LAC/RSD REGIONAL HEALTH PROGRAM ASSESSMENT 2004–2009

APRIL 2010
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LAC/RSD REGIONAL HEALTH PROGRAM ASSESSMENT 2004–2009

DISCLAIMER
The authors’ views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.
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<th>Description</th>
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<tbody>
<tr>
<td>A&amp;ME</td>
<td>Bureau for Asia and the Middle East or Asia and the Middle East Region, USAID</td>
</tr>
<tr>
<td>AA</td>
<td>Assistant administrator (USAID)</td>
</tr>
<tr>
<td>AAD</td>
<td>Activity Approval Document</td>
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<tr>
<td>ACT</td>
<td>Artemisinin-based combination therapy</td>
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<tr>
<td>ADS</td>
<td>Activities Data Sheet or Automated Directives System</td>
</tr>
<tr>
<td>AFR</td>
<td>Bureau for Africa or African Region, USAID</td>
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<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
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<tr>
<td>AIP</td>
<td>Avian-Influenza Program</td>
</tr>
<tr>
<td>ALAPE</td>
<td>Latin American Pediatrics Association (Asociacion Latinoamericana de Pediatria)</td>
</tr>
<tr>
<td>AME</td>
<td>Bureau for Asian Middle East Region, USAID</td>
</tr>
<tr>
<td>AMI</td>
<td>Amazon Malaria Initiative</td>
</tr>
<tr>
<td>AMR</td>
<td>Antimicrobial resistance</td>
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<tr>
<td>AMS</td>
<td>Administrative Management Staff (LAC Bureau)</td>
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<tr>
<td>AMTSL</td>
<td>Active management of the third stage of labor</td>
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<tr>
<td>API</td>
<td>Avian pandemic influenza</td>
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<tr>
<td>BCC</td>
<td>Behavior change communication</td>
</tr>
<tr>
<td>CA</td>
<td>Cooperating agency or cooperative agreement</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<tr>
<td>CHT</td>
<td>Country health teams</td>
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<td>CLAP</td>
<td>Latin American Center for Perinatology and Human Development</td>
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<tr>
<td>CONCASIDA</td>
<td>Central American STD/HIV/AIDS Congress (Congreso Centroamericano de ITS/VIH/SIDA)</td>
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<tr>
<td>CPR</td>
<td>Contraceptive prevalence rate</td>
</tr>
<tr>
<td>CS</td>
<td>Contraceptive security</td>
</tr>
<tr>
<td>CSH</td>
<td>Child survival and health</td>
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<tr>
<td>DALYS</td>
<td>Disability-adjusted life years</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>DLI</td>
<td>Development Leadership Initiative</td>
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<tr>
<td>DOD</td>
<td>U.S. Department of Defense</td>
</tr>
<tr>
<td>DOS</td>
<td>U.S. Department of State</td>
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<tr>
<td>DOTS</td>
<td>Directly-observed treatment, short course</td>
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<tr>
<td>EGAT</td>
<td>Economic Growth and Trade Bureau, USAID</td>
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<tr>
<td>EPHFs</td>
<td>Essential public health functions</td>
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<td>EQA</td>
<td>External quality assurance</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith-based organization</td>
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<tr>
<td>FCI</td>
<td>Family Care International</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>FEPPEP</td>
<td>Pan American Federation of Nursing Professionals (Federacion Panamericana de Profesionales de Enfermeria)</td>
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<tr>
<td>FLASOG</td>
<td>Latin America Federation of Obstetrics-Gynecological Societies (Federacion Latinoamericana de Sociedades de Obstetricia y Ginecologia)</td>
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<tr>
<td>FO</td>
<td>Front office</td>
</tr>
<tr>
<td>FOIA</td>
<td>Freedom of Information Act</td>
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<td>FP</td>
<td>Family planning</td>
</tr>
<tr>
<td>FS</td>
<td>Field support</td>
</tr>
<tr>
<td>FSI</td>
<td>Food Security Initiative</td>
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<tr>
<td>FSN</td>
<td>Foreign service national</td>
</tr>
<tr>
<td>FSO</td>
<td>Foreign service officer</td>
</tr>
<tr>
<td>FSO BS 50</td>
<td>Foreign Service Officer Backstop 50</td>
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<tr>
<td>FY</td>
<td>Fiscal year</td>
</tr>
<tr>
<td>GH Tech</td>
<td>Global Health Technical Assistance Project</td>
</tr>
<tr>
<td>GHB</td>
<td>Bureau for Global Health, USAID</td>
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<td>GHCS</td>
<td>Global Health and Child Survival Account</td>
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<td>GHI</td>
<td>Global Health Initiative</td>
</tr>
<tr>
<td>HAF</td>
<td>Health Action Framework</td>
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<td>HHS</td>
<td>U.S. Department of Health and Human Services</td>
</tr>
<tr>
<td>HIDN</td>
<td>USAID Office of Health, Infectious Diseases and Nutrition</td>
</tr>
<tr>
<td>HIS</td>
<td>Health information systems</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>HMIS</td>
<td>Health management information systems</td>
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<tr>
<td>HMI</td>
<td>Health Metrics Network</td>
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<tr>
<td>HQ</td>
<td>Headquarters</td>
</tr>
<tr>
<td>HRH</td>
<td>Human resources for health</td>
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<td>HSS</td>
<td>Health systems strengthening</td>
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<td>IAA</td>
<td>Interagency agreement</td>
</tr>
<tr>
<td>IADB</td>
<td>Inter-American Development Bank</td>
</tr>
<tr>
<td>ICM</td>
<td>International Confederation of Midwives</td>
</tr>
<tr>
<td>ID</td>
<td>Infectious diseases, or USAID Infectious Diseases Division</td>
</tr>
<tr>
<td>IDHN</td>
<td>Integrated delivery health networks</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated management of childhood illnesses</td>
</tr>
<tr>
<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
</tr>
<tr>
<td>IR</td>
<td>Intermediate result</td>
</tr>
<tr>
<td>IRTF</td>
<td>Interagency Regional Task Force</td>
</tr>
<tr>
<td>JSI</td>
<td>John Snow International</td>
</tr>
<tr>
<td>LAC</td>
<td>USAID Bureau for Latin America and the Caribbean or Latin America and Caribbean Region</td>
</tr>
<tr>
<td>LAC/RSD/PHN</td>
<td>Population, Health and Nutrition Team. Office of Regional Sustainable Development, LAC</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>--------------</td>
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</tr>
<tr>
<td>LWA</td>
<td>Leader with Associate</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
</tr>
<tr>
<td>MARPS</td>
<td>Most-at-risk populations</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and child health</td>
</tr>
<tr>
<td>MCHIP</td>
<td>Maternal and child health integrated program</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>MDR TB</td>
<td>Multidrug-resistant tuberculosis</td>
</tr>
<tr>
<td>MEASURE</td>
<td>MEASURE Evaluation Project</td>
</tr>
<tr>
<td>MH</td>
<td>Maternal health</td>
</tr>
<tr>
<td>MIS</td>
<td>Management information system</td>
</tr>
<tr>
<td>MMB</td>
<td>Maternal mortality baseline</td>
</tr>
<tr>
<td>MMSS</td>
<td>Maternal Mortality Surveillance System</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal, neonatal, and child health</td>
</tr>
<tr>
<td>MNH</td>
<td>Maternal and neonatal health</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>MTCT</td>
<td>Mother-to-child transmission (of HIV/AIDS)</td>
</tr>
<tr>
<td>NCD</td>
<td>Noncommunicable diseases</td>
</tr>
<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
</tr>
<tr>
<td>NHA</td>
<td>National Health Authority</td>
</tr>
<tr>
<td>NIPPSS</td>
<td>National Influenza Pandemic Preparedness Plans</td>
</tr>
<tr>
<td>NTD</td>
<td>Neglected tropical disease</td>
</tr>
<tr>
<td>OAS</td>
<td>Organization of American States</td>
</tr>
<tr>
<td>OGAC</td>
<td>U.S. Office of the Global AIDS Coordinator</td>
</tr>
<tr>
<td>OHA</td>
<td>USAID Office of HIV/AIDS</td>
</tr>
<tr>
<td>PAHO</td>
<td>Pan American Health Organization</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary health care</td>
</tr>
<tr>
<td>PHN</td>
<td>Population, health, and nutrition</td>
</tr>
<tr>
<td>PMP</td>
<td>Performance management plan</td>
</tr>
<tr>
<td>PMS</td>
<td>Central American Health Project (Proyecto Mesoamericano de Salud)</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission (of HIV/AIDS)</td>
</tr>
<tr>
<td>POPPHI</td>
<td>Prevention of Postpartum Hemorrhage Initiative</td>
</tr>
<tr>
<td>PPC</td>
<td>Policy and program coordination</td>
</tr>
<tr>
<td>PPM</td>
<td>Public-private mix</td>
</tr>
<tr>
<td>PPR</td>
<td>Performance plan and report</td>
</tr>
<tr>
<td>PRH</td>
<td>USAID Population and Reproductive Health Office</td>
</tr>
<tr>
<td>QAP</td>
<td>Quality Assurance Project</td>
</tr>
<tr>
<td>RAMOS</td>
<td>Reproductive Age Mortality Survey</td>
</tr>
<tr>
<td>RCS</td>
<td>Global Health Bureau Office of Regional Country Support</td>
</tr>
<tr>
<td>RFP</td>
<td>Request for Proposals</td>
</tr>
</tbody>
</table>
RH  Reproductive health
RHIS  Routine health information system
RHP  Regional health Program
RHS  Reproductive health survey
ROP  Regional operating plan
RPM+  Rational Pharmaceutical Management Plus
RSD  USAID Office of Regional Sustainable Development
SAIDI  South America Infectious Diseases Initiative
SAR  South America Regional Program
SO  Strategic objective
SOP  Standard operating procedure
SOTA  USAID state of the art course
SOW  Scope of Work
Stop TB  Stop Tuberculosis Partnership
TA  Technical assistance
TB  Tuberculosis
TDY  Temporary duty
TFR  Total fertility rate
U.S.  United States
UN  United Nations
UNAIDS  Joint United Nations Program on HIV/AIDS
UNDP  United Nations Development Program
UNFPA  United Nations Population Fund
UNICEF  United Nations Children’s Fund
URC-QAP  University Research Corporation-Quality Assurance Project
USAID  United States Agency for International Development
USAID/W  USAID/Washington
USG  United States government
USP  United States Pharmacopeia
VCT  Volunteer counseling and testing
WB  World Bank
WHO  World Health Organization
WLM  Women Leaders Meeting
XDR TB  Extreme drug-resistant tuberculosis
EXECUTIVE SUMMARY

This is primarily a qualitative assessment of the regional Population, Health, and Nutrition Program that is based in the Office for Regional Sustainable Development (RSD) within the Bureau for Latin America and the Caribbean (LAC) of the United States Agency for International Development (USAID) in Washington, DC. Commissioned by the Population, Health and Nutrition Team (LAC/RSD/PHN), its major purposes were to review the work done by LAC/RSD/PHN over the last five years (2004–09) and to examine the range of its functions and current environment. The assessment is intended to inform the drafting of a new strategy for 2010–15.

PHN gave the assessment team three tasks: a retrospective assessment of the 2004–09 strategy; a prospective analysis of strategic and programmatic directions and options for the 2010–15 strategy; and active engagement with the PHN team in conducting the previous two tasks. An outside and fresh perspective would give PHN the benefit of a different, more objective perspective of its past and future functions within the agency and LAC, and with its external partners. The assessment team interviewed LAC Mission Health Office staff, USAID/Washington colleagues, and partners; extensive document review provided background information.

The PHN health team is one of five sector teams within the LAC/RSD. The team is currently comprised of six technical advisors and specialists who provide strategic leadership, technical assistance, and related support to 13 countries with bilateral health programs and three subregional programs. The team also manages six regional activities that are buy-ins to large Global Health Bureau (GHB) projects and two consecutive Pan American Health Organization (PAHO) grants funded through the Global Health and Child Survival Account. Through much of the 2004–09 period, the PHN team had only four technical staff, and clerical support for the entire RSD office was minimal.

Within the current USAID organizational structure, regional bureau health teams have several functions. Discussions with the PHN team made it clear that they tried to adhere to these functions over the period assessed. The regional teams work in concert with the GHB; each region has a slightly different focus and number of staff, depending on regional needs. PHN staff are knowledgeable about and provide technical leadership to the LAC region, which while not a USAID priority area, still suffers from serious health challenges and inequities.

While the primary articulation of the PHN strategy and activities for 2004–09 rested in the original Activity Approval Document, due to evolving circumstances within the Department of State, the strategy needed to be updated several times when PHN planned new awards. Interviews with a variety of individuals and organizations suggest that PHN’s strategy, portfolio management, and monitoring have suffered from a variety of constraints beyond its managerial control.

The assessment team conducted a qualitative review of accomplishments under the PHN strategic objective (SO) for 2004–09 period, “Population, Health and Nutrition Priorities and Programs Developed and Advanced in LAC.” The strategic objective (SO) was bolstered by three intermediate results (IRs) and six technical areas. The three IRs are (1) Improved Health Program Planning, Performance and Accountability; (2) Improved Targeting and Evidence-based Decision Making; and (3) Greater Resources Leveraged and Coordination Improved. The six technical areas are (1) Strengthen Health Systems; (2) Reduce Transmission and Impact of HIV/AIDS; (3) Prevent and Control Infectious Diseases of Major Importance; (4) Improve Child Survival, Health, and Nutrition; (5) Improve Maternal Health and Nutrition; and (6) Support Family Planning. For each of the six technical areas and the two PAHO grants, the team assessed PHN’s
leadership and support role, implementing partners, background, primary activities, accomplishments, and future challenges. This report also describes cross-cutting themes of equity, quality assurance, integration of health programs, synergies of the health sector with other sectors, alliance building, and South-to-South collaborative activities and accomplishments.

In 2004–09, PHN’s portfolio focused on health priorities in the LAC region; PHN staff acted as pathfinders and leaders in the health arena, disseminating knowledge of best practices and lessons learned. For example, every two years, with LAC funding support, PAHO publishes updated guidelines on treatment of infectious diseases prepared by regional experts; and the LAC Newborn Alliance is an effective vehicle for disseminating evidence-based neonatal approaches throughout the region. PHN intended both to help Missions build country-specific capacity and to build broader regional capacity so as to bolster health as an essential component of social and economic development and equity.

PHN technical intervention areas emphasized maternal, neonatal, and child health; family planning and reproductive health; control and prevention of infectious diseases, especially HIV/AIDS and tuberculosis, and slowing development of resistance to antibiotic drugs.

This assessment report closes with a number of conclusions that review LAC’s functions and the future of regional activities and funding to help guide PHN and LAC/RSD in developing a follow-on strategy for 2010–15:

**BUREAU FUNCTIONS**

1. There is an imbalance in the staff mix in the PHN team. There are four technical specialists but only two of the staff, the team leader and one advisor, are broad-based generalists who can respond to a wide range of bureaucratic demands in USAID/W and PHN programmatic requests from Missions. Missions are in need of support for increasingly complex interagency requirements while at the same time supporting and training new staff. PHN should reinforce its staff with broader programmatic, managerial, and budgetary skills.

2. Historically there have been three primary options for addressing the technical support needs of the regions where USAID works. Considering that the justification for regional technical support may be revisited by new agency leadership and with the USAID, State, and Department of Defense priorities and major initiatives of the Obama Administration, PHN and LAC/RSD should compare what they are currently doing with USAID prototype functions for regional bureaus and their health teams. If necessary, PHN should realign with those functions while also tailoring specific functions to its own geographical needs.

3. Whether or not USAID decides to revisit the rationale for housing health professionals in regional bureaus, LAC/RSD and PHN may wish to consider a different mix of expertise while maintaining overall staff levels and ensuring the requisite administrative and clerical staff to improve the productivity of the professional staff.

4. Overall, the PHN team functions relatively well and the programs and the activities it funds have had impact at both regional and country levels. However, PHN did not manage its portfolio as proficiently as it could have.

5. To function more fully as a team in future, PHN should:
   - Articulate a new vision statement for the follow-on strategy.
   - Design a robust strategic framework and more narrowly focused technical interventions (programs, activities, budgets).
- Strengthen the staff to include more programmatic, managerial, and financial skills.

- Clarify job responsibilities within the team and institute a system of matrix management (a project or activity manager with a backup) to assure comprehensive understanding of the portfolio, individual responsibilities, mechanisms for coordination and communication, both internal (within LAC/RSD and PHN) and external (with GHB, Missions, other geographic bureaus).

- Considerably improve the organization and management of the documentation of its programs.

6. PHN’s leadership within the LAC Bureau and its general support and technical assistance to Missions has been highly appreciated. Its support to PAHO is appreciated by PAHO headquarters in Washington but less well recognized at the country level.

7. While PHN has led successful technical initiatives and responded to frequent requests from Missions for temporary duty (TDY) technical and other assistance, it has faced enormous change and uncertainty within the agency and the LAC Bureau. Yet each team member has continued to work hard under fluid and arduous circumstances.

8. PHN has a unique role as an interlocutor between GHB-managed projects, contractors, and organizations that implement activities in the LAC Region and with national governments.

REGIONAL ACTIVITIES AND FUNDING—THE FUTURE

1. As part of the LAC Bureau’s umbrella strategy, PHN’s new strategy needs to reflect the major changes in the LAC region over the last five years, consolidate gains, promote greater equity in access to health care services, and advance the health priorities of the Obama administration under the Global Health Initiative (GHI) and other major initiatives.

2. PHN will need to continue to be flexible, opportunistic both programmatically and financially, and agile in coping with new agency management, the transition as the Foreign Assistance Act is updated, and the realities of the GHI. Staff must also continue to be responsive to the needs of the 17 different field programs that count on PHN for support, advocacy, technical advice, and updates tailored to particular LAC needs.

3. A prosperous and democratically stable LAC region remains vitally important to the United States and its foreign policy priorities. In most of the LAC region the rationale for a regional health program is clear and technical capacity to partner effectively with USAID is high. Through continuing engagement in the health sector there, the U.S. has the opportunity to make significant contributions to the region, and in doing so to build credibility and respect.

4. Currently, neither USAID nor LAC health programs align completely with the actual and emerging health priorities of many countries in the region. In great part, this is due to a lack of flexibility in the earmarking of health funds. Until USAID can better align its health interventions with Congressional mandates, the PHN team could: (a) with GHB, advocate within the Department of State and in Congress for recognition of emerging priorities to allow for other uses of allocated funding; (b) assist countries in the region in devising strategies and programs to address priority diseases with non-USAID funding; or (c) permit the agency to use account funds to build health sector capacity through health system strengthening interventions, so as to better align its health programs with the GHI principle of encouraging country ownership and investment in country-led plans.”
I. ASSESSMENT METHODOLOGY

PURPOSE

The assessment team was tasked by the USAID Bureau for Latin America (LAC) Office of Regional Development (RSD) Population, Health and Nutrition (PHN) team to carry out three tasks, two of which were specific products: (1) a retrospective assessment of the 2004–09 strategy; and (2) a prospective analysis of strategic and programmatic direction and options for the 2010–15 follow-on strategy. The third task was to actively engage the PHN team in the conduct of tasks (1) and (2). By inviting an outside and fresh perspective on these tasks, PHN would have a better understanding of its past and future functions within the USAID and LAC in terms of its roles and responsibilities; internal and external work environment; and relationships with field Missions and regional programs, projects, and platforms, as well as with other donors and international or national organizations working in the health sector (see Appendix A).

