Methodology:

Interviews with different types of personnel at all levels of the delivery system.

Analysis of the original propositions (norms, procedures) and changes introduced during the operational stage of the project.
6. MANAGERIAL ASPECTS (Cont'd)
   Methodology (Cont'd)
   Analysis of administrative methods, follow-up of decisions and analysis of results at operational levels.

   Evaluation of programming techniques, data collection and analysis of the information obtained.

7. HEALTH LEVELS
   Objectives:
   Analyze the effect produced by the program actions on the mortality and morbidity levels.

   Methodology:
   Combination of recording and sampling techniques. The indicators to be selected will be of specific morbidity and mortality (age, cause). Global social-economic indicators shall be used as control.

8. DEGREE OF EFFECTIVENESS OF THE PROJECTS
   Objective:
   Obtain an over-all evaluation of the program by integrating all aspects previously considered with the purpose of obtaining conclusions on the convenience and feasibility of extending the experience to other areas of the country and of the utilization of more adequate methods and managerial procedures in the operation of similar projects.
Basis of the Evaluation Model

1. Follow-up of the Programs

2. Regionalization/Participating Agencies
3. Health Delivery System Model
4. Training Model
5. Community Participation Model

6. Managerial Aspects
   Programming
   Communications
   Delivery Systems
   Information Systems
   Cost Analysis

7. Health Levels

8. Degree of Effectiveness of the Projects
## APPENDIX III

### PROJECT BRAZIL-5160

**STATUS OF PAHO TECHNICAL ASSISTANCE**

#### A. LONG TERM

<table>
<thead>
<tr>
<th>Position Number</th>
<th>Title of Position</th>
<th>Official Station</th>
<th>Grade</th>
<th>Candidates</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>4672</td>
<td>Coordinator</td>
<td>Rio de Janeiro</td>
<td>P. 5</td>
<td>Dr. J. Arestivo</td>
<td>At Post</td>
</tr>
<tr>
<td>4675</td>
<td>Planning Officer</td>
<td>Rio de Janeiro</td>
<td>P. 5</td>
<td>Efrain Lazo</td>
<td>Awaiting approval of PAHO Director</td>
</tr>
<tr>
<td>4673</td>
<td>Medical Officer</td>
<td>Caruarú-Fernambuco</td>
<td>P. 4</td>
<td>A. J. Espínoza de Toledo</td>
<td>Left June 1976</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Awaiting new candidate</td>
</tr>
<tr>
<td>4674</td>
<td>Medical Officer</td>
<td>Montes Claros-Minas Gerais</td>
<td>P. 5</td>
<td>H. Farjagodoy</td>
<td>Being considered</td>
</tr>
<tr>
<td>4679</td>
<td>Specialist in organization and community participation</td>
<td>Montes Claros-Minas Gerais</td>
<td>P. 3</td>
<td>Jorge Carbajal, Berta L. Muñoz</td>
<td>Being evaluated by PAHO</td>
</tr>
<tr>
<td>4676</td>
<td>Public Health Nurse</td>
<td>Caruarú</td>
<td>P. 3</td>
<td>Lola Ortiz</td>
<td>Accepted by GOB; due date by September 1976</td>
</tr>
<tr>
<td>Not given</td>
<td>Evaluation Expert</td>
<td></td>
<td>P. ?</td>
<td>Have names of qualified</td>
<td>No candidate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>individuals</td>
<td></td>
</tr>
</tbody>
</table>

Information received July 28, 1976, from PAHO

Note: Earlier candidates were either not acceptable to GOB or not available for the job.
### Project Brazil - 5160

**Status of PAHO Technical Assistance**

#### B. Short Term

<table>
<thead>
<tr>
<th>Field of Activity</th>
<th>Station</th>
<th>Duration</th>
<th>Candidates</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Epidemiology</strong></td>
<td>Rio de Janeiro</td>
<td>4 months</td>
<td>Moncayo</td>
<td>Accepted by GOB; ready to send</td>
</tr>
<tr>
<td></td>
<td>Recife</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Community Development</strong></td>
<td>Rio de Janeiro</td>
<td>3 months</td>
<td>Dr. Hector G. Manzanedo (Recife project)</td>
<td>Possible replacement (Luis Medina) identified</td>
</tr>
<tr>
<td></td>
<td>Recife</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Montes Claros</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Information and Evaluation System</strong></td>
<td>Rio de Janeiro</td>
<td>4 months</td>
<td>No candidate</td>
<td>No candidate</td>
</tr>
<tr>
<td></td>
<td>Montes Claros</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maternal and Child Health</strong></td>
<td>Rio de Janeiro</td>
<td>6 months</td>
<td>No candidate</td>
<td>No candidate</td>
</tr>
<tr>
<td></td>
<td>Recife</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Administrative Methods and Procedures</strong></td>
<td>Rio de Janeiro</td>
<td>6 months</td>
<td>Dr. Luis A. Arcilla Montoya</td>
<td>PAHO is processing him for departure</td>
</tr>
<tr>
<td></td>
<td>Recife</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Community Development</strong></td>
<td>Rio de Janeiro</td>
<td>6 months</td>
<td>Sr. Guillermo A. Medina</td>
<td>At Post</td>
</tr>
<tr>
<td></td>
<td>Caruarú</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Montes Claros</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Systems Analysis</strong></td>
<td>Rio de Janeiro</td>
<td>6 months</td>
<td>(Names of possible persons: Valerin, Moreno, and Rios)</td>
<td>No candidate</td>
</tr>
<tr>
<td></td>
<td>Montes Claros</td>
<td></td>
<td></td>
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<tr>
<td><strong>Nursing</strong></td>
<td>Recife</td>
<td>6 months</td>
<td>Paniagua</td>
<td>To leave August 10</td>
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<tr>
<td></td>
<td>Montes Claros</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Social Security Medical Analysis</strong></td>
<td>Rio de Janeiro</td>
<td>6 months</td>
<td>No candidate</td>
<td>Seeking candidate</td>
</tr>
<tr>
<td><strong>Instruction in Health Integration</strong></td>
<td>Recife</td>
<td>6 months</td>
<td>4 persons being contacted</td>
<td>None chosen</td>
</tr>
<tr>
<td></td>
<td>Montes Claros</td>
<td></td>
<td></td>
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</tbody>
</table>

Information supplied by PAHO July 28, 1976

Note: Earlier candidates were either not acceptable to GOB or not available for the job.