METHODOLOGY

Since the Scope of Work (SOW) did not include trips to the field, this assessment is based solely on a review of a large number of documents and extensive interviews with the PHN team, Mission PHN officers, USAID senior staff, contractors, and other stakeholders. Capturing adequately the major changes in program and budgeting systems that USAID underwent during the period and then constructing a complete picture from available resources was often challenged by the inadequacy of PHN’s program documentation and budget tracking processes for 2004–09; its central archiving and retrieval process, especially of key documents and budgets; the difficulty of tracking performance results against the Program Management Plan (PMP); and the fact that the assessment team too often had to extract even sketchy information from such sources.

In January and February 2010, the assessment team of three consultants contracted by the Global Health Technical Assistance Project (GH Tech), occasionally accompanied by PHN staff, conducted extensive interviews with USAID and headquarters (HQ)-based stakeholders, Mission PHN officers, and LAC/RSD/PHN-funded grantees and contractors. The consultants each addressed specific technical areas: David L. Piet, team leader (family planning [FP]/contraceptive security [CS], HIV/AIDS, health system strengthening [HSS], and cross-cutting themes); Mellen Duffy Tanamly (maternal/neonatal mortality; nutrition/food security; Pan American Health Organization [PAHO]); and Maria Insua (infectious diseases, neglected tropical diseases [NTDs], PAHO) (See Appendix B).

The PHN team was involved at every opportunity through individual interviews, meetings, and joint workshops. The assessment team also conducted phone interviews with 9 of 13 LAC Missions to gain insights into how LAC/RSD/PHN supported bilateral programs.

The assessment SOW, the workplan, and lists of individuals interviewed are provided in Appendices B, C, and D.

Scheduling and Assessment Workplan Development

- Data and document collection and review—gathered before and during the assessment (see Appendix E for a list of documents reviewed)
- Assessment team meeting, defining expectations and methodology
- Assessment team planning for joint workshop with LAC/RSD/PHN
- One-day workshop with the PHN team
• Planning and preparation for the assessment

• Drafting standardized questionnaires for interviews (USAID/Washington personnel; PHN officers; partner organizations; LAC/RSD/PHN staff) (see Appendix F).

• Interviews, in person or by phone, with Mission PHN officers, LAC/RSD/PHN-funded partners, and external partners. Interviews were held with USAID/W, headquarters (HQ)-based partner organization personnel, in-country contractors, and Mission PHN officers (see Appendix D).

• Analysis, stock-taking briefings, and report writing: several iterations of the draft were shared with LAC/RSD/PHN for comment.

• Report writing: Each assessment team member drafted specific sections of the assessment report, which was then reviewed by all team members. Iterations of the draft report were submitted to the LAC/RSD/PHN team for comment in preparation for joint meetings. Joint meetings were held twice to review drafts and make corrections.

• Revisions based on feedback on the content, provision of additional information, and clarification from LAC/RSD/PHN: A final report was submitted to LAC/RSD/PHN on March 31, 2010, for final review to correct facts and provide any additional input before the report was submitted to GH Tech for editing.

The team interviewed 55 individuals, Missions, and organizations identified by USAID and others as relevant to this assessment. These included LAC/RSD, LAC/RSD/PHN, regional and pillar bureau staff, Mission PHN officers in nine countries, and PAHO and contractor HQ staff.
II. LAC/RSD/PHN STRUCTURE AND MANAGEMENT

FUNCTION

There is no single operational model for USAID’s regional health programs and teams; and the four regional bureaus (LAC, Asia and the Middle East [A&ME], Europe and Eurasia [E&E], and Africa [AFR]) and their geographic coverage differ greatly. The LAC/RSD/PHN team described performing the following functions:

1. Provide support to USAID Mission health programs and teams in the LAC region.
2. Provide technical leadership on priority health issues and conditions for Latin America and the Caribbean.
3. Promote truly regional programming (what is best done at a regional level to achieve economies of scale).
4. Promote key regional health policies and international partnerships.
5. Engage in effective participation with multisectoral and cross-cutting development initiatives of the RSD office.
6. Provide mentoring and training for new USAID health staff and fellows.
7. Demonstrate U.S. government (USG) commitment to and engagement in the LAC region.

The Regional Bureau Functions Matrix in Appendix H compares these PHN team functions with prototypical regional and pillar bureau functions; key functions of bureau health teams; and regional bureau health team interaction with the Global Health Bureau (GHB) (see below). While the wording of the functions in these three categories differs somewhat and several functions do not match exactly, for the most part the LAC/RSD/PHN team does operate fairly typically, though it needs to clarify how it should interact with GHB.

The LAC/RSD/PHN team accomplishes these functions by providing both direct technical consultations and assistance and through activities the team funds and manages. The team and Mission PHN officers interviewed consider one of its most important functions to be support for Mission PHN staff and country health programs.

The assessment team was asked to reflect on whether the functions set out above continue to be appropriate and whether they need to be modified either in terms of the functions per se or their relative weight; it explored these issues in interviews with staff in other regional bureaus and Mission PHN Officers (see Appendix F for interview questions and Appendix G for responses).

The assessment meetings and interviews, especially one with staff from the A&ME and AFR bureaus, yielded a deeper understanding of current regional and pillar bureau functions and roles and responsibilities. There has been a long-standing debate within USAID about the roles of regional bureau technical teams in relation to the pillar bureaus, especially GHB. This meeting also provided insights into how regional technical offices could be structured to function in the future.

The justification for the existence of regional technical teams, and how they relate to pillar bureaus, may be revisited again under the new Agency leadership. Historically there have been three primary options for dealing with the regional/pillar bureau relationship: (1) continue to have health teams staffed with technical specialists housed in regional bureaus; (2) move these technical specialists to, thus concentrating all health staff in one unit; or (3) assign more technical
staff to field missions. A combination of these has also been suggested. In view of the possibility that the issue will be revisited, there is utility and wisdom in the LAC PHN team reviewing the functions it performs against those presented by the A&ME and AFR Bureau health teams, so that the team is better prepared to respond to the winds of change.

Prototype Regional and Pillar Functions

- Assistant Administrator (AA) [Front Office]. Because Mission directors report to regional bureau AAs, a regional bureau is the primary focus for Missions.
- Administrative Management Support (AMS) Office
- Strategic planning and policy
- Budget: regional and country budget allocations
- Technical assistance and support
- Program management

Key Functions of Regional Bureau Health Teams

- Advise the Front Office on health issues.
- Provide technical assistance (TA) and strategic support to Missions.
- Participate in Mission strategy development, budget allocation recommendations, strategy approvals, assessments, preparation of procurement mechanisms, such as requests for proposals (RFPs), and annual report reviews.
- Coordinate with other USG agencies, Congress, the National Security Council, the Office of the Global AIDS Coordinator (OGAC), the Department of Defense (DOD), and other donors.
- Support PHN activities in regional offices and non-presence countries.
- Examine regional health issues, horizon issues, and demonstration activities.
- Work with GHB staff on technical issues.

How Regional Bureaus and the GHB Work Together

- Both are members of the PHN Sector Council.
- GHB staff act as leads for LAC countries; the LAC Bureau is represented on each country team.
- Both review Mission operational plans, strategies, reports, and draft procurement mechanisms.
- Both support Mission programs through email, conference calls, and temporary duty (TDY).

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Historically, regional and pillar bureaus have operated in accordance with these prototypical functions, but both regional health teams and the geographic regions they cover differ widely and there is no “one size fits all.” Considerations of country size, number of countries in the region, whether the sociocultural composition is heterogeneous or homogeneous, level of development, health status, budget, and strategic importance to the USG all need to be considered in determining the functions and roles of a regional bureau health team.

Discussions with the regional PHN team made it clear that it tried to adhere to many of these functions during the last strategy period. However, interviews with Mission PHN officers, other USAID staff, and implementing partners suggest that LAC/RSD/PHN’s strategy and vision are opaque and its portfolio management and monitoring for results have suffered from a variety of constraints beyond its control. Constraints include the increasing domination of USAID’s development mandate by the Department of State; periodic seismic shifts in accepted wisdom about how the agency should conduct its business under the 3-‐Ds (development, diplomacy, defense); a total withdrawal of responsibility for strategic planning from field missions to the State Department and centralization of policy and program formulation, budgeting, etc.; disagreements about continuing to fund the health sector among senior LAC leadership and some Missions; periodic changes in the team leader and other staff; and LAC/RSD/PHN not fully utilizing coordination and communication systems (country teams, representation at meetings, etc.) to reinforce its function as a strong entity within the regional bureau.

ROLES AND RESPONSIBILITIES

The six-member PHN team is one of five sector teams within the LAC/RSD office (see Appendix I). Through much of the 2004–09 period, the team had only four technical staff. At no point has the team had clerical support.

The core strength of the health team resides in these six hard-working, dedicated, technically experienced, field-oriented technical advisors and specialists who have been stretched and pulled in many directions while having to do more with less. The team members include a team leader (currently a Foreign Service Officer), three senior advisors, and two technical advisors (Fellows) (Appendix J).

LAC/RSD/PHN supports Missions with a wide array of programmatic and technical assistance (TA) ranging from strategy and program design and evaluation to responding to requests for budget advocacy and information searches. It supports 13 countries with bilateral health programs and 3 subregional programs, and manages 6 regional activities that are buy-‐ins to large GBH projects and 2 PAHO grants. In USAID’s four regional bureaus, health teams differ in composition and numbers of staff, organization charts, oversight for country programs, and budgets. There is no consistency in staffing ratios or country responsibilities. Moreover, GHB staffing resources are predominantly dedicated to health programs in Africa and Asia/Middle East.

Integral to this assessment was an analysis of how the PHN Team’s workload is distributed. A standardized questionnaire developed in collaboration with LAC/RSD/PHN was used to interview each team member. Individual and collective responses are shown in Table I (see Appendices F and G). It was somewhat difficult for team members to assign proportionality of time devoted to specific work categories because by the nature of the work the categories overlap, and there is great variability from day to day. Nonetheless the responses do provide useful insights.
This exercise (1) raised individual and team awareness of time spent daily and monthly on various responsibilities; (2) will serve as a basis for both self-alignment and LAC/RSD/PHN portfolio management when compared to job description functions and priorities; (3) will inform decisions for future team assignments and portfolio management; and (4) will strengthen coordination of team activities by priority or need. Notably, every team member emphasized that the lack of administrative and clerical support staff in LAC/RSD greatly inhibits efficiency since they all spend many hours each month on clerical matters. The lack of systems and organizational support for travel-related tasks was considered especially problematic.
<table>
<thead>
<tr>
<th>TABLE 1. ESTIMATES OF TEAM MEMBER TIME SPENT PER MONTH PER FUNCTION AS A PERCENTAGE OF TOTAL TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TEAM LEADER</strong></td>
</tr>
<tr>
<td>Providing direct technical and programmatic assistance to Missions (including evaluation of mission program performance [PPR review]) and program design; assistance may be provided in person or virtually</td>
</tr>
<tr>
<td>Development of, coordination of, participation in, and/or follow-up after regional events and processes (e.g., SOTA, CONCASIDA, PAHO Directing Council, and other multicountry conferences and workshops; includes official representation of USAID)</td>
</tr>
<tr>
<td>Keeping informed and up-to-date about own technical areas and LAC regional developments</td>
</tr>
<tr>
<td>Advocacy and information-sharing for LAC health priorities (within LAC, with other USAID bureaus, interagency, donors, and other external organizations)</td>
</tr>
<tr>
<td>Internal LAC/RSD/PHN program functions: strategy and budget development, activity management, and evaluation (including current activities: PAHO grant, field support activities, and task order; planning future work)</td>
</tr>
<tr>
<td>Responding to &quot;taskers&quot; from the LAC Front Office, the Administrator's Office, Congress, etc. (include FOIA requests, FO briefings, and Family Planning Compliance investigation and documentation)</td>
</tr>
<tr>
<td>Administrative/office management functions (travel, leave, scheduling, personnel and resource planning, staff evaluations, maintenance of records and files, etc.)</td>
</tr>
<tr>
<td>Mentoring/coaching new personnel (newly assigned FSOs, new USAID/W hires, and Development Leadership Initiatives.)</td>
</tr>
<tr>
<td>Coverage for other staff who are out of the office (on TDYs, leave, etc., including &quot;acting&quot; responsibilities within RSD)</td>
</tr>
<tr>
<td>Others</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
</tr>
</tbody>
</table>

**Percentages of total time spent in the field and at meetings**

| Estimated percent of time is spent providing TA in the field (weeks per year) | 4% (2w/y) | 6% (3w/y) | 15% (8w/y) | 25% (13w/y) | 0% |
| Estimated time spent in meetings as a % of total working time* | 70% | 75% | 40% | 15% | 40% |

* LAC/RSD/PHN participates in 24 working groups.
Note: The data are based on self-perceived estimates.
The time spent in each function depends on the area of expertise and activities managed. While the team fulfills all these functions, most of its time goes to five of the 10 functions considered: direct technical assistance to Missions; internal LAC/RSD/PHN program functions; coordination, participation, and follow-up of regional activities; advocacy and information-sharing; and staying current in their technical areas.

For the most part, the proportion of time spent by each team member on each of the functions is comparable. Nevertheless, the assessment team found several variations that stand out. For example, the HIV/FP senior technical advisor spends 40% of her time providing TA to Missions but other team members spend only 10–20% of their time doing so. The HIV/FP advisor also spends 25% (13 weeks a year) of her time in the field providing TA while the HSS senior advisor spends only 6% (3 weeks in a year) of her time in the field.

### FOR THE TEAM AS A WHOLE, TIME SPENT PER FUNCTION IS ESTIMATED AS FOLLOWS:

1. Internal LAC/RSD/PHN program functions: 18%
2. Providing direct technical and programmatic assistance to Missions: 17%
3. Keeping up to date about technical areas and regional developments: 16%
4. Activities related to regional activities and processes: 13%
5. Advocacy and information-sharing: 11%
6. Administrative/office management functions: 7%
7. Coverage for other staff: 7%
8. Mentoring/coaching new personnel: 4%
9. Others: 4%
10. Responding to —takers—: 3%

Senior advisors spend 5–10% of their time keeping up to date on technical information. Nevertheless, after analyzing the amount of time the team as a whole spent on this activity, a skewed picture emerges—16% of time spent on this activity. This is partly because one scientific fellow spends 50% of her time on this function.

PHN team members spend a significant amount of time attending meetings, though the amount varies considerably: the team leader and the HHS senior advisor spend 70–75% of their time attending meetings, two other team members spend 40%, and the HIV/FP senior advisor only 15%. The team participates actively in 24 committees and working groups, some of which meet twice a week (see Appendix K).
The LAC/RSD/PHN portfolio consists of oversight and support responsibilities for programs in 13 countries: Bolivia, Brazil, Dominican Republic, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Paraguay, and Peru. Ecuador does not have a bilateral health program; Colombia has a health officer but no program. The team oversees three subregional programs: two for HIV/AIDS (one for Central America, based in Guatemala, and one for the Caribbean, based in Barbados), and a third for malaria and infectious diseases (based in Peru). The portfolio also covers six region-wide activities and a grant to the Pan American Health Organization (PAHO). The portfolio is concentrated in six technical areas and is funded through the Global Health and Child Survival (GHCS) Account with congressional earmarks for HIV/AIDS, tuberculosis (TB), malaria, maternal and child health (MCH), FP, other public health threats, and influenza.
In 2004–09, the team focused on health program priorities in the LAC region by acting as pathfinders and leaders in the health arena and disseminating knowledge of best practices and lessons learned. Examples of their efforts:

1. Every two years PAHO publishes updated guidelines on the treatment of infectious diseases prepared by regional experts with LAC funding support.

2. The LAC Newborn Alliance is an effective vehicle for disseminating evidence-based neonatal approaches.

3. A National Neonatal Plan of Action was created to provide a continuum of care for mothers and newborns from pregnancy through childbirth into childhood. This plan emphasized effective policies; interventions in health care services and in the community within a health systems approach; strengthening surveillance systems; and targeting the poor and marginalized populations.

4. A collaborative surveillance for pathogen resistance was conducted in hospitals of participant countries in the region. The results led to the 4th edition of Treatment Guidelines for Infectious Diseases, which is widely used by medical practitioners in the LAC region.

LAC/RSD/PHN intends to help build both country-specific capacity with Missions and broader regional capacity to bolster health as an essential component of social and economic development and equity.

LAC/RSD/PHN provides technical intervention in such areas as maternal, neonatal, and child health (MNCH); FP and reproductive health (RH); control and prevention of infectious diseases, including HIV/AIDS and tuberculosis (TB), and slowing development of resistance to antibiotic drugs.

The program aimed to strengthen host country health systems in such areas as training health personnel, logistics for delivery of essential drugs and contraceptives, and collecting information in order to improve data for decision-making and the quality of health care delivery. It gave special attention to decreasing mortality and severe morbidities in mothers and newborns.

LAC/RSD/PHN also promoted health sector reform (sometimes under the rubric of “good governance”) and worked to foster self-reliance and the expansion of institutional capacity within host-country organizations and institutions. It has also done much work on policy formulation and on maternal and newborn care, especially in partnership with PAHO. Specific information on its responsibilities for managing the PAHO grants and many other activities the program funded can be found in Section III.

Even recognizing that LAC/RSD/PHN operates in a complex context, it is difficult to assess with precision what actually transpired. This is due in great part to the situation described above, but also perhaps unwittingly on the PHN team’s rather incoherent documentation of its management, program implementation, and budgets and the results achieved. While the PHN team attempted to act strategically in order to maximize limited resources, its portfolio and projects seem to have been managed in a fragmented and vertical rather than strategically focused and holistic way. The team is aware of this situation and, through this assessment process, is prepared to consider concrete options to tighten its leadership and portfolio management in the future.

It is long-established USAID policy that most of the funding for health and other development sectors that the LAC Bureau receives is actually directed to USAID Missions. Of total health funding to LAC, only about 5% is retained for the Regional Health Program ($6.5 million of total LAC funding of about $131 million in 2009).
Funding for USAID’s health programs is complicated by the complex and ever-changing structure of congressional earmarks and frequent changes in the names of the accounts through which USAID receives appropriations. In 2009, LAC/RSD/PHN received funding from the Global Health and Child Survival (GHCS) account, which combines two previous accounts, the Child Survival and Health (CSH) account and the Global HIV/AIDS Initiative (GHAI) or PEPFAR account. The latter was managed by the OGAC in the State Department. Funds from the new GHCS account are appropriated directly both to the State Department through the GHCS-State sub-account for PEPFAR HIV/AIDS activities and to USAID (GHCS-USAID) for all other global health activities.

GHCS-USAID finances LAC/RSD/PHN’s work in MCH, FP, and TB, and about one-third of its HIV work. During 2009, for unknown reasons, the RHP received combined funding from GHCS-State and GHCS-USAID for HIV/AIDS.

HSS does not have a dedicated element in the Foreign Assistance Framework but is designated as a key issue and utilizes funds from other elements within the GHCS account.

In addition to the funding that LAC/RSD/PHN receives directly for health programs, GHB designs and funds several infectious disease activities in the LAC region that are jointly managed by staff in both bureaus, such as avian-pandemic influenza (API) and neglected tropical disease (NTD) activities. In another permutation, malaria activities in the Amazon Basin receive funding from the Presidential Malaria Initiative (PMI) and are now designed and managed by USAID’s subregional health platform in USAID/Peru. The proliferation of management models reflects differences in disease epidemiology and the location within USAID of technical capacity to design and manage suitable programs.

LAC/RSD/PHN received a minimal amount of funding for other infectious diseases, which is used for anti-microbial-resistance (AMR) activities and is included in the PAHO grant agreement.

Technical activities within LAC/RSD/PHN are implemented through a grant agreement with PAHO; GHB projects that LAC/RSD/PHN buys into (often referred to as field support mechanisms); and GHB mechanisms where the procurement action is in LAC (the 4th Sector Health and Links Media agreements).

<table>
<thead>
<tr>
<th>Congressional Earmark by Program Element</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Funds Rec'd</td>
<td>% of Total</td>
<td>Funds Rec'd</td>
<td>% of Total</td>
</tr>
<tr>
<td>FP</td>
<td>1,600</td>
<td>15%</td>
<td>1,367</td>
<td>12%</td>
</tr>
<tr>
<td>HIV</td>
<td>700</td>
<td>6%</td>
<td>509</td>
<td>5%</td>
</tr>
<tr>
<td>Influenza</td>
<td>1,800</td>
<td>16%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Malaria</td>
<td>2,020</td>
<td>18%</td>
<td>5,000</td>
<td>46%</td>
</tr>
<tr>
<td>MCH</td>
<td>2,275</td>
<td>21%</td>
<td>2,475</td>
<td>23%</td>
</tr>
<tr>
<td>Other threats</td>
<td>1,000</td>
<td>9%</td>
<td>808</td>
<td>12%</td>
</tr>
<tr>
<td>TOTAL FUNDS RECEIVED.</td>
<td>10,964</td>
<td>10,980</td>
<td>11,183</td>
<td>6,496</td>
</tr>
</tbody>
</table>
An analysis of LAC/RSD/PHN’s funding mechanisms, budget, and funding levels for 2006–2009 shows:

- Even though funding for malaria activities was included in the LAC/RSD/PHN budget for 2006–08, the Amazon Malaria Initiative (AMI) and the South America Infectious Disease Initiative (SAIDI) were largely managed in the field. In 2008, their funding was formally transferred to USAID/Peru, where they are managed as subregional activities.

- For the LAC/RSD/PHN program, funding for MCH and FP activities remained fairly constant over the period considered. Funding for TB activities was cut in half, from $2.1 million in 2006 to $800,000 in 2009, while funding for HIV activities doubled, with funding coming from both the GHCS-State and GHCS-USAID subaccounts.

- The percentages data presented in Table 2 for 2009 need to be viewed with caution. They appear to show a false increment because funding for malaria activities was transferred directly to the subregional program in Peru.

- AIP activities received a total of $13 million for 2005–2009, but most of this funding was managed by the GHB Avian and Pandemic Influenza Unit and used in global mechanisms to combat pandemics. Of these funds, $4.3 million was programmed by LAC, of which $2.5 million went to PAHO and $1.8 million to the Links Media contract. In 2006, funding for LAC influenza programs was obligated based on a transfer of funding from GHB. In later years, influenza funding managed by LAC was based on an allowance from GHB, but the funds remained in the GHB not the LAC budget.

COMMUNICATIONS AND INTERAGENCY AND DONOR COORDINATION

Field Missions

LAC documents state that LAC/RSD/PHN works in close coordination with its field Missions to provide the best technical expertise available and to advance international best practices and share lessons learned. This is essentially accurate, as indicated by interviews with Mission PHN officers, who greatly appreciate the team’s understanding of and support for their health programs, especially the high-quality TA. However, many Missions had little comprehension of LAC/RSD/PHN’s strategy, workplans, or staff other than those who provided regular TDY assistance.

For many years, the GHB has utilized a unique system of country health teams (CHTs) for each geographic region. While there is variability in how each CHT operates, they all provide Washington-based points of contact for Mission PHN officers. CHTs also act as a source of advocacy, TA, and related support for Missions. All CHT leads are GHB staff, often assisted by a GHB alternate. LAC/RSD/PHN staff are full members of these teams; other members include representatives from the GHB Regional Country Support Unit, Regional Bureau Country Desks (desk officers), a country assistant, and (—virtually”) Mission PHN personnel.

In discussions with Mission PHN Officers, it was clear that some PHN officers communicate almost exclusively with their GHB lead or with other personalities they know better rather than with LAC/RSD/PHN, though others prefer to communicate directly with LAC/RSD/PHN. To change this mechanism so that the process is more transparent and collaborative, there should be a quid pro quo in the communication and coordination with the Missions, who are LAC/RSD/PHN’s primary clients. LAC/RSD/PHN should actively engage colleagues in the field in the development of its future raison d’être, organizational structure, follow-on strategy, and activities. It should continue to share with Missions key documents (operational plans and PPRs)

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2 Budget figures were available only for 2006–09, not the whole strategy period (2004–09).
and incorporate their feedback where possible. LAC/RSD/PHN should also encourage Missions to review and comment on documents posted on the LAC website.

Since the CHT structure often works very well and will continue to exist, LAC/RSD/PHN needs to work closely with GHB to reinvigorate this mechanism so it better incorporates CHT staff and works to LAC’s advantage. It is in LAC’s best interests to ensure that it is appropriately represented on behalf of the region. In short, while many Missions particularly appreciate the general support and TA they receive, LAC/RSD/PHN needs to improve its image to clarify its functions and value to the Missions it serves.

GLOBAL HEALTH INITIATIVE (GHI)

Over the last several years, interagency communication, coordination, and cooperation with other USG entities and donors have become more important, first under PEPFAR and more recently under the emerging GHI, which is pursuing a comprehensive whole-of-government approach. At the same time, particularly with other USG agencies, interagency coordination has become increasingly time-consuming with LAC/RSD/PHN staff currently serving on 24 working groups or committees (see Appendix K). Interagency processes often lead to confusion about roles and responsibilities, as well as competition for turf and funding. Coordination and cooperation are likely to get even more cumbersome and competitive under the new GHI, as has happened when other global health initiatives have been introduced.

International Organizations

During this strategy period, LAC/RSD/PHN has exclusively funded PAHO to help influence health policies in the LAC region. This close relationship is greatly appreciated by PAHO, which fully expects continued assistance under the next strategy. On a more limited basis, LAC/RSD/PHN has also worked with the World Bank, the Inter-American Development Bank (IADB), the Organization of American States (OAS), UNICEF, and other regional and international organizations and NGOs in designing and implementing assistance programs and supporting regional entities. Such collaboration helps USAID influence development policy, advise on the direction of other donors’ programs, and facilitate sustainable development. Recently, LAC/RSD/PHN has begun to coordinate a number of its programs with other donors, especially UNFPA and the International Planned Parenthood Federation (IPPF) for contraceptive security (CS) and FP graduation, as well as funding several branches of the Centers for Disease Control (CDC) for AMI and SAIDI activities.

LAC/RSD/PHN-funded activities with PAHO and other partners seem to have been effective in bringing a wide range of professional, government, and private actors into alliances that advocate for sound health programs, especially for the poor and under-served, and for the budgets and policies required to support them.

Implementing Mechanisms

Over the last five years, LAC/RSD/PHN utilized three types of implementing and procurement mechanisms: grants to PAHO; buy-ins to GHB-managed field support projects; and task orders contracted by the LAC Bureau. These latter mechanisms, which both complement and supplement the PAHO grants in a number of technical areas included Links Media, Stop AI, BASICS III, the Maternal and Child Health Integrated Program (MCHIP; previously the Prevention of Post-Partum Hemorrhage Initiative [POPPH]I), CDC, Rational Pharmaceutical Management Plus (RPM +), Management Sciences for Health, U.S. Pharmacopeia (USP) Drug Quality and Information, TASC II, and the Global Research Activity. Other projects have supported HIV/AIDS work (AIDSTAR One, Capacity and Capacity Plus) and FP (JSI/DELIVER, Policy and Health Policy Initiatives [HPI]).
These mechanisms and results are discussed in detail in Section III.C. of this report under the corresponding technical areas.

**PAHO Grants:** In brief, LAC-funded PAHO activities have aimed to institutionalize gains made in the delivery of quality health services while expanding access to the underserved groups (see Section III.C). However, two cross-cutting components within these grants have received special attention: (1) strengthening the capacity of national health authorities (NHAs) to formulate policies and implement strategies that reduce fragmentation in health by the integration of services, public health capacity building, and the creation of synergies between programs and systems; and (2) improving the quality of health services by strengthening national capacity to organize appropriate and accessible quality health care services that are evidence-based and reflect recognized standards and best practices. The first PAHO grant included one buy-in from USAID/Mexico for TB. The current grant has no Mission buy-ins.

**Results Monitoring**

During 2004–09 period, the agency emphasized the use of numerical indicators for all official reporting purposes. The indicators were primarily input or process indicators that did little to capture outcomes or results achieved. Individual operating units were expected to design their own program monitoring tools. In the absence of official strategic planning guidelines over the past few years and with the reliance on input and process indicators, and the lack in LAC/RSD/PHN of a robust and annually updated PMP, the value of monitoring and evaluation (M&E) to measure results has been severely compromised. While LAC/RSD/PHN has a number of PMP-like documents against which they track the progress of programs and activities, monitoring has been less than vigorous across the portfolio. One LAC/RSD/PHN member summed up the utility of indicators over the last several years:

(1) “The nature of the regional program does not easily lend itself to traditional health indicators, since national-level indicators do not reflect pockets of unmet need. (2) The agency has been forced to use standard numerical input, target, or process indicators (rather than outcome indicators), which in reality tell one very little about impact or results; and (3) the impact of LAC/RSD/PHN’s portfolio on the region has been significant, but more indirect.”

However, in spite of the limited utility of the agency’s own indicators, LAC/RSD/PHN has both advocated for and invested wisely in more important and programmatically useful means to produce information and data for health sector decision-making. Examples are investments in surveillance systems for infectious diseases and related issues; Demographic and Health Survey–type studies/surveys; maternal mortality surveillance systems; commodity and contraceptive security systems; and methodologies to assess and improve the public health workforce. The information generated by these surveys and monitoring systems was widely disseminated both within countries and regionally through many different channels.

In 2003, LAC/RSD/PHN led the Agency in the development of health trends analysis in the region. The original trends analysis covered nine technical areas in depth, including, for example, FP/RH, maternal health, HIV/AIDS, infectious diseases, health sector reform, and wealth quintiles. The analysis was updated in 2005, 2007, and 2009–10 and was expanded to cover non-communicable diseases. In the absence of more robust tools, these analyses have been invaluable to both the LAC Bureau and the Missions by tracking the big picture over time.
III. STRATEGY: OBJECTIVES, PRIMARY ACTIVITIES, ACCOMPLISHMENTS, AND CHALLENGES

Strategic Objective: Population, Health and Nutrition Priorities and Programs Developed and Advanced in LAC:

Intermediate Result #1: Improved Health Program Planning, Performance & Accountability

Intermediate Result #2: Improved Targeting & Evidence-based Decision Making

Intermediate Result #3: Greater Resources Leveraged & Coordination Improved

Between 2004 and 2009, the LAC Bureau’s Strategy was forced to evolve as circumstances changed in USAID. The original strategy from 2003–07 was extended for two years when it was unclear what the strategic planning process would entail in light of foreign assistance reform. Once the process was established, strategic plans were modified annually by the operational plan. Meanwhile the primary articulation of LAC/RSD/PHN’s plans and activities for longer periods became their activity approval document (AAD). This document, which was originally aligned with the strategy, was updated several times to meet pre-obligation requirements when LAC/RSD/PHN planned new awards. Due to this fluid situation and modifications in wording and intent of objectives and intermediate results over the period, the assessment team was uncertain about how to refer to specific health areas.

The AAD of February 2004 specified strategic objectives and intermediate results according to then-current USAID strategic planning guidelines. It was amended for the FY 2007–09 period, and the SO and IRs modified yet again, as were terms used to describe specific areas of health endeavor. Ultimately, and for the sake of clarity, LAC/RSD/PHN and the assessment team agreed to use the term “technical area” to describe the six areas of LAC/RSD/PHN’s work rather than use previous terminology (thematic area, program component, or element). Thus, the SO and IRs above and the six technical areas below are from the amended AAD.3

TECHNICAL AREAS

Technical Area 1: Health Systems Strengthening

Objective: Assist the LAC region to strengthen public sector health systems in the areas of health sector reform, health information systems (HIS), infectious disease and maternal mortality surveillance, and human resource capacity.4

LAC/RSD/PHN Leadership and Support: Periodic support and technical assistance in health systems strengthening (HSS) was provided to Nicaragua, Ecuador, and Honduras over the strategy period. Similar but more limited assistance was provided to Paraguay and Peru.

Implementing Partners: The MEASURE evaluation activity (a field support buy-in to a GHB project) was used to document experiences in improving HIS. An associate award to the Health Systems 20/20 project (a Leader with Associate Award under a GHB project), the 4th Sector Health Project, was used to increase resources (human and financial) for health in the region, develop alliances with the private sector, and foster South-to-South exchanges to strengthen

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3 The amended AAD included “Address Other Health Vulnerabilities” as a technical area. Since little was done in this area, it was omitted from this report.

4 The amended AAD lists health systems strengthening (“Strengthen Public Sector Executive Function”) as a component. For the sake of simplicity, it is listed here as a technical area.
human resource capacity. PAHO was also a primary partner in strengthening health systems, focused primarily on health sector governance (see Section III.C. PAHO).

**Background:** HSS is difficult to define in a standard way. Too often activities are labeled as HSS by organizations, including USAID and many of its implementing partners, that do not reflect the full complexities of true HSS. As a recent issue of *Global Health* (January 26, 2010) points out, the word “system” conjures up an image of a rational, organized, well-planned operation where cause equals effect and everyone knows beforehand what the outcome will be. Health systems defy that concept. They tend to be more like living organisms: amorphous, evolving, and reactive, comprised of many facets. They reflect a country’s history, political and social structure, and character as much as its health needs.

Despite the complexities of HSS, it is fundamental to ensuring health outcomes, and LAC/RSD/PHN should be applauded for initiating such interventions during the last strategy period.

For some time USAID, and now the GHI, has stressed the importance of HSS activities in projects and bilateral programs as a critical way to address health systems barriers that constrain the delivery of effective health interventions. However, since no funds are earmarked in the current GHCS account for HSS, global, regional, and bilateral programs rely on subaccounts to work in this area. Since the GHI includes HSS as one of its goals, it is hoped that HSS will be specifically tracked in the future so that USAID can tell a compelling story about this important work. Such a change would expand LAC/RSD/PHN’s opportunities to continue its USAID pathfinder role for HSS activities.

**Primary Activities:** HSS activities were implemented by PAHO and the MEASURE Evaluation Project, University of North Carolina at Chapel Hill, which assisted LAC countries to assess and reinforce their HIS for improved health systems performance. The 4th Sector Health Project from Abt Associates also worked to increase private resource flows into the health system. Under this technical area, LAC/RSD/PHN provided funding through direct grants to PAHO. These incorporated USAID goals and objectives into existing PAHO work areas and cofunded activities that supported the drafting of guidelines for assessment of health sector stewardship and trained leaders from eight countries in application of the guidelines. Best practices in the stewardship aspects of leadership and regulation were also developed, as was a National Health Authority Institutional Mapping tool.

The program also worked to compile information that would allow health systems to effectively strengthen their performance against essential public health functions. The assurance of public health performance capacity is a key aspect of the Ministry of Health (MOH) steering role. For the local level, two tools were adapted from private-sector uses to assist municipal governments with programming and obtaining resources to improve the health of their constituencies.

LAC/RSD/PHN has also worked on health sector reform by strengthening essential public health functions by assessing the public health workforce and improving postgraduate curricula. A web page on essential public health functions (EPHFs) was designed. Guidelines for assessing performance of stewardships for health systems were finalized and best practices were shared.

South-to-South collaboration was used as a strategy to build the capacity of national institutions by providing technical country-to-country collaboration and to facilitate elimination of perceived barriers in the recipient institutions.

Finally, based on preliminary HIS assessment and monitoring and successful experiences in Brazil and Mexico, TA was provided to Honduras, Paraguay, Peru, and the Dominican Republic to assess and document their HIS. This experience led to the development of standardized...
Assessment tools and recommendations for how countries can strengthen the use of routine health information at central and local levels for monitoring and responding to health situations.

Cross-cutting health systems activities are implemented by PAHO, which assists countries to evaluate and strengthen health sector governance and performance of public health functions based on tools, guidelines, and methodologies developed with support from LAC/RSD/PHN. A review of country experiences in improving public health functions identified a need to better understand the linkages between health sector governance and improving public health practice. PAHO also began work to integrate HSS with health service delivery. For details on PAHO activities and technical areas, see Section III.C.

**Accomplishments:** LAC/RSD/PHN has addressed problems of inadequate health systems, inefficient health delivery systems, and poor health sector stewardship by working on improving routine HIS, enhancing the steering role of health authorities and seeking new sources of funding for health programs by forging public/private partnerships.

Advances have been made in health sector stewardship—the notion that the decentralization of health systems in the LAC region requires that the role of MOHs evolve from delivering health services to regulating health systems. However, the successes or challenges of decentralization vary from country to country, and MOH capacity to adapt to this changing role remains weak in most of Latin America.

**Future Challenges:** Because each country health system evolves in a unique way, the regional program will need to consider where common approaches can be developed or are needed to influence progress in HSS. Under the GHI the importance of sustainability will increase, and the regional program should consider formulating measures of the sustainability of health programs and activities that would support sustainability. Though implemented differently in each country, regional experiences with HSS can also provide lessons learned for other regions and should be documented and disseminated.

Additional challenges of decentralizing responsibility for health personnel and budgets from central to subnational authorities, as well as the integrating activities in a number of countries, complicated HSS efforts.

Limited staffing and funding have constrained decisions on which components of HSS to appropriately fund.

**Technical Area 2: Reduce Transmission and Impact of HIV/AIDS**

**Objective:** Assist the LAC region in strengthening host country programs and services to prevent most-at-risk populations from transmitting or acquiring HIV/AIDS, and in providing effective care and treatment for persons infected with HIV.

**LAC/RSD/PHN Leadership and Support:** A wide variety of direct support and technical assistance in HIV/AIDS was provided to Missions and contractors working in the region over the strategy period. Missions supported were Bolivia, Caribbean and Central American Regional Programs, Dominican Republic, El Salvador, Guatemala, Guyana, Honduras, Jamaica, Mexico, Peru, and Paraguay. Virtual assistance was provided to all of them plus Ecuador, and Brazil. LAC/RSD/PHN also assisted in planning a number of international HIV/AIDS meetings and sponsored the recent meeting on Prevention Among Most at Risk Populations in Latin America.

**Implementing Partners:** The Capacity Project (a GHB project implemented by Intrahealth) provided TA to Global Fund recipients to strengthen and improve the functioning of their grants to support regional capacity-building and work in nonpresence countries. AIDSTAR One (a GHB project implemented by John Snow International [JSI]) helped increase knowledge of regional HIV/AIDS issues and shared best practices.
Background: While the epidemic is still a concentrated one in most of Latin America and the Caribbean, information on the epidemic and its drivers is incomplete. However, the trends analysis conducted for LAC/RSD/PHN in 2010 highlights four points5:

First, national prevalence rates and populations infected varied widely. In most of the region the epidemic is concentrated in certain most-at-risk populations (MARPS): male and female sex workers and their clients and partners; people living with HIV/AIDS; mobile populations; and specific groups, such as the Garífuna in Central America. Men who have sex with men (MSM) continue to be a prime driving force of the epidemic, with prevalence rates of 10–20% in many countries. However, data on them is often unavailable or undercounted, and governments are often reluctant to deal with this group. As a result, prevention spending does not yet reflect the fact that sex between men is a driving force of the epidemic.

Second, HIV prevalence generally seems to have been fairly stable, with some countries showing decreases (e.g., the Dominican Republic, Haiti, and Honduras), mostly due to better surveillance and some changed behaviors, and others showing increases (e.g., Belize, Suriname, Colombia, and Peru), also probably due to improved surveillance.

Third, although the proportion of women living with HIV continues to grow, they are still outnumbered by men in Latin America, but in the Caribbean women now represent almost half the HIV cases. However, it is not clear if the availability of prevention of mother-to-child transmission (PMTCT) programs means that women are tested more and therefore have their prevalence rates are better understood than the rates of men, who are much less likely to be tested.

Fourth, the number of people living with HIV continues to grow, increasing the burden on health care systems in the region.

Primary Activities: LAC funding focused on TA to build capacity; improve health systems to respond better to the epidemic, including enhancing human resource planning and implementation; improve the functioning of HIV/AIDS Global Fund grants; support improved policy making and implementation; conduct needs assessments in Jamaica and Peru and a training needs assessment with the Caribbean CHART health professional HIV/AIDS training network; ensure that best practices based on evidence-driven programs and data are used for decision-making; and decrease stigma and discrimination related to HIV. LAC also drafted a series of case studies and technical briefs highlighting successful experiences and sponsored a technical consultation on prevention with MARPS in Latin America and will use the findings from that consultation to plan future actions. A similar consultation is planned for the Caribbean.

HIV/AIDS funding was used to provide TA to two Global Fund grants; and provide policy analysis and system strengthening in response to a request from OGAC to provide assistance to troubled Global Fund awards in the region, particularly in countries that do not have USAID or CDC health programs. Funding also helped build regional alliances for health. In addition, regional funds provided TA to help six Caribbean countries prepare for eligibility to receive Global Fund funding.

The Human Resources for Health Action Framework (HAF) assisted governments and health managers in developing and implementing strategies for an effective and sustainable health workforce. In collaboration with USAID’s Office of HIV/AIDS and the PAHO, the HAF website was made available in Spanish and key tools and resources were translated. Health planners and decision makers from six Andean countries were trained to use the HAF to build and carry out

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5 HIV Trend Analysis, LAC/PHN (January 2010).
national strategies to improve human resources for health. Specific TA was provided to Peru to implement the HAF.

Given the enormous amount of work required by PEPFAR rules, LAC/RSD/PHN HIV/AIDS staff worked with GHB and Mission staff to develop country and regional operational plans, partnership frameworks and their five-year implementation plans, and participated in numerous meetings, phone calls, and TDYs to help make these functional. Staff also worked as part of the PEPFAR team reviewing the documents.

**Accomplishments:** LAC regional HIV/AIDS activities increased awareness of HIV/AIDS among health providers, policy makers, and decision-makers through improving strategic planning, workforce policy, planning and leadership, and communications and teamwork skills training aimed at strengthening the health workforce and the systems that support it to implement quality HIV/AIDS programming. LAC worked with PAHO and others to develop the HAF in the Andean region, with a focus on Peru and planned expansion to other countries.

LAC’s HIV/AIDS program also sponsored a consultation on MARPS that is leading to more targeted programming, and produced and disseminated publications on issues related to MARPs throughout Latin America. Publications aimed to improve current programs, design new ones, and advocate with policy makers for more targeted prevention, testing, and treatment programs for these populations. A website launched in late 2002 and later merged into the USAID HIV/AIDS website included information on best practices, tools, guidelines, reports, country profiles, and other materials relevant to the LAC region in selected thematic areas.

As the PEPFAR program evolved, LAC/RSD/PHN provided TA and other support to the LAC missions in two regions and three countries to develop country operational plans and partnership frameworks and their implementation plans. LAC also provided TA to the Government of Guyana and NGOs to develop the National Monitoring and Evaluation Plan for the Multi-Sectoral Response to HIV/AIDS in Guyana 2007–2011. This not only ensured a national strategic approach to M&E but also ensured that data were collected and used by decision-makers.

Because the USG provides almost one third of Global Fund funding, LAC/RSD/PHN has tried to ensure that Global Fund grants in the region are successful. It collected information from LAC Missions to identify issues and TA needs of the HIV/AIDS grants in the region and then funded TA in two countries and one regional program where Global Fund projects were failing. LAC also provided TA to six Caribbean countries to help them create the structures needed to qualify for grants.

LAC/RSD/PHN also worked in Central America by assisting four universities (in Costa Rica, El Salvador, Guatemala and Nicaragua) to improve pre-service education on comprehensive HIV/AIDS care and treatment by updates for faculty and new training materials; establishing the Belize National HIV Training Center at the University of Belize to upgrade its role in the national response to HIV and establish it as a training center for HIV counselors; and providing volunteer counseling and testing training for university students from medical, nursing, social work, and other health related disciplines at 10 Central American universities.

The assessment team found it very difficult to correlate or attribute the tangible role played by LAC/RSD/PHN staff in the primary activities and accomplishments listed in the 2004–09 documents reviewed from which the above information was gleaned. This may be due to lack of clarity in the documents, the prescriptive manner in which they have to be written, or perhaps the multiplicity of organizational players and funding mechanisms. In any case, it was difficult to understand directly what LAC/RSD/PHN staff did. In its future strategy the PHN team needs to better document its HIV/AIDS programming, results achieved, and funding.
LAC/RSD/PHN has successfully leveraged support from several missions to enable it to do more HIV/AIDS work, such as for example, joint funding with the Central American HIV/AIDS program to improve human resources for health to deliver quality, comprehensive HIV/AIDS care and treatment and the December 2009 Prevention with MARPS meeting; and co-funding with USAID/Mexico of studies on HIV/AIDS and drug use and working with faith-based organizations (FBOs) on HIV/AIDS.

**Future Challenges:**

- The latest epidemiological data suggest that the epidemic in Latin America is stable. With a regional HIV prevalence of 0.5–0.6%, epidemics in Latin America are primarily low-level and concentrated.\(^6\)

- Although it accounts for a relatively small share of the global epidemic—0.7% of people living with HIV and 0.8% of new infections in 2008—the Caribbean has been more heavily affected by HIV than any region outside sub-Saharan Africa, with the second highest adult HIV prevalence (0.9–1.1%). AIDS-related illnesses were the fourth leading cause of death among Caribbean women in 2004 and the fifth among Caribbean men.\(^7\) In many cases, young people aged 15–24 are those most infected.\(^8\)

- The variations in epidemiological patterns throughout the region require different programmatic responses within each country i.e., adult and adolescent females regionally and the Caribbean subregion are at higher risk. What is also clear is that programs have been less successful at reaching certain groups with prevention messages that lead to behavior change, especially MSM.

- LAC/RSD/PHN needs to continue to work with USG and other partners to find ways to better address key HIV/AIDS issues and coordinate roles and responsibilities related to the spread of HIV/AIDS; improving the functioning of Global Fund grants; prevention, especially among MARPS; policy improvement and implementation; training health providers; decreasing stigma and discrimination; and response capacity.

- Prevalence is high in many countries among adolescents who engage in high-risk behaviors. This population requires prevention and treatment programs tailored to their behaviors and needs.

- The apparent rise in female prevalence indicates the need to better address HIV and gender issues to support the prevalent PMTCT programs. Counseling on infant feeding should be part of PMTCT activities. WHO recommends that “Mothers known to be HIV-infected should be provided with lifelong antiretroviral therapy or antiretroviral prophylaxis interventions to reduce HIV transmission through breastfeeding.”\(^9\)

- MARPS are often neglected in favor of more politically palatable groups, such as mothers and children, since governments often do not want to deal with MARPS. How to get governments to follow the epidemic is a major issue that needs to be addressed.

- LAC’s HIV/AIDS activities are underfunded, except in a few countries that have been targeted by PEPFAR, yet in-country needs continue to increase. The challenge is how

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\(^7\) Caribbean Epidemiology Centre, 2007.

\(^8\) Ibid.

best to utilize PEPFAR funds especially when PEPFAR makes all the decisions about countries to fund and funding levels.

- With the A&ME and AFR regions getting increasing attention and funding, how can LAC continue to make the important case for prevention and addressing specific MARPs?
- How can issues of HIV-TB co-infection be addressed with appropriate programs?
- Communicating, cooperating, coordinating, and implementing LAC HIV/AIDS strategies, workplans, and activities with a multiplicity of USG entities and field Missions under PEPFAR and the Whole of Government approach, and perhaps the GHI, will be extremely time-consuming for the small PSN team and Mission staff.

Technical Area 3: Prevent and Control Infectious Diseases of Major Importance\(^{10}\)

**LAC/RSD/PHN Leadership and Support:** The LAC/RSD/PHN program has provided support for field Mission design and evaluation of their infectious disease programs, especially TB activities. The team liaises closely with GHB programs on pandemic influenza, merging pandemic threats (EPTs), and NTDs, as well as TB, malaria, antimicrobial resistance, and building capacity in surveillance systems.

**Objective:** Assist the LAC region in strengthening infectious disease surveillance networks with emphasis on quality control of laboratories and address the threat of TB by identifying cases in the community and multidrug resistant (MDR) TB. Enhance readiness to respond and mitigate the effects to other major threats, including the emergence of new infectious diseases capable of evolving into a pandemic, such as H1N1 influenza.

**LAC/RSD/PHN Leadership and Support:**

- **Tuberculosis**

**Implementing partners:** The program is implemented through two PAHO grants. Field support goes to measuring evaluation and strengthening pharmaceutical systems through the CDC IAA Agreement II, 4\(^{th}\) Sector Health, Capacity Project.

**Background:** TB is a preventable and curable disease that afflicts over 466,000 people in the region, causing 50,000 deaths every year. TB rates in Latin American and the Caribbean are 61.5 per 100,000 and in Andean area countries 55.5 per 100,000. In the last decade, a resurgence of TB has been observed in part due to TB/HIV co-infection and the resistance of TB to multidrug therapy. Due to migrant mobility in the Americas, many U.S. cities are discovering that many of their TB cases originate in the LAC region. This trend has serious implications for domestic and foreign objectives related to U.S. security.\(^{11}\)

**Primary Activities:** Regional TB activities funded by LAC focused on (a) building regional capacity through a TB Fellows Program; (b) funding critical studies to improve regional work such as on the private-public mix and TB in prisons; and (c) conducting evaluations of national TB programs, anti-microbial resistance, and TB control policies.\(^{12}\)

**Accomplishments:** Ten Fellows were trained in TB, providing South-to-South technical consultation on the directly observed treatment – short course (DOTS) treatment protocol.

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\(^{10}\) This technical area expanded to include influenza, NTDs and EPTs during the assessment period.

\(^{11}\) FY07 LAC/RSD Health Operational Plan.

\(^{12}\) USAID/LAC Regional Program Portfolio Review Health 2009.
TB laboratory networks improved the accuracy of diagnoses with quality control both internally and externally (international reference laboratory).

Nine countries were engaged in the public-private mix initiative that LAC/RSD/PHN promoted in FY 2008. This initiative sought to decrease the availability without prescription of TB drugs from private pharmacies in order to eliminate substandard drugs and prevent drug resistance. Six of the countries carried out surveys to determine patient volume, cost, and treatment standards for TB patients electing private sector care.

LAC/RSD/PHN directed efforts in the region to address TB and MDR/XDR (extremely drug-resistant) TB in prisons and coordinated financing of care through social security institutions, private NGOs, and FBOs.

Bolivia, Paraguay, and Peru conducted trainings in hospital infection control of TB, which continues to be critical throughout the region because drug-resistant TB is primarily transmitted within hospitals. The training addressed the main contributors to the problem: poor ventilation, poor sputum collection logistics, and faulty hygiene. Paraguay and Bolivia introduced the use of individual treatment kits for TB through the SAIDI initiative, an effort with demonstrated successes in improving TB drug management and utilization.

In 2007, for the first time all 35 target countries in the LAC region reported data to the WHO web data collection program on TB and TB/HIV co-infection. Data were used to ensure that TB patients were tested for HIV and HIV patients tested for TB. According to PAHO, 49% of all registered TB cases in 2007 were tested for HIV, a 17% increase over the previous year. Twenty-two of the 35 countries achieved the target of 70% TB detection through a positive smear test, five more than in the previous year.

**Future Challenges:** Raise awareness within MOHs that do not perceive TB as a significant problem. Ensure that registered TB patients are tested for HIV, which has progressed slowly in the region.

Private hospitals and NGOs need to be integrated into the TB surveillance system since most TB cases are diagnosed in private hospitals that do not have adequate or accurate quality controls. For example, only 30% of Ecuadorians utilize public hospitals where TB surveillance is done.

There is a need to promote use of clinical antimicrobial resistance guidelines in health care delivery.

The lack of English language skills of TB Fellows impeded representation of the LAC region in international forums.

- **Antimicrobial Resistance (AMR)**

**Implementing partners:** PAHO received grants in 2004–07 and 2007–09. Other implementers were Management Sciences for Health, United States Phamacopeia, the CDC, and Links Media.

**Background:** Through creation of the SAIDI Initiative (now based in the USAID South America regional hub in Peru), and through PAHO grants, LAC/RSD/PHN raised awareness of the problem of antimicrobial resistance through workshops.

**Primary Activities:** Quality control activities were designed to evaluate the accuracy of laboratories identifying antimicrobial resistance. The focus of surveillance was on laboratories within hospitals in participating countries and on identification of MDR and XDR TB.

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Accomplishments: AMR was presented as a quality of care issue and 13 microbiology laboratories from participant countries were evaluated for AMR testing. A new pattern of surveillance for MDR and XDR TB was implemented. An evaluation in hospitals of 10 participant countries to determine AMR and a study on antibiotic consumption in hospitals were conducted. Achievements of significant importance were the development of a new tool to assess hospital infection surveillance, prevention, and control and the publication of the 4th edition of Treatment Guidelines for Infectious Diseases 2009–2010. The treatment guidelines are extremely popular with students and clinicians. Standard treatment guidelines for respiratory infections were produced and approved and are ready to be published.

Other remarkable achievements made by countries during the assessment period:

- Efforts in adopting state-of-the-art infection prevention and control national guidelines progressed in Honduras, El Salvador, and Guatemala.

- A quality assurance curriculum was introduced in pre-service education programs in Paraguay, and lessons learned will be incorporated when the curriculum is moved to four more countries.

- Bolivia, Paraguay, and Peru prepared country profiles describing their AMR situation. As a result, Paraguay launched guidelines for prescribing antibiotics in veterinary medicine. In Callao, Peru, the local laboratory network improved its organization and capacity to provide information on local resistance patterns, resulting in the regional level being accredited as complying with good storage practices. Standard treatment guidelines for respiratory infections were produced and approved by participant network countries.

Future Challenges: AMR-related activities were delayed because country public health and infectious disease staff were fully occupied with H1N1 influenza issues.

A strategy for strengthening sentinel laboratories is still needed. A survey of their quality control showed that only 87.7% produced results with correct bacterial identification and 85.4% resulted in a correct interpretation of antibiotic susceptibility testing.

- **Pandemic Influenza**

Implementing Partners: PAHO AI Grant, and Links Media. Field support: STOP AI, AI Comm, DELIVER, CDC.

Background: Emergent diseases, such as influenza pandemics, pose a major global threat not only for the morbidity and mortality of the population but will also dramatically impact national economies due to disruption of social and economic activities.

Primary Activities: Pandemic influenza activities focused on increasing public awareness of the consequences of a pandemic, providing technical support for drafting pandemic country plans, and enhancing preparedness and responses in Latin American countries.

Accomplishments: LAC/RSD/PHN took the initiative to improve country preparedness to confront and mitigate the effects of an avian influenza pandemic. As a result, the region of the Americas went from having only six countries with National Influenza Pandemic Preparedness Plans (NIPPPs) in 2005 to all having such plans as of July 2007. LAC/RSD/PHN advocated for local preparedness efforts to achieve effectiveness and funded a Municipal Level Pandemic Preparedness and Response toolkit that has been tested and adapted for El Salvador, Bolivia, Nicaragua and Guatemala.

Through the PAHO grant, a three-day multisectoral simulation training was conducted in El Salvador and technical support as provided to the National Subcommittee on Risk
Communication for formation and implementation of a national communication strategy for avian and pandemic influenza. Multiple table and simulation exercises have been conducted in the region to test national pandemic preparedness plans.

The grant to PAHO also made it possible to strengthen the capacity of laboratories and sentinel site surveillance in 11 countries in the region.

Through a contract with Links Media, LAC/RSD/PHN provided material for communication campaigns to control and mitigate the H1N1 pandemic.

**Future Challenges:** Countries need to be urged to raise their current policy-level planning to more robust operational planning for pandemic influenza response and containment. Next steps will be more municipal-level simulations to form the basis for operational planning.

There is a need to expand on the surveillance platform developed for API to cover other emerging zoonotic disease threats.

While financial and technical management for the AMI and SAIDI were fully transferred to the South America Regional program (SAR) at the beginning of FY 2009, LAC/RSD/PHN continues to provide some advocacy and support for them.

**Malaria**

**Implementing Partners:** The malaria program was funded under PAHO Grant 2004–2007.

**Background:** Malaria still occurs in 21 countries of the Americas and an estimated 250 million people live in zones of high risk of transmission. More than a million cases are reported each year, disproportionately children under 5, among whom malaria is responsible for 0.4% of deaths.\(^\text{14}\)

**Primary Activities:** Since AMI and SAIDI management was transferred to SAR in 2009 and an independent evaluation was conducted in 2008, this assessment team did not explore this area in any depth.

**Accomplishments:** LAC/RSD/PHN through the AMI successfully promoted introduction of artemisinin-based combination therapy (ACT) for malaria in eight countries. LAC also funded senior technical advisors to manage malaria-related TA to improve patient adherence to treatment. Countries implemented activities that improved drug quality assurance, adherence to treatment, vector control, and supply management. Limited funds were dedicated to program design and exchange of best practices within the region.\(^\text{15}\) SAIDI achievements were focused on AMR activities and were covered in that section.

**Neglected Tropical Diseases**

The estimated burden of NTDs in LAC is 1.4–4.8 million disability-adjusted life years (DALYs), the upper limit being higher than the combined burden of HIV/AIDS, TB, and malaria. There have not been any direct monies from USAID to support control of NTDs in LAC, though it has supported control of Chagas disease for many years with bilateral investments in Bolivia.

**Accomplishments:** This program was only initiated in LAC in 2009. LAC/RSD/PHN had a one-year contract Franklin Fellow to provide support on NTDs.

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\(^\text{14}\) Pan American Health Organization, *Health in the Americas 2007*.

\(^\text{15}\) FY07 LAC/RSD Health Operational Plan.
**Future Challenges**: Under the NTD Initiative, USAID intends to reduce the prevalence of seven NTDs by 50% among 70 percent of the affected population, so as to contribute to elimination of (1) onchocerciasis (river blindness) in Latin America by 2016; (2) lymphatic filariasis globally by 2017; and (3) leprosy.\textsuperscript{17}

**Primary Activities and Background**\textsuperscript{18}: These are the areas where the NTD Initiative is expected to concentrate in the LAC region:

1. **Onchocerciasis**: 500,000 people in the region are at risk; the program will focus on 13 areas in Brazil, Colombia, Ecuador, Guatemala, Mexico, and Venezuela. Interruption of transmission in the Yanomami area (Southern Venezuela and the Brazilian Amazon) is the greatest challenge for achieving the goal of elimination by 2016.\textsuperscript{19}

2. **Lymphatic filariasis (elephantiasis)**: More than 11 million people in the region are at risk, notably 90% of Haitians.

3. **Leprosy**: 24 countries in the region reported cases in the last three years; the incidence was 42,000 new cases a year.

Chagas disease, leishmaniasis, and dengue fever are not currently targeted. Other NTDs prevalent in the LAC region that require intensified efforts are soil transmitted helminthes and schistosomiasis. Comprehensive public policies aimed at community development (water, sanitation, and hygiene) and poverty reduction (instead of the mass drug administration approach) would be required to achieve control of NTDs in LA. Their cost is significant.

**Technical Area 4: Improve Child Survival, Health and Nutrition**

**Objective**: Assist the LAC region in reducing newborn and child mortality and improving child health and nutrition.

**LAC Leadership and Support**: The LAC/RSD/PHN team have been leaders in raising awareness of threats to newborn health and more importantly in gathering regional stakeholders into an effective alliance to tackle this challenge. Team members have worked closely with PAHO and other partners to shape a plan of action that addresses many factors that can be improved for newborn health. Technical support has also been provided directly to many MOHs for drawing up national plans.

**Implementing Partners**: PAHO, BASICS III, LAC Newborn Alliance, and MCHIP. PAHO has been key in bringing together the many partners of the Newborn Alliance and obtaining political support from region MOHs for newborn action planning. The LAC Newborn Alliance combines the leadership and resources of several key organizations in the region, including the four most important professional organizations, and coordinates efforts to reduce newborn deaths. MCHIP is the new GH flagship project that will follow up on work begun by BASICS/PATH.

**Background**: Progress in reducing early and avoidable child mortality within the LAC region has largely been the result of specific primary care interventions, such as increased vaccination coverage, oral rehydration therapy, and FP. Infant and under-5 mortality rates have decreased significantly. Deaths in children under 5 fell dramatically between the early 1980s and the end of


\textsuperscript{17} Ibid.

\textsuperscript{18} Elimination of Neglected Disease and Other Poverty-related Infections. 49th Directing Council Pan American Health Organization

\textsuperscript{19} Ibid.
the 1990s, and the goal of reducing the 1990 figure by one-third was attained in 2000. However, the proportion of those deaths that occur in the neonatal period, the first month of life, now accounts for over 70% of infant mortality and nearly 40% of mortality in children under 5. Newborn death rates have not declined for 15 years.

Child survival interventions supported by USAID have been well implemented in many countries in the region. The LAC Bureau has been committed to ensuring that national vaccination programs achieve high coverage and reach the most hard to reach groups. Its PHN team has partnered with PAHO for two decades to help build national capacity for protecting children from vaccine-preventable diseases, including fostering strong surveillance systems. Early in this strategy period, attention was focused on sustaining high quality and coverage. Governments are now including funding in their national budgets and other partners, such as the Global Alliance for Vaccines and Immunization, are now involved, in assisting low-income countries to purchase needed vaccines at reduced prices through the United Nations Children’s Fund (UNICEF) Supply Division and the PAHO Revolving Fund.

Integrated management of childhood illness (IMCI) efforts were also an early focus when technical support through PAHO helped to strengthen IMCI programs and build national capacity to implement and sustain IMCI services. In 2005, a neonatal health component was added, and IMCI was implemented at the community level in coordination with other international agencies and NGOs. The LAC PHN team played a regional policy role to complement country initiatives.

Preliminary data on diseases targeted by the IMCI approach have shown decreases in mortality rates in children less than 5 years of age in all LAC countries implementing IMCI.

**Primary Activities:** The PHN team took the initiative in signaling the newborn health challenge within the region and assembled a working group to work on a strategy to tackle this complex area. (At the same time the PHN team was working to lower maternal mortality, linking the two objectives within a continuum of care. Maternal health promotion is covered in Technical Area 6.) Simple, inexpensive, high-impact interventions based on sound scientific evidence are now available to improve neonatal health even in the poorest areas. The LAC team has done an excellent job in ensuring that these interventions are known to USAID PHN staff through state-of-the-art (SOTA) courses, publications, and other means.

Regional partners drafted a strategy and plan of action for newborn health that the region’s Ministers of Health adopted the 2008 annual meeting of the PAHO Directing Council. The document is the “Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care.” The resolution calls for developing country action plans to address newborn health especially within the first 48 hours of life.

With the joint leadership of LAC and multiple partners, the working group evolved into a formal LAC Newborn Alliance to advocate for newborn health. The alliance worked with other key agencies to specify common newborn indicators and support IMCI-newborn initiatives. Special efforts were targeted to controlling newborn sepsis in several countries. Through a joint effort with BASICS III PAHO also supported development of a generic tool for rapid assessment of neonatal health services, which will be used by national programs, counterparts, and partners.

Although it is estimated that 90% of mothers in Latin America and the Caribbean breast-feed their newborns, less than one-third do so exclusively for the first six months. LAC promoted immediate and exclusive breastfeeding within neonatal health services, especially sepsis prevention, and recently started support for expansion of Kangaroo Mother Care by sponsoring study tours from regional centers of excellence to Colombia, where this approach to care for and promote bonding with premature and low-birth-weight babies was pioneered. Family Centered
Maternity, an approach to promoting breastfeeding for facility-based births developed in Argentina, is being tested in the Dominican Republic.

**Accomplishments:** The LAC Newborn Alliance harnesses the technical talents of four leading professional associations (the Latin American Association of Pediatrics [ALAPE], the Latin American Federation of Societies of Obstetrics and Gynecology [FLASOG], the International Confederation of Midwives [ICM], and the Latin-American Federation of Nursing Professionals [FEPPEN]) as well as USAID, PAHO, UNICEF, Save the Children/Saving Newborn Lives and several USAID-funded programs to continue leadership in this important public health problem. LAC and PAHO leadership and implementing partners such as BASICS and Save the Children created the alliance, which has had significant success at the policy and strategy levels. This group advocated for the adoption of better neonatal health policies throughout Latin America.

The strategy approved by the PAHO Directing Council directs all priority countries in the region to develop action plans. The LAC Newborn Alliance Plan of Action covers four interdependent strategic areas: (1) create an enabling environment for promotion of peri-neonatal health; (2) strengthen health systems to improve access to maternal, newborn, and child health services; (3) promote community-based interventions; and (4) develop and strengthen monitoring and evaluation systems. Each area can be supported by the PHN team and its partners to complement bilateral efforts.

The LAC Newborn Alliance and the technical information and tools and guidance in the Plan of Action are helpful to countries with USAID Missions and those without. With very little money, the LAC/RSD/PHN team was able to use the PAHO strategic planning process and enhance newborn care policy in the region.

Exclusive breastfeeding for the first six months of a child's life is the best and most cost-effective intervention to give newborns the nutrients they need and to improve infant and children survival rates. There has been some progress in promoting immediate and exclusive breastfeeding across the LAC region, as documented in recent DHS and RHS reports. A recent study published in *Pediatrics* documented that 16% of neonatal deaths could be saved if all infants were breastfed from day 1 and 22% if breastfeeding started within the first hour.

**Future Challenges:** Measuring changes in newborn outcomes will require solid M&E systems in hospitals and communities. The DHSs and RHSs, which are currently assisted by Macro and CDC in the LAC region, are an important means of documenting improvements in neonatal mortality. It will be crucial for this effort and other regional priorities for LAC/RSD/PHN to devise a plan with GHB to ensure that these or similar surveys (possibly shorter to lower costs) are carried out in the region in the future, especially after FP graduation. Even though there is now technical expertise within most countries to conduct these large population-based surveys, many countries will probably still need external funding to conduct this type of sophisticated national survey. The LAC/RSD/PHN team is proactively exploring ways to conduct lower cost-surveys and share cost more widely, especially with national governments. However, few donors seem interested in helping to fund these very expensive undertakings.

Undernutrition among young children in LAC is still a problem. According to a USAID publication –Malnutrition and Rising Food Prices in Latin America and the Caribbean,” in 2006 rates of stunting among children under 5 included —46% in Guatemala, 29% in El Salvador, 27% in Bolivia, 25% in Peru, 24% in Haiti and Honduras, 23% in Ecuador, 20% in Nicaragua, and 3% in Jamaica. Rates are much higher in rural areas than in urban areas.” Stunting, chronic undernutrition needs to be prevented within the first two years of life, before it causes irreversible

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major damage. Better infant and young child nutrition practices can help improve the mental and physical capacity of children so they have more productive lives.

USAID is investing additional resources in ending hunger and improving health that which can be used to improve the nutrition status of the most vulnerable populations in LAC. The PHN team is reviewing proposals for ending food insecurity to ensure that the nutrition dimension is incorporated into USAID-supported country plans. To track nutrition improvements within target groups will require continuous involvement with the LAC/RSD and EGAT Agriculture teams as new food security and agriculture programs are developed, implemented, and assessed. The leadership of LAC/RSD/PHN can be very helpful to Mission staff who may need technical guidance and extra capacity to plan and evaluate the nutritional aspects of these programs.

The optimal time to intervene to prevent irreversible damage from under-nutrition is from pregnancy through the first two years of the child’s life. It is important to ensure that pregnant women are well cared for and have adequate diets since a woman’s nutrition status affects the health of her fetus as well as her own wellbeing. Early initiation of breastfeeding has health benefits for both mother and baby. For the mother, it helps stimulate the uterus to contract, decreasing blood loss. LAC/RSD/PHN can disseminate information about successful experiences to increase immediate and exclusive breastfeeding within hospital and home births through the LAC Newborn Alliance and directly to Missions. Most Missions do not have the resources or expertise to target this intransigent problem, which will get worse as c-sections increase in the region.

The evidence suggests that the first week of life is the most vulnerable in terms of neonatal mortality risk and that the first 24 hours are determinants for the child’s future. Based on the lifecycle approach to improving newborn and young child health, newborn health activities should focus more attention on skin to skin contact with mothers immediately after birth and breastfeeding within the first hour after birth.

Breastfeeding is recognized as a key factor in newborn and infant health, especially early, exclusive breastfeeding. About 90% of mothers in LAC breastfeed their newborns, but only 35% do so exclusively for six months, and immediate breastfeeding is not widely practiced either at home or in facilities. Giving newborns prelacteal feeds (a liquid such as sugar water or an herbal tea before initiating breastfeeding) and the early introduction of other fluids and non-use of colostrum are common harmful practices in the region. There is resistance at hospitals in using the scarce time of health providers to promote exclusive breastfeeding, and routine practices do not usually include immediate skin-to-skin contact of mother and newborn. The LAC Newborn Alliance will have need clear objectives, targets, and interventions as well as follow-up and monitoring to achieve more progress in this area, but the benefits of reducing neonatal mortality justify the effort.

Iron deficiency anemia persists in the region among young children and their mothers, despite some efforts to improve iron intake through iron fortification and supplementation. This stubborn micronutrient deficiency continues to affect the productivity of children in school and women in the workforce. There is evidence that some countries have been able to reduce anemia considerably among children under 5 and women of child-bearing age by combining iron supplementation and regular treatment of parasites. Recent studies have demonstrated that iron stores and hemoglobin can be improved in neonates born to anemic mothers by delaying cord clamping at birth. LAC/RSD/PHN can assist Missions by informing them about strategies that have worked in other regions to control iron deficiency anemia and other micronutrient problems.

Technical Area 5: Improve Maternal Health and Nutrition

**Objective:** Assist the LAC region in improving maternal health and reduce maternal mortality in the LAC region.

**LAC/RSD/PHN Leadership and Support:** The LAC/RSD/PHN team has provided the region with technical leadership for maternal health by introducing and supporting adoption of improved care to reduce the leading causes of avoidable deaths and strengthening maternal mortality surveillance. The standards of care and new approaches to maternal mortality surveillance have complemented bilateral programs and reached countries where maternal mortality is high, but no bilateral MCH activities continue. In addition, technical support has been provided directly to many Missions for national health programs.

**Implementing Partners:** PAHO, POPPHI, URC-QAP, CDC in the early part of the strategy period. Most recently MCHIP, USP, and PAHO URC-QAP assisted LAC and PAHO in assembling data and preparing a "Regional Strategy for the Reduction of Maternal Mortality and Morbidity." CDC has been involved in improving maternal mortality surveillance in the region. MCHIP as a follow-on to the POPPHI agreement will provide technical support for "active management of the third stage of labor (AMTSL) and to help regional partners address hypertension during pregnancy, the other leading cause of maternal death in the region. USP is a new partner in the MNH area that has been funded to test the quality of emergency drugs used in maternity services in two countries.

**Background:** One of LAC/RSD/PHN’s objectives is to improve maternal health and reduce maternal mortality in the region, where high maternal mortality is a major public health problem. In some countries levels generally are high, but in others the rates for poor, minority, and indigenous women are disproportionately higher. Maternal mortality has been the health indicator most resistant to change within USAID-assisted countries.

It is imperative to provide women with continuous care that starts before to conception and continues during pregnancy, childbirth, and puerperium, including care of the newborn. Pregnant women infected with HIV must be provided with delivery conditions that meet established protocols to minimize the probability of transmission to the newborn and be counseled about infant feeding options. WHO recommends, "Mothers known to be HIV-infected should be provided with lifelong antiretroviral therapy or antiretroviral prophylaxis interventions to reduce HIV transmission through breastfeeding." Use of a breast–milk substitute during the first six months of life should only be considered in certain circumstances. Access to contraceptives is indispensable for reducing unwanted pregnancies and maternal morbidity and mortality, and to prevent sexually transmitted infections, including HIV/AIDS (physical barrier contraceptives).

LAC has led initiatives to assist public and private providers and communities in their work to scale up proven lifesaving strategies, especially in rural and underserved areas; community approaches to birth preparedness; and standardization of treatment guidelines. Technical specialists have been made available through such GHB mechanisms as POPPHI and most recently MCHIP; the regional program will work to expand the use of successful models of coordinated efforts between communities and health facilities to assure that women have access to essential obstetric care and skilled attendance at birth. MCH programming has promoted the use of proven, low-cost interventions that reduce morbidity and prevent mortality.

**Primary Activities:** The LAC maternal mortality initiative started in 1996 in 11 priority countries selected for their high maternal national mortality ratios or stark subregional disparities in maternal mortality. Major partners were PAHO and University Research Corporation Quality

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Assurance Project (URC-QAP). A —Regional Strategy for the Reduction of Maternal Mortality and Morbidity,” was endorsed by all member states at the Pan American Sanitary Conference in September 2002, and an Inter-Agency Strategic Consensus for Latin America and the Caribbean conference was held. These initiatives helped focus attention on the need to incorporate evidence-based practices into clinical practice and to analyze the effects of health sector reform on quality and access of the poor to services. PAHO developed formal assessments of the provision of essential obstetric and newborn care.

All 11 target countries made advances at the policy level. Ten of them increased the use of maternal mortality audits in hospitals. The initiative developed a model that links improved service delivery with community mobilization primarily to reduce maternal mortality. The model was pilot-tested in Bolivia, Ecuador, and Honduras with impressive results. Efforts continue to build policy support for reducing maternal mortality and to develop national and local capacities for skilled attendance at birth and delivery of high-quality essential obstetric care services.

LAC/RSD/PHN strengthens Mission efforts through TA and South-to-South exchanges. Recently, it has targeted three approaches to reducing maternal death rates:

1. Improve obstetric practices, first through prevention of postpartum hemorrhage and more recently by addressing hypertensive conditions of pregnancy.
2. Increase skilled attendance at birth.
3. Improve maternal mortality surveillance.

There are many relatively simple practices that could save thousands of maternal and newborn lives. One of these is AMSTL to prevent life threatening hemorrhage. POPPHI, a GHB centrally funded program, was enlisted as a LAC partner to train and support health providers in this evidenced-based practice. As a result, professional societies included this topic in annual meetings. Most of USAID’s LAC missions have worked to foster AMSTL in their country programs.

During FY 09, LAC/RSD/PHN implementers funded and disseminated a POPPHI study of AMSTL compliance through a regional conference. The study showed that this procedure was correctly used only 3–7 % of the time in four Central American countries. Dissemination of these results and follow-up activities led MOHs to increase their efforts to promote AMSTL.

POPPHI distributed the Spanish version of the Prevention of Postpartum Hemorrhage Toolkit in the region, and awarded small grants for joint proposals from midwifery and obstetric/gynecology associations from Bolivia, the Dominican Republic, Paraguay, and Peru for activities to expand the use of AMSTL.

Increasing skilled attendance at births is an essential strategy to improve maternal and newborn outcomes. LAC/RSD/PHN once again took the initiative to support revival and expansion of midwifery training to increase access to skilled care at birth. A new partnership engages nurses and midwives to expand midwifery in a way that is appropriate to each country. PAHO also provided support to WHO/PAHO midwifery collaborating agencies to enhance regional exchange through virtual meetings and targeted consultancies. A classic midwifery textbook by Varney was translated into Spanish and made available for purchase.

Monitoring the occurrence and causes of maternal deaths is crucial for reducing those deaths. A web-based Colombian pilot study of real-time reporting of maternal mortality was completed in
LAC/RSD/PHN supported the development of maternal mortality baselines in the Dominican Republic and El Salvador using the Reproductive Age Mortality Survey (RAMOS) methodology. CDC provided TA for implementing both studies. Maternal Mortality National Surveillance Systems in Bolivia, Honduras, and Guyana received technical support from PAHO especially to review guidelines and forms. Workshops were held to review these tools and train MOH personnel. The maternal mortality surveillance system is now part of the Health Information System in Bolivia and Honduras.

**Accomplishments:** LAC/RSD/PHN has been exceptionally effective in bringing a wide range of professional, government, and private actors into alliances that advocate for strong maternal child health programs, especially for the poor, and for the budgets and policies required to support them.

Maternal health information for decision-making and quality improvements in the region has improved. Several promising approaches to improve maternal mortality surveillance systems have been advanced, particularly the “web-based, real time” reporting system tested in Colombia, which can provide information promptly to allow managers and providers to make improvements quickly.

Regional activities can be summarized as (a) representing the region in global forums, (b) providing innovation and up-to-date practices to the region, and (c) testing new maternal and neonatal mortality reduction strategies. LAC also represents USAID on the Regional Maternal Mortality Reduction Task Force. Issues addressed in several countries include real-time reporting of maternal mortality, neonatal sepsis reduction, and AMTSL. PAHO and the CLAP/WHO Collaborating Center have begun to strengthen midwifery schools to expand access to trained attendants for birth. This is especially important for the minority, poor, and rural women who are midwife clients.

**Future Challenges:** C-section rates within LAC are more than double the level to be expected. The increase in surgical interventions has resulted in higher maternal and newborn morbidity and mortality. Technical leadership is needed to begin to study ways to curtail this trend and the overuse and abuse of other technologies. The abuse of c-sections seems to be related to profit for private doctors and convenience of scheduling. This will require a behavioral change approach for providers and pregnant women. The problem fits nicely within the GHI, as does the entire maternal mortality area, since it is a woman’s empowerment and woman-centered issue.

Much more attention is needed to expand the number and quality of professional midwives in the region. The curricula of midwifery schools needs to be upgraded to better educate this cadre of health providers, who can play a critical role in improving maternal and newborn survival.

There has been little attention to women’s nutrition within the LAC/RSD/PHN portfolio. Poor nutrition in women affects not only their own health and wellbeing but also the survival of their children. Iron deficiency anemia is a persistent micronutrient problem in the region and exacerbates the severity of postpartum hemorrhage. Despite fortification of staple foods with iron and other nutrients and widespread availability of iron supplements, women continue to suffer from iron deficiency anemia and other micronutrient deficiencies. This assessment concluded that more attention to children’s nutrition is needed and improving women’s nutritional status is important both for their own wellbeing and for the health of their children.

Chronic diseases prevalent in the region are affecting reproductive health. Cardiovascular disease, diabetes, and obesity all affect women’s RH and also the newborn, e.g., hypertension.
and diabetes in pregnancy, contraceptive choice for women with cardiovascular conditions, and risk factors. Better screening and treatment of cervical cancer are also needed to save women’s lives in the LAC region, where the incidence rate is as high as 40 per 100,000 people. RH care should include regular screening for cervical cancer, but in many countries quality treatment is lacking. The PHN team is well positioned to be in the forefront of policy dialogue within the USG on this issue.

To better understand the growing epidemic of noncommunicable diseases in the region, the LAC/RSD/PHN office commissioned a study by researchers at Johns Hopkins University. The study found that people in the LAC region are as likely to die prematurely from just one NCD, cardiovascular disease, as from all communicable diseases combined. NCDs affect people of all ages, including children and women of childbearing age. The cost associated with NCDs can inhibit the economic growth of the LAC countries and eventually would divert resources from other health programs, reducing the effectiveness of communicable disease and MCH programs. The study also lays out potential avenues for USAID action based on successful implementation of programs in the region to address smoking cessation, nutrition and health habits, alcohol consumption, diabetes, and hypertension asthma control in children, among others.  

**Technical Area 6: Support Family Planning**

**Objective:** Assist the LAC region in supporting the development of a regional CS strategy and improving the quality of and access to FP information and services so that national programs are sustainable once countries have been graduated from USAID assistance.

**LAC/RSD/PHN Leadership and Support:** The Bureau provided a variety of FP support and TA to Missions and contractors working in the region during the strategy period. Missions supported include: Bolivia, Dominican Republic, El Salvador, Guatemala, Honduras, Jamaica, Peru, and Paraguay, with virtual assistance to several others. Funding was also provided to help Ecuador and Guyana implement their DHS and RHS surveys.

**Implementing Partners:** DELIVER (JSI). Field support: the POLICY/Health Policy Initiative Projects (HPI; The Futures Group/Constella Futures). DELIVER assisted countries in developing CS committees to work to obtain the political will, funding, and plans and ensure appropriate implementation of supply chain management systems for contraceptives. POLICY/HPI developed leadership and promotion of population/FP/RH policies for CS and more equitable availability of quality, accessible FP services. Both projects worked with Missions in countries identified for graduation and several not currently scheduled for graduation – DELIVER on developing logistics systems and financing and POLICY/HPI on the development of advocacy, leadership, and promotion and implementation of population policies for CS. They also worked to ensure better market segmentation, working with MOHs Health to ensure their programs reached the most needy and with Social Security institutes to get them to take responsibility for providing FP services to the middle classes.

**Background:** LAC support for FP over several decades has had profound health, economic, and social benefits for families and communities, resulting in tremendous increases in contraceptive prevalence and reductions in total fertility rates. Increased FP use contributed to a gradual decline in the total fertility rate (TFR) from 3.2 to 2.4 and an increase in the modern contraceptive prevalence rate (CPR) from 47.4 to 62.5 over the last 15 years. In spite of decreases in the TFR, there are still large gaps between socioeconomic strata and rural and urban rates. Similarly, while

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24 Ibid.
CPR and modern method use steadily increase, geographical gaps and gaps in population groups served continue to be a challenge.

As the 2010 trends analysis and other data make clear, FP programs have produced impressive results. However, increasing demand for modern methods, unmet need, and extending information and quality services to hard-to-reach and underserved populations within and across most LAC countries, coupled with the planned graduation of seven countries from USAID FP assistance, threaten these gains. But these factors may also provide new opportunities and new partners. The increasing number of women entering reproductive age, combined with increasing demand for modern methods, is pushing up demand for FP information and services. At the same time, starting in about 2004 USAID has been gradually shifting an increasing proportion of its FP resources (contraceptives and funding) from the LAC to the AME and AFR regions, despite the unmet need for FP in LAC.

**Primary Activities:** The Contraceptive Security (CS) Initiative supports the phase-out of USAID FP assistance whether countries are or are not yet scheduled for graduation. It also works to ensure USAID’s investments in FP are sustained by countries (including contraceptive and other RH supplies, research, and population-based monitoring surveys), other donors, and the private sector. LAC/RSD/PHN worked to stimulate a more diversified funding and procurement base for contraceptives to better ensure that FP gains are cost-effective and sustainable within national programs. The program also assists governments and civil society in helping couples achieve their fertility goals.

DELIVER provided TA to Missions and countries to design, develop, and strengthen safe, reliable, and sustainable commodity and contraceptive supply systems. These systems include supply chain management, commodity security, and procurement services. POLICY/HPI provided TA to country programming in health policy development and implementation. Every year since 2003, one of these contractors has sponsored a regional meeting on such themes as CS and poverty reduction, and procurement options. The two have also published a large number of studies and guides, all of which are available on the LAC website (under contraceptive security).

**Accomplishments:** LAC/RSD/PHN leadership, technical assistance and funding contributed to the

- Development of a number of policies and guidelines for improving access to and use of FP/RH services
- Introduction of a number of new approaches to FP implementation
- Use of improved management information systems (MIS) by a number of institutions
- Conduct of yearly Latin American conferences on such topics as improving equity in the CS context; these also fostered discussions of lessons learned
- Stimulation of a more diversified funding and procurement base for contraceptives, better ensuring that FP gains are sustained
- Establishment of a Regional Contraceptive Security Forum to share experiences and lessons learned and country-specific strategies on future contraceptive procurement practices
- Publication of a number of studies on such topics as assessments of six countries’ CS situation; contraceptive procurement experiences and options; and FP in decentralized and integrated health programs.
**Future Challenges**: Six LAC countries are graduating from USAID FP assistance between 2009 and 2012 (see Appendix J for the list). To ensure successful graduation, LAC supports CS efforts that identify common and priority CS issues and help design and implement regional and national interventions to help achieve efficient and equitable CS. CS ensures that people can choose, obtain, and use a wide range of high-quality, affordable contraceptive methods and condoms. TA is provided to national CS committees (composed of government, NGO, and donor representatives) to ensure sustainable logistics; strengthen local procurement capacity; and obtain government financing for FP supplies. CS assessments, market segmentation analysis, publications on best and innovative practices, and regional meetings have also helped move CS forward, as have partnering with other major contraceptive donors and procurement agencies, such as UNFPA, IPPF and the Reproductive Health Supplies Coalition.

While the objectives of this intervention have been largely achieved, there remains great concern among LAC/RSD/PHN, LAC Missions, other donors (UNFPA, IPPF), and countries in the region that national programs may not be sustained as articulated in the USAID Graduation Plan or the country-specific plans.

DHSs have been conducted in most countries and graduation may threaten this highly reliable source of population-based data unless Missions fund, or co-fund with LAC/RSD/PHN, the DHS Family Planning Module in countries before or soon after graduation.

The interconnected issues of CS and graduation must remain a priority for LAC/RSD/PHN and its Mission, donor, and national program partners for the next several years. It will be especially important for LAC to continue monitoring graduated countries to ensure that they do not backslide. It is also important to determine how best to continue supporting graduated countries, including advocating for continuous CS. Thus, the PHN team needs to plan for TA after graduation as needed. This means that it needs similar, and perhaps increased, funding for its FP efforts over the next five years to ensure that graduation is successful and sustainable.

Elements of HSS in policy analysis, health governance and finance, and host country human resource capacity and leadership remain critical to institutionalized and sustainable national programs.

The number of women reaching reproductive age, combined with increasing use of modern FP methods, will likely result in a growing demand for FP services and contraceptives in the region. And as USAID disseminates the growing evidence of the maternal-child health benefits of longer birth spacing (three to five years), the demand for FP services and counseling will certainly increase.

Country-specific challenges will arise with changes in government leadership across the political spectrum (rightist-centrist-leftist) and opposition to FP by government, religious, and conservative groups.

Rural-urban and socioeconomic disparities in FP usage indicate that USAID must tailor programs to overcome barriers to services in rural areas, such as geographic isolation, language, religion, and access to indigenous groups. It also means that many LAC countries need to improve their mix of modern contraceptive methods, especially permanent methods.

While not scheduled for graduation in the medium term, special focus should be placed on increasing the CPR in Bolivia, Guatemala, and Haiti, where modern method CPR remains low, and on reaching population groups with high unmet needs throughout the region.
CROSS-CUTTING THEMES

Equity

The LAC/RSD/PHN program is designed to support more equitable access to quality healthcare. The most challenging fact in health—and in every other sector USAID supports in LAC—is the persistence of socioeconomic inequities. The LAC region experiences the greatest inequities in the world.\(^\text{25}\)

The most-in-need populations—the poor, the poorly educated, and geographically isolated, indigenous, and minority groups—have not benefited from improvements in the quality of or access to health care and health status as other populations have.

The LAC/RSD/PHN team has consistently called attention to this issue and collated data to help decision makers understand that, although many regional health indicators may be better in LAC than in other parts of the world, minority, poor, and rural families disproportionately suffer disability and death from lack of adequate health care. The team has consistently advocated with the GHB for resources to attend to some of the most egregious health inequities, particularly maternal and newborn mortality, FP coverage, and infectious disease prevalence. LAC/RSD/PHN and its partners focus on supporting HSS within target countries to ensure that they reach the underserved with services to promote, protect and restore health.

Quality Assurance

For quality assurance, a number of activities were conducted to assess the capacity of national primary health care services. Evaluations were conducted using the PAHO Guidelines for Accreditation of Primary Health Care (PHC) Networks and health personnel were trained in quality assurance through a Virtual Course for Development of Competencies for Primary Health Care services launched in the 2009 Virtual Campus of Public Health. Students from 13 countries participated in this six-month course. The PHC accreditation model developed was pilot tested and validated in three countries and implemented in one (Ecuador).

Under the External Quality Assurance Program for national laboratories, 25 LAC countries improved their external quality assurance (EQA) capacity, raising the rate of correct microscopy results. For example in 2007, 73% of the estimated new smear-positive TB cases were detected under the DOTS initiative. Also evidenced was enhanced capacity of endemic countries for increased coverage of HIV, malaria and TB prevention, treatment, and care.

Quality assurance for AMR used evidence-based data collected in 2006 and 2007 through surveys on correct bacterial identification and susceptibility test correct interpretation. Both were published in a peer-reviewed journal in 2009. To ensure that quality control practices were followed, National Evaluation Groups on Infection Control were established in four countries.

Quality assurance practices were introduced into academic curricula for bacteriology and susceptibility testing in several countries with the active participation of universities and MOHs. The new curricula were disseminated through PAHO’s virtual campus. Other documents published to improve quality assurance surveillance and practice on antibiotics management were

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\(^{25}\) Those perceptions are not independent of Latin America’s very slow progress in reducing poverty and its offensively high and persistent inequality in the distribution of income and assets. The share of the population living below the poverty line (as measured by ECLAC) fell only marginally from the early 1990s, to about 40 percent in 2005–06, while the number of poor people in 2006 was the same (about 205 million) as in 1997. At the same time, measured income inequality in Latin America remained among the highest in the world and in some countries has increased since the early 1990s.” Birdsell, N., de la Torre, A., and Menezes, R., Fair Growth: Economic Policies forLatin America’s Poor and Middle-Income Majority, Center for Global Development (2008).
the Treatment Guidelines for Infectious Diseases (2009–2010) and manuals for the restrictive use of antibiotics in hospitals to prevent AMR.

Integration of Health Programs

There is a strong movement toward integration of vertical programs into national health systems. This is necessary because financial and human resources are scarce. It can also enhance the quality of health care. For example, in the maternal and neonatal health activities supported by LAC/RSD/PHN, health professionals are learning about the continuum of care based on the recognition that the mother’s birth attendant is usually the same person that provides newborn care. IMCI is a prime example of the integration of vertical programs for better child care. As some LAC countries graduate from USAID FP support, better integration with other MCH services may help to ensure continued coverage. Another example is the need to integrate surveillance systems in general and those for TB and HIV in particular.

Anecdotal evidence suggests that including FP in traditional postpartum and postabortion programs may be falling by the wayside, and that FP may not be a key component of postpartum HIV/AIDS prevention. Moreover, it appears that PMTCT programs may not actually be including FP. Thus, it is critical that as integration proceeds it is done with care so that such key interventions are not subsumed in the wider agenda.

Although Congressional dictate constrains USAID from initiating chronic disease programs, there are a few areas where noncommunicable diseases must be addressed within the continuum of care. For example, hypertension during pregnancy leading to eclampsia is the second leading cause of maternal mortality in LAC; it must be treated in order to save women’s lives. There is a need to continue dialogue with lawmakers about the heavy burden on poor and middle class families and health systems of highly prevalent chronic illnesses. HSS should include improving prevention and management of chronic conditions that affect a large proportion of the population.

PAHO has also assisted in integrating health programs. PAHO’s policy for integrating the health care delivery networks (IDHN) based on PHC urges member states to elaborate public-private partnership plans of action to promote the creation of IDHNs as the preferred modality for health services delivery. All PAHO member states made a commitment to implement IDHN. This is a continuing process in countries that are searching for synergies between priority programs, new GHI interventions and the general health system. Countries are using a revised methodology to update and disseminate information on the health system within their own borders and across the region.

Until recently, integration achieved was presented in commissioned case studies in several countries: Peru - integration of HIV/AIDS; Colombia - integration of TB programs; Guatemala - integration between MOH and the Social Security Institute; Chile - integration of service networks, and MCH programs; Brazil - integration of HIV/AIDS in the Unified Health System, as well as integration of service networks; Trinidad and Tobago - integration of HIV/AIDS; and Dominican Republic - integration of HIV/AIDS.

Another major aspect is the integration of public and private practitioners in TB control. Under this initiative public and private practitioners and the public-private mix working under the Stop TB Strategy will report to the national TB program. There is special emphasis on prisons, social security institutions, NGOs, and FBOs.

The PAHO/USAID project is working with HMN and Projecto Mesoamericano de Salud (PMS, through its HIS component) to harmonize national HIS strategic plans among countries in the region.
Integration of surveillance for TB and HIV/AIDS led in 2007 to 49% of all registered TB cases being tested for HIV, a 17% increase over the previous year due to activities funded by LAC/RSD/PHN. All priority countries in the region are implementing TB/HIV collaborative activities to some degree.

The PAHO Regional Plan of Action approved in 2008 promotes creation of National Neonatal Plan of Action in the context of maternal, newborn, and child care. It was supported by 10 countries in the region and approximately 1,200 newborns received essential care through USAID in priority countries.

**Synergies—Health Sector with Other Sectors**

The organization of LAC, with PHN being co-located with other technical sectors AC oversees, presents opportunities for future synergies with democracy and governance (DG), food security initiatives, and climate change programs. In the future, such opportunities should be rigorously pursued.

Surveys in LAC show widespread concern with political corruption and rising crime rates. Many citizens are losing confidence in their national institutions due to poor access to quality services and widespread corruption. Achieving equitable access and other elements of a sound health system requires good governance. Health services can be the focus of governance strengthening efforts that will both improve the performance of the health system and reduce waste and abuse. One example of intra-RSD collaboration is that the DG team has expressed interest in health behavior change activities (as a transfer of technical knowledge), which might be useful for anti-gang activities. Systems must not only be able to support quality facilities, but provide qualified personnel and provide them with good supervision. A strong health system that provides quality services to all its citizens is a visible sign of a government that is serving its people and that people can trust. This was important in the recent H1N1 pandemic and will be crucial in future emergencies.

The Food Security Initiative is a golden opportunity to direct resources toward improving the nutrition status of the most vulnerable: children under 2 in particular. The PHN team can collaborate with the EGAT team to keep a nutrition focus within food security strategies and plans and ensure that nutrition expertise is available in the region for implementation.

As PHN’s proposed health strategy for Haiti points out, the linkages between FP and other sectors also provide excellent opportunities. For example:

- Programs to meet the unmet FP need can be integrated into broader health and nutrition programs.
- FP programs are strongly associated with decreasing maternal and infant mortality.
- Offering FP planning services if a key activity for the PMTCT program
- FP programs can be linked with nutrition programs, to provide greater stability and sustainability to agricultural households.
- FP can be supported as an integral component of a broader RH strategy that is responsive to women’s needs and contributes to wellbeing.

**Alliance Building**

*Tuberculosis:* Nine countries were engaged in a new public-private initiative, expanding on initial efforts in FY 2008. Four countries carried out surveys to determine current patient volume, costs, and treatment standards for TB patients electing private care.
LAC/RSD/PHN’s funding of Abt Associates assisted in building regional alliances for health. The project pursued partnerships on all priority health topics through almost 100 meetings with private corporations, foundations, membership groups, and implementing partners. Procter and Gamble signed a memorandum of understanding to pre-position a water purification product for use in disasters and pledged to provide $150,000 through this alliance. As of 2008, discussions were underway on creating regional alliances for maternal and neonatal care on the Nicaraguan/Honduran border.

Other examples of alliance-building:


- Public-private and public-public collaborations were put together for TB control in public institutions, prisons, private centers, social security institutions, NGOs, and FBOs.

- The PAHO/USAID project on HIS worked with HMN, Proyecto Mesoamericano de Salud (PMS, through its HIS component) and MEASURE-Evaluation to harmonize national HIS strategic plans within the region.

- Various partnerships and alliances were effective in supporting country efforts to develop or strengthen midwifery as a skilled attendance strategy. For instance, the Global Alliance for Nursing and Midwifery carried out a global forum in 2008 to promote dialogue and exchange information on how to change practices based on evidence, focusing on AMTSL.

- The Interagency Regional Task Force (IRTF) on Maternal and Neonatal Health was relaunched in 2008. Partner organizations are UNFPA, IADB, FCI, USAID, and PAHO-CLAP. IRTF is also coordinating a Women Leaders Meeting to encourage action to reduce maternal mortality rates and generate political commitment around remaining challenges.

- The USG supported creation of the Neonatal Alliance, whose partners include Save the Children, USAID, Basics, UNICEF, Plan International, Asociacion Latinoamericana de Pediatria (ALAPE), Federacion Latinoamericana de Obstetricas y Ginecologia (FLASOG), International Confederation of Midwives (ICM) and the Federacion Panamericana de Profesionales de Enfermeria (FEPPEN).

South-to-South

South-to-South collaboration was used as a strategy to strengthen the capacity of national institutions by providing technical country-to-country collaboration, and facilitate the elimination of barriers perceived in recipient institutions. This has been especially effective in the FP area.

Examples using LAC/RSD/PHN funding include:

- The AMI and the SAIDI, both of which were transferred to SAR in 2009.

- The Regional TB Fellows program, which supported the regional TB program with emphasis on pediatric TB and laboratory monitoring activities.

- TB/HIV meetings, which engendered firm country commitment to integrate surveillance systems for TB/HIV and collaborative activities.
- Multiple regional meetings where technical knowledge and best practices were shared.
- PAHO’s virtual campus and AMR PAHO SharePoint.
- Regional strategies, plans of action, and activities on MCH, accreditation, and laboratory working groups to promote TB/HIV collaboration.
- Regional partnerships such as the Maternal Neonatal Health Task Force and the Latin American Center for Perinatology and Human Development.
- The 4th Sector Health Project being tasked to create content for a virtual exchange community with stakeholder participation; launch a virtual exchange community for health survey demographers; and support one to two South-to-South interpersonal exchanges.

**PAN AMERICAN HEALTH ORGANIZATION (PAHO) GRANTS**

LAC/RSD/PHN has been partnering with and funding grants to PAHO for 20 years. These grants incorporated USAID goals and objectives into existing PAHO work areas. For the assessment, activities implemented by PAHO under the two most recent USAID Umbrella Agreements were reviewed. The first agreement covered 2004–2007 with total funding of $13,124,000. In 2007, USAID signed a $5,756,904 umbrella grant with PAHO to cover the period from 2007–09, with activities being implemented through FY 2010. The new grant builds on achievements to date and has two major themes: (1) strengthening health systems and services in the context of primary health care; and (2) improving the quality of health care services. It was focused on developing policies and implementation strategies to reduce the fragmentation of health services through integration. The grant also focused on public health capacity building and the creation of synergies between programs.

**TECHNICAL AREAS IN THE 1ST USAID–PAHO UMBRELLA AGREEMENT 2004–2007**

- The SAIDI: A subregional strategy managed from the Mission in Peru to address critical infectious disease concerns.
- Infectious diseases: Focused on AMR and TB control policies throughout the region.
- Maternal and neonatal health: Focused on regional health policy and TA to countries to reduce maternal and newborn mortality and morbidity.
- Health sector reform: Strengthening essential public health functions and improved linkages with reform and vertical programs.
- Health information systems: Consolidation of routine information systems to better meet public health priorities.
- Pandemic influenza.
TECHNICAL AREAS INCLUDED IN THE 2ND PAHO–USAID UMBRELLA AGREEMENT 2007–2009

- Tuberculosis
- AMR
- Pandemic influenza
- Maternal and neonatal health
- Health systems and services

After a long partnership between USAID and PAHO in the region, the LAC/RSD/PHN team is reevaluating its strategy and partnership with PAHO beyond the current agreement and considering a number of options to best implement its future portfolio. The assessment team therefore analyzed the pros and cons of the USAID-PAHO partnership, taking into consideration observations and suggestions made by mission PHN officers and those interviewed in USAID/Washington, LAC/RSD, GHB, and other Regional Bureau Health teams.

STRENGTHS IDENTIFIED

1. Since PAHO is an intergovernmental organization, all MOHs in the Americas are part of PAHO’s governing bodies. Countries agree upon an annual agenda in the Directing Council that meets once a year. As a multilateral organization, PAHO plays a unique political role in the policy and regulatory processes by enabling a legal framework under which member LAC states can implement health programs and activities.

2. PAHO has representation, offices, and personnel in each LAC country that promote close communication between the organization and local health authorities. This positions PAHO as a preferred platform to share best practices and state of the art knowledge and tools among LAC countries. It also means that USAID regional initiatives can reach countries that have no USAID bilateral health activities to assist with urgent health problems, e.g., maternal mortality reduction in Guyana and midwifery training in Ecuador.

3. PAHO plays a significant role in donor coordination that enables it to implement its operational plan while encouraging other donors to buy into its organizational areas of interest, such as chronic diseases, mental health, violence, and emergencies and disasters.

4. PAHO is recognized in the region as a reliable source of technical knowledge and innovative thinking that translates into the design of tools, guidelines, and protocols to improve the health of people in the Americas. PAHO is also one of the most accepted sources of publications on public health and other technical topics.

5. The consensus among Mission PHN officers and USAID/W personnel was that maintaining a relationship with PAHO is politically important. However, they recommended that in the next grant agreement that LAC/RSD/PHN continue to “play PAHO’s areas of strength,” as it does in the most recent grant while finding alternatives to balance PAHO’s limitations—program implementation in particular.

6. Under the PAHO-USAID Umbrella Agreement 2007–2010, PAHO reports appropriately detailed progress achieved against indicators established in the agreement and in the completion of annual activities. The report also presents success stories that have resulted from the PAHO-USAID cooperation.
Because of these strengths, LAC/RSD/PHN partners with PAHO to facilitate implementation of regional health programs. However, as an implementing partner PAHO does have several limitations.

LIMITATIONS IDENTIFIED

1. The USAID-PAHO grant agreement is geared toward policy development at the regional level. While considering national participation and consensus-building strategies, its main focus is not on detailed local implementation activities. LAC PHN officers consider this as a limitation of PAHO’s record of performance in implementing programs. This may also be due to overly bureaucratic processes and the extensive coordination of activities embedded in PAHO’s structure, which creates an inertia that causes delays. Missions have found that in bilateral programs other contractors usually perform better and in a more timely fashion in implementing activities.

2. A complaint heard frequently from Missions is that PAHO does not share with PHN officers what it is doing under its USAID-PAHO Umbrella grants. The lack of information has led some Missions to duplicate activities that LAC had included in its PAHO grants. Some Missions expressed the opinion that PAHO does not respect USAID at the country level and this inhibits communication and local coordination and partnership. Since the agreement with PAHO is at the regional level, if a Mission program were to buy-in to a program under the USAID/W-PAHO Umbrella agreement, PAHO reports only to the regional office, leaving (it is feared) the Mission out of the loop.

3. PAHO has never had any real expertise in FP because UNFPA is the regional FP funding and TA agency in the region.

4. Some Mission PHN Officers, as well as the assessment team, question whether there is real accountability for program implementation with PAHO, particularly the utility of their reporting on indicators under the grant agreements. It would be appropriate to revisit the issue of indicators in any future USAID-PAHO grant. Both LAC personnel and PAHO officers in the field need to communicate better with PHN Mission officers on activities supported by the regional bureau since several PHN officers stated that they were not aware of anything concrete produced by PAHO.”

5. Like many organizations, PAHO has frequent changes in personnel and there is often variability within different offices and units in terms of programmatic and technical leadership, as well as how proactive and collaborative they are.

From interviews with nine LAC PHN officers, the assessment team extracted consolidated responses regarding their experience and relationships with PAHO.

Strengths

- Close communication with MOHs
- Politically official advisor to ministries; PAHO only valid intermediary with government, since some Missions do not have bilateral agreements and even US NGOs are not registered
- Provides technical opinion/assistance to ministries
- Good technical expertise
- Good job on TB; “We will work with them in accident reduction and violence.”
- Gets things done because PAHO has government support
Limitations

- PAHO does not communicate with or support the Missions. Bilateral programs put money in the Umbrella Agreement and PAHO does not communicate results to RSD or the Mission.

- There are numerous problems: inconsistency implementing programs, too bureaucratic, everything takes a lot of time.

- PAHO overstates its role (it wants to monitor the Missions).
IV. CONCLUSIONS

BUROAE FUNCTIONS

There is an imbalance in the staff mix on the LAC/RSD/PHN team. There are four technical—specialists; only the team leader and one advisor are broad-based generalists who can respond to a wide range of bureaucratic demands in USAID/W and Mission PHN programmatic requests. Missions are in need of support for increasingly complex interagency requirements while supporting and training new staff.

The team is currently staffed with six hard-working, dedicated, programmatically/technically skilled and experienced, and field-oriented professionals: a team leader (currently an FSO); three senior advisors and two technical specialists (time-limited fellows). A third of the team is funded by sources other than LAC’s own budget. All but the team leader are employed through short-term mechanisms that do not give them permanent USG employment status even though they are considered long-term employees. This situation is frustrating to both the employee and LAC/RSD/PHN and should also be of concern to LAC and the agency given the impermanent nature of these hiring mechanisms and its need for dedicated long-term employees. The core strength of the team resides in these six individuals.

Whether or not USAID decides under the new administration to revisit the rationale for housing health professionals in regional bureaus, every consideration should be given to both increasing the number of technical staff and providing the administrative and clerical support they need.

The LAC/RSD/PHN Team functions relatively well together and the programs and the activities it funds have had both regional and country impact. However, the assessment team found that LAC/RSD/PHN did not manage and implement its portfolio as proficiently as it could have. While the PHN team attempted to be strategic so as to maximize limited resources, it tends to manage projects and the whole portfolio in a fragmented and vertical rather than strategically focused and holistic way.

With interagency representation requirements growing, field mission shortages, and the need to supervise and mentor new junior officers, the current LAC/RSD/PHN staff allocation must be assessed. While it is difficult to fill positions in USAID/W with FSO BS 50s when there is a general employee shortage in USAID, it may be possible to recruit personnel who can take on broad programmatic responsibilities. As the PHN team designs its new strategy and responds to the changing needs of the field and the GHI, FSI, and other USG programs, a careful look at staffing should be part of the planning. There is a need to ensure that PHN team members with broad experience are available for operational and programmatic functions.

To function more fully as a team in future, LAC/RSD/PHN should

- Articulate a new vision statement for the follow-on strategy.
- Formulate a robust strategic framework and more narrowly focused technical interventions (programs, activities, budgets).
- Add to staff broader programmatic, managerial, and financial skills.
- Clarify job responsibilities within the team and institute a system of matrix management (a project or activity manager with a backup) to assure that everyone understands the portfolio, individual responsibilities, and coordination and communication mechanisms, both internal (within LAC/RSD and PHN) and external (with GHB, missions, other geographic bureaus)
• Improve considerably organization and management of its program documentation (project, M&E, and financial tracking).

PHN’s leadership within the LAC Bureau and the team’s general support and TA to Missions has been highly appreciated. Its support to PAHO is greatly and appreciated by PAHO headquarters in Washington, D.C. but less well recognized at the country level. Its efforts over the strategy period brought together a wide range of professional, government, and private actors in alliances that advocate for effective health programs, especially for the poor and underserved, and for the budgets and policies required to support them. (See Appendix G: Mission PHN Officer Responses to Interviews).

During the period assessed, the PHN team effectively advocated for the poor, rural families, and underserved minorities in the region and for Mission bilateral health programs that targeted these groups. The team also represented the unique health, population, and nutrition needs of the region to the GHB as well as to LAC and obtained financial and technical resources and support for priority challenges. Its members have shown leadership in assembling partners to tackle common problems, such as maternal mortality and infectious diseases. They have organized support to help prepare Missions and countries for FP graduation. The team also promoted South-to-South technical sharing and cooperation in innovative ways.

Even as LAC/RSD/PHN led successful technical initiatives and responded to frequent requests from Missions for technical and other assistance, it has had to deal with enormous change and uncertainty within USAID and the LAC Bureau. The way foreign assistance has been planned, budgeted, and implemented was altered several times during the strategy period. The few staff members have been called upon more and more to represent LAC and USAID in a plethora of working groups and interagency forums, e.g., negotiating with other USG agencies under PEPFAR, participating in GHI working groups, and jointly planning crisis management for pandemic flu.

The members of the PHN team have had to be multivalent: capable of policy discussions and budget advocacy and able to handle strategic and operational planning with Mission staff, all while staying current in a variety of technical areas and LAC regional developments. Undoubtedly they will need to strategize more in political terms as they assist Missions in finding a balance between shorter-term diplomacy and security sector assistance and longer-term development assistance and move to reflect the balance of the 3Ds in their own regional programming. Infectious diseases that affect the hemisphere are a good example of how LAC has done this, and where it can do more.

The primary functions of the LAC/RSD/PHN Team are mentoring and training new staff and technical support for Mission personnel. The biannual SOTA meetings jointly planned and conducted with GHB are high-quality in-service technical training for both LAC/RSD/PHN staff and Mission PHN officers, including the critically important Foreign Service nationals. The quality and relevance of those meetings were applauded by most of the Mission staff interviewed. USAID is now increasing its field staff through the Development Leadership Initiative (DLI), which is recruiting and orienting new FSOs, including many new Backstop-50 (PHN) officers. When the new hires are assigned to LAC Missions, the LAC health team is involved in supervision and mentoring during the 16 or so-week rotation period in USAID/W. In addition, the team leader, as an FSO, is the supervisor of record for some of the new hires during their time in USAID/W. And with scarce field staff, it will be important for LAC/RSD/PHN staff to continue to provide the support the new hires need to develop into capable FSOs, particularly while they are working in the Missions. Similarly, there is a critical need to orient and support other new staff, such as fellows, as they are incorporated into the health team. These important functions will undoubtedly increase as more junior officers are brought in and senior health staff remain in short supply.
REGIONAL ACTIVITIES AND FUNDING: THE FUTURE

As stated earlier, historically the primary options for addressing regional technical support needs have been to (1) continue to have health teams staffed with PHN technical specialists housed in regional bureaus; (2) move these specialists to the GHB; or (3) assign more technical officers to field missions; or (4) a combination of the previous options. In view of the possibility that the justification for regional technical support may be revisited under new agency leadership; and the evolving USAID-State-DOD priorities and major initiatives of the Obama administration, LAC/RSD/PHN and LAC/RSD should compare USAID’s prototype functions for regional bureaus and their health teams with those they themselves are currently following. If necessary, LAC/RSD/PHN should align itself with the main functions while also tailoring specific functions to its own geographical needs.

As an integral exercise for both the short and long term, LAC/RSD/PHN should compare its current functions and staffing requirements with those of other regional and pillar bureaus and if necessary align itself more closely with prototypical bureau and regional health team functions and relationships. This exercise will prepare LAC/RSD/PHN to accommodate itself within the agency’s future organizational structure once it has been determined. Appendix H, Column 3, lists functions that Missions see LAC/RSD/PHN currently performing and those they feel should be priorities.

In 2010, complementary to the LAC Bureau’s overall strategy, LAC/RSD/PHN is designing a new strategy to reflect major changes that have occurred in the LAC region in the last five years, to consolidate gains, to promote greater equity in access to health care services, and to advance the health priorities of the Obama Administration under the Global Health Initiative and other major initiatives.

The LAC/RSD/PHN team will need to continue to be flexible, opportunistic of purpose both programmatically and financially, and agile in coping with new management, the transition in updating the Foreign Assistance Act, and the realities of the GHI. At the same time they must continue to be responsive to the needs of the 17 field programs that count on them for support, advocacy, technical advice, and updates tailored to the particular needs of LAC. They will need to maintain their alliances with GHB, PAHO, and others to best meet the needs of the underserved men, women, and children of LAC. In short, given the magnitude of change and the multiplicity of initiatives, new and current, the challenge before LAC/RSD/PHN is how to respond to the changing environment while focusing and concentrating its portfolio.

LAC/RSD/PHN plays a unique role as an interlocutor between GHB-managed projects, contractors, and organizations operating in the LAC region and with national governments. While LAC/RSD/PHN and the GHB share the same general health goals and objectives, GHB’s view of the world is global rather than regional. Thus, the context for making decisions about allocating agency resources means applying epidemiological, social, economical and cultural criteria to identify priority countries and funding levels, rather than taking into account subnational considerations that often apply to parts of the LAC region.

In addition, much of the LAC region has a different health profile from other regions of the world. It is undergoing an epidemiological transition with an aging and a more sedentary population, changes in social behavior, more organized health systems, and better socioeconomic and developmental conditions. This transition makes it necessary to adjust the focus of health programs in the LAC region to accommodate both underserved populations within countries and infectious diseases that cross borders, as well as the huge burden of noncommunicable diseases.

A prosperous and democratically stable LAC region is vitally important to the United States and its foreign policy priorities. The rationale for a regional health program and the technical capacity to partner effectively with USAID is high in most of the region. Through continuing engagement
in the health sector in LAC, the U.S. has the opportunity to make significant contributions to the region, and in doing so to build credibility and respect.

A key recommendation from a recent CSIS report pertaining to the GHI states:

U.S. foreign assistance priorities on global health do not presently align with the emerging trends in Latin America and the Caribbean. U.S. agencies should move quickly to identify opportunities to undertake cooperative work on non-communicable diseases, dengue fever, and other emerging conditions while continuing to address traditional challenges related to infectious diseases, maternal and child health, access to family planning, and improved water and sanitation in key countries.  

Currently, neither USAID nor LAC Bureau health programs align with a number of actual and emerging health priorities in the region. In great part this is due to Congressional interests and the earmarking of funds in the CSH and PEPFAR accounts. Until USAID is able to better align its health interventions with Congressional mandates, the LAC/RSD/PHN team could: (a) with GHB, advocate with the Department of State and Congress to recognize the emerging situation and to allow for other uses of funding with the accounts; (b) assist countries in the region in devising strategies and programs to address priority diseases (chronic diseases, dengue fever, Chagas) with non-USAID funding; or (c) use Account funds to build health sector capacity through HSS interventions. If this were possible, these interventions would have sustainable spill-over benefits for improving the quality of and access to health service in general. Such a change would align nicely with the GHI principle that —Encourages country ownership and investment in country-led plans.”

However, if USAID is to more closely align its health programs with the health priorities of countries in the LAC region under the GHI, Congress will need to modify the current practice of earmarking the GHCS Account. Rather than continuing to place a plethora of strict earmarks on the account by element and sub-element, a more flexible option would be to simply earmark a —general health fund” that would enable USAID to more fully align its health programs with those of host governments.

APPENDIX A. FINAL ANNEX B FROM SCOPE OF WORK


The issues and questions listed below indicate the scope and depth of the assessment USAID requires. This list should be considered illustrative and may be adjusted after discussing with the LAC RHP team.

SCOPE OF WORK

This assignment comprises three main components, as described below.


The GH Tech Team proposes that the order of Parts A and B be switched since we believe that a better understanding of the LAC-RHP’s roles and responsibilities; internal and external work environment; relationships with Missions and Regional Programs, etc. will lead to a better understanding of the programs—in short, the raison d’etre of the LAC Bureau’s health program.

Part (A) will include an examination of the purposes (the raison d’etre) of the LAC Bureau’s health program. A preliminary list of its -rations or dimensions is provided here: (1) support of USAID’s mission health programs and teams in the LAC Region; (2) technical leadership on health issues/conditions that are priorities for Latin America; (3) truly regional programming (that which is best done at a regional level due to economies of scale, etc); (4) promotion of key regional health policies and international partnerships; (5) effective participation in multisectoral or cross-cutting development initiatives of the RSD office; (6) provision of mentoring and training for new USAID health staff and fellows; (7) demonstration of USG commitment to and engagement in the LAC Region. The assessment process may identify additional rationales, or modify these.

Part (B) will be a primarily qualitative assessment of the LAC Bureau’s 2004-2009 Regional Health Program (RHP). It will provide an analysis of what did and what did not work well, and why. It will examine the overall design of the RHP, technical approaches selected, implementing mechanisms used, utilization of the team’s own technical advisors, and progress made toward program objectives over the period. The GH Tech team will also evaluate the success of the RHP in partnering with other organizations (especially PAHO), and catalyzing and leveraging the commitment of public and private institutions toward the RHP’s goals. The assessment will take into account the budget and policy constraints within which the RHP must operate.

Part B will also describe the most important features of the environment in which the LAC RHP now operates, and identify implications and opportunities for the program going forward. Among these features may be: USG and USAID policies; budget levels; PAHO’s strategic plans; cross-sectoral approaches being developed in the RSD office; the situation and needs of health programs in the field missions; and the USG’s -white of government” approach.

The assessment document will present a summary and analysis of the extensive information gathered by the GH Tech team via interviews, meetings, and document review. It will provide well-supported recommendations related to both (A) and (B), including how the RHP should be oriented going forward; what in the current program should be preserved, modified, or jettisoned, what could be done more effectively, and what new focus areas (if any) would be appropriate for the 2010–2015 program.
PART A: FUNDAMENTAL PURPOSE, WORKING ENVIRONMENT AND PROGRAM FIT

Illustrative Questions to Guide Assessment of the LAC Regional Health Program 2004–2009

1. Fundamental Purpose: What is the RHP for? What is its *raison d’être*? Does this vary by technical focus area?

   Preliminary —*rationales*:

   a. Support of USAID’s Mission Health Programs and Teams in the LAC Region
   b. Technical Leadership of Health Issues/Conditions that are priorities for Latin America
   c. Truly Regional Programming (that which is best done at a regional level due to economies of scale, etc.)
   d. Promotion of Key Regional Health Policies and International Partnerships
   e. Effective Participation in Multi-Sectoral or Cross-cutting Development Initiatives of the RSD Office
   f. Provision of Mentoring and Training for New USAID Health Staff and Fellows
   g. Demonstration of USG Commitment to and Engagement in the LAC Region
   h. Others?

2. Organization: Is RHP organized appropriately vis-à-vis within LAC-RSD and other geographic bureaus? What is the *value added* of housing technical staff in LAC-RHP rather than in the Global Health Bureau? What proportion of the staff’s time should be used for strategic planning and managing programs vs. providing direct assistance to the field and interacting with other USAID/Washington offices? Does this vary by technical area? How much staff time is spent in meetings (daily/weekly) in USAID/W, with funded partners, and external organizations? Is too much time spent in meetings, too little, just right? Are they effective/productive? Are there better ways to do business?

3. Technical Assistance: What major lines of work are carried out by the RHP technical advisors apart from activity management? E.g., strategic planning, policy dialogue, technical assistance, other.

4. Support to Missions and Subregional Teams: What do health teams in the field feel is RHP’s role? What kinds of technical or other assistance do they request from RPH? Are they satisfied by the support they receive from RHP?

5. RHP’s Relationship with Other Donors: In what technical areas are other donors, multilaterals, and the private sector (both for-profit and NGOs) contributing in the region? How well is the RHP working with these other actors? How important is it to work closely with PAHO as a partner in the health sector?

6. RHP’s Relationship with Other USG Entities: Does RHP coordinate, plan, and implement with other USG entities: (a) at the U.S. domestic level; and (b) at country level? If so, how? What are the roles/responsibilities of other USG entities such as the State Department (this one in particular), CDC, DOD, HHS, Peace Corps, etc.?
PART B: PROGRAMMING

1. Impact:
   - How closely has LAC-RHP been able to follow and implement activities under its 2004–2009 strategy?
   - How closely has LAC-RHP been able to utilize its PMP and indicators as well as those contained in the LAC-PAHO grant over the strategy period? What has been RHP’s experience in terms of ease of collection, reliability, and utility for assessing performance?

2. Key Technical Focus Areas: What were the key objectives of the RHP with respect to the following technical focus areas? Were these objectives met? What were the significant achievements and any problematic issues associated with the RHP-supported activities in each technical focus area? What remains to be done, what are the major problems that still need to be tackled in these areas within LAC?
   - Family planning/reproductive health
   - Maternal, neonatal, and child health
   - Infectious diseases (including TB, antimicrobial resistance, and pandemic influenza)\(^{27}\)
   - HIV/AIDS
   - Health governance
   - Health information systems

\(^{27}\) Note that the Amazon Malaria Initiative, and the South America Infectious Disease Initiative are two subregional infectious disease activities that were included in the RHP at the beginning of the period being assessed but were transferred to the USAID/Peru Mission in 2008 and have been evaluated separately.
– Health system strengthening
– Chronic diseases
– Human resources planning (staffing projections)

3. Role of PEPFAR, PMI, or other USG Initiatives: What place do PEPFAR and PMI have in LAC/RHP programs? PEPFAR and the Country Frameworks are important in LAC. Lindsay Stewart will be able to brief the GH Tech team on these. USAID addresses malaria in the LAC region through a single program: the Amazon Malaria Initiative (AMI). It was managed by the LAC health team (in AID/W) until two years ago, when it was transferred to the Peru Mission. AMI is now run as a subregional activity from USAID/Peru. That activity was evaluated about 20 months ago.

4. To what extent has the RHP been successful in transferring state-of-the-art technical knowledge into country-level (both mission programs and country government) programs?

5. Funding: Specifically, what CSH accounts are used for which key technical area and in which countries? What are the funding levels and sources (DA, ESF, Field Support, Specific Earmarks, etc)? What is the trend by specific activity (e.g., partner collaboration, design of interventions)?

6. Synergy with Missions:
   a. To what extent are RHP’s mission programs involved in supporting the same policies/practices through their own programs? Are the RHP and mission programs ―in sync‖ or linked with other mission strategic objectives or USG initiatives? What are the needs of the mission programs from a technical perspective? To what extent are these needs being met by RHP? What activities and/or approaches are most appreciated by Missions?
   b. Have regional Mission HPN offices conducted any self-assessment(s) of the current strategy which include work with national governments, local partners and USAID-funded cooperating agencies/contractors? If so, can it be shared with the team?

7. Duplication of Effort: Is there redundancy or overlap of population/health/nutrition in mission health programs that could be streamlined or redundancies reduced? The regional program seems to be pretty lean and streamlined—we’ll be interested in your views. There is a lot of discussion now about ―integration‖ of health programs to increase efficiency, impact, sustainability. There may be a role for the RHP in promoting/encouraging integration of health programming in missions.

8. Partnership with PAHO: How effective has the PAHO grant been in achieving LAC/RHP’s strategic objective and intermediate results? What specifically has PAHO contributed in each thematic area with USAID funding? Has LAC-RHP considered other alternatives on funding mechanisms (e.g., USAID-funded cooperative agreements or contracts) than entering into another grant with PAHO? What are the pros/cons of each approach?

9. Overall: What has worked well and should be preserved? What could be done differently and more effectively? Are there new opportunities which should be considered?
A DRAFT STRATEGY FOR THE REGIONAL HEALTH PROGRAM: 2010-2015

Based on findings from the assessment, the GH Tech team will work with the LAC Health Team to develop a preliminary strategy document for the next LAC regional health program, 2010–2015.

The strategy will describe the appropriate mix and weighting of rationales that should orient the RHP going forward. Working with the LAC health team, the GH Tech team will identify the most important foci for regional intervention and develop program approaches for those areas. Using the “F” framework (including technical elements and subelements) as a basis, the GH Tech team will develop a draft results framework for the 2010–2015 strategy and outline how indicators will be monitored during the life of the strategy. The new strategy will incorporate RSD multisectoral initiatives in which the RHP will collaborate and reflect the “whole of government” approach as appropriate. The strategy will treat the technical assistance supplied by the RHP advisors as an explicit part of the program and plan for its best use.


NEED TO POSE FOUR STRATEGIC PLANNING QUESTIONS AT EACH LEVEL OF STRATEGY DEVELOPMENT:

1. Where are we now? [the purpose of the GH Tech Team assessment]
2. Where do we want to be in the next 5 years, 2010–2015?
3. How will we get there?
4. Will it all be worthwhile?

The GH Team will explore these questions in greater detail during the assignment.

1. Strategies/Initiatives/Congressional Priorities: What is the status of the following strategies and/or initiatives and how will LAC-RHP synchronize its 2010–2015 Strategy these USG as well as national (country-level) or regional strategies?
   a. The Obama Administration’s “whole of government approach” under the Global Health Initiative (GHI)
   b. The new State/USAID GHI
   c. The Food Security and Global Climate Change Initiatives
   d. What is the status of the current State-USAID Strategy: 2007–2012?
   e. What is the status of LAC-RSD’s new strategy and how will LAC-RHP’s fit within it?
   f. To the extent they are knowable, what are the key Administration and Congressional priorities in the health sector for the LAC region? How will these priorities/initiatives, such as GHI, eventually be integrated into the LAC 2010–2015 strategies?
   g. Should the RHP help missions address integration in health programs, as called for in these strategies/initiatives? If so, how?
   h. Are LAC missions and/or regional offices developing new 2010 – 2015 strategies? If so, will they be synchronized with LAC/RHP’s and LAC/RHD’s?
   i. Assuming that each LAC country/regional program has, or will be developing new strategies, how do these strategies work within and under national (country) strategies? If they do, how so? If they do not, why not? These are really important questions and we
should discuss to what extent the LAC Regional Health Program should be involved in assessing “country ownership” questions for the missions’ health programs. We do review operational plans and performance reports. We provide a lot of TA to mission health teams. Missions have a great deal of autonomy, and our role is mainly to provide guidance/support.

j. What opportunities exist for collaboration, partnership with the above? Do other actors have an advantage in any areas currently being addressed by the LAC-RHP team? Are there opportunities for LAC-RHP’s involvement to expand its partnerships, collaboration of effort (not duplication of effort), teamwork, etc?

State:

OGAC
Biosecurity Engagement Program
Office of Environment & Science

CDC:

Coordinating Office for Global Health (COGH)
Global AIDS Program (GAP)

HHS:

Office of Global Health Affairs

DoD:

SouthCom
Peace Corps

Others

2. RHP Organization: Given Point 1 above and its possible implications for the LAC Bureau and LAC-RSD, should the LAC-RHP organize itself differently?

a. Change its unit structure or staffing?

b. Change its distribution of effort/emphasis? If so, why? How?

c. What is the best role for the technical advisors? Are there functions that could be performed by different types of staff/mechanisms?

3. Advancing Relationships and Coordination with USAID/Washington and Missions:

a. Improved Coordination within USAIDW: Are there opportunities which should be explored to coordinate/collaborate more effectively with other geographic bureaus, but especially with the Global Health Bureau?

b. Do country population/health/nutrition strategies and/or programs work with other Mission strategies or activities where relevant? E.g., economic growth, education, civil society, etc.? This is also a good question. Should our RHP be looking at ways to promote/encourage cross-sectoral programming? What would be the issues involved in doing so? We can discuss this on January 6th.
c. Has LAC communicated with Missions regarding this assignment, especially the development of a new multiyear strategy, and if so what feedback have they received? We have not yet communicated with them in a systematic way about the assessment—but agree that it will be critical to get their feedback about various aspects of the RHP’s performance.

4. Future Programming (Team will consider information gathered in the key informant interviews):
   a. What proportion of time should the LAC-RHP team spend on strategic planning, policy, technical assistance, coordination, etc?
   b. What types of specific technical interventions should be prioritized within the key technical focus areas?
   c. What are the major unmet needs in health programming in the region that could be appropriately addressed through the regional program (rather than, or in addition to, bilateral programs)?
   d. What are the major needs of the LAC mission and subregional programs that the RHP could help address? Status of USAID’s new hiring of new staff, role of LAC/RHP in training of staff, and future and realistic staffing prospects for LAC-RHP and LAC Missions? How does USAID currently assign staff to overseas assignments? Is LAC/RHP involved?
   e. How could the RHP develop synergies between health and other LAC/RSD development programs to further regional priorities and objectives? What could reasonably be achieved with current staffing patterns and what might need new staff or new skills sets to achieve?

5. New Technical Focus Areas: Are there ways to maintain some involvement in areas such as chronic and noncommunicable diseases or key neglected diseases (Chagas, dengue) indirectly, if we receive no funding in those elements?

NOTE: Given the increases in chronic diseases and the importance of addressing a range of chronic diseases, and the long-term costs to national health budgets, chronic diseases should be carefully considered for the LAC region. The Team should review the data on various chronic and infectious diseases and weigh priorities and interventions. Chronic diseases—diabetes, heart disease, hypertension, obesity, and cancer—are major causes of morbidity and mortality. Behavioral risk factors which contribute to these conditions include poor nutrition, lack of exercise, smoking, and not practicing healthy life styles.

6. Based on what, if anything, within/across countries has been achieved thus far with GDAs (or similar agreements), does the development of public–private or Global Development Alliance (GDA) partnerships make sense at the regional level?

7. Which countries or subregions should be the focus of regional efforts? Should this vary by technical area? Should different levels of programming be provided to presence vs. non-presence countries?

8. What major assumptions underlie the strategy? What are the likely consequences if one or more of these assumptions does not hold true? How can the strategy be made resilient and robust?
9. Is the health program more or less susceptible to uncertainties if it is designed in an integrated way with other USAID programs (e.g., pop-health-environment activities, co-location of health and democracy interventions)? With other donor health programs?

10. Based on the findings of the assessment, what implementation approaches should be replicated/scaled up?

11. What are the implications of the new programmatic recommendations for LAC Health Team staffing? How can this program be most efficiently implemented and managed?

   NOTE: This will depend on USAID’s current hiring, training, and assignment of staff.

12. Future Partnerships: Is LAC/RSD open to new or different partnerships/implementing mechanisms for its regional activities, e.g., a different relationship with PAHO, a LAC/RHP specific technical assistance contract or cooperative agreement, etc?

13. New LAC-RHP Strategy and PMP – Monitoring and Evaluation: What are appropriate results-oriented indicators by which to judge the success of the new strategy? Would the same indicators be used by all implementing partners, Missions, and Regional Programs so that data could be analyzed across countries and, perhaps, regions?

14. MDG Goals: What relationship do Mission HPN offices have to MDG goals in their countries? If so, how? If not, how could country programs be better aligned to assist in achieving MDG goals? Very good question—only recently has the USG come out emphatically in favor of the MDGs. We should discuss whether we (the RHP) could have a role in focusing USAID health investments in LAC to achieve them—or whether the missions and RHP are already doing as much as possible.
APPENDIX B. SCOPE OF WORK FOR ASSESSMENT OF USAID/LAC/RSD HEALTH PROGRAM AND DESIGN OF A NEW HEALTH STRATEGY

October 15, 2009

I. OBJECTIVES AND PURPOSE OF ASSIGNMENT

The Regional Sustainable Development office of USAID’s Latin America Bureau (USAID/LAC/RSD) seeks assistance from GH Tech for a two- to three-month assignment that will yield:

1. An assessment of the current LAC/RSD Regional Health Program’s (RHP’s) performance and situation, including an examination of the program’s fundamental purpose and its aptness for the environment in which it is now operating

2. A preliminary design for a new RHP strategy for the 2010–2015 period, based on the findings of the assessment

3. The active participation of the LAC health team will be key for both of these components, and facilitating this participation should be considered a third component of this assignment.

II. PERFORMANCE PERIOD

This assignment is envisioned to begin in early November 2009 and to be completed by mid-February 2010.

III. FUNDING SOURCE

The assignment will be funded through field support to GH Tech, using funds from multiple elements under the Global Health and Child Survival account.

IV. BACKGROUND

Health in the LAC Region. The LAC Region has made great progress over the last three decades in the areas of public health on which USAID focuses—reducing infant and child mortality, increasing the use of voluntary family planning and reproductive health services, and controlling the spread and impact of infectious diseases, including HIV/AIDS. USAID’s investments in the region have been an important contributor to those advances. Public health and health care infrastructure and human capacity in the LAC region are relatively well-developed when compared to many developing areas of the world.

However, there is considerable unfinished business in public health in LAC, which continues to undercut the development of the people of the region. Income disparities in Latin America between the wealthy and the poor are the most extreme in the world, and that reality is directly reflected in health disparities—something which is not apparent in conventional health indicators represented as national averages. Public investment in health and education is far too low in most LAC countries to provide quality basic health services to the poor. Conflict and corruption continue to destabilize many LAC countries, in turn undermining public health and other social programs. Girls and women suffer from widespread gender-based discrimination that affects access to health information and services. The many indigenous groups throughout the region constitute an excluded underclass that has markedly worse health status. And international donor agencies have greatly reduced their assistance to LAC countries during this decade, or left the
region altogether. USG assistance has declined dramatically, but it is the largest bilateral donor for health in the LAC region.

USAID’s LAC health programs will face several major challenges in the next 5–10 years. USAID plans to phase out support for most of its bilateral family planning programs in the region, making it imperative to strengthen in-country systems needed to sustain those programs. USAID will also continue to support broader health systems strengthening to enable countries to extend quality primary care services to the poor and effectively oversee the health sector. High levels of chronic childhood and maternal malnutrition persist in many areas in LAC, as well as recurrent localized bouts of acute food insecurity. USAID may increase investments in nutrition and food security in the region, and maximizing their impact will be crucial for improving the health status of the poor. USAID will continue to coordinate closely with and support the region’s governments in preparing for and managing emerging pandemic threats. USAID will expand work in LAC countries to control selected neglected tropical diseases and participate in a campaign to eliminate onchocerciasis from the region. USAID will continue to support programs to stop the spread of HIV/AIDS, especially among most at risk populations (MARPs), and to control tuberculosis. The RHP will continue to collaborate with the USAID/Peru Mission to manage the Amazon Malaria Initiative (AMI).

The LAC Bureau’s Health Programs. USAID’s LAC Bureau operates bilateral missions in 17 countries in the hemisphere, and 13 of these have health programs. There are also 3 LAC subregional (multicountry) programs that address health. In addition, USAID/Colombia runs a health program for internally displaced persons (IDPs) that is funded via the State Department. The LAC Regional Health Program (the focus of this assignment) is based in the LAC Bureau’s Regional Sustainable Development Office in USAID/Washington, which also includes technical teams for education, economic growth, environment, and democracy. A new RSD Office strategy will be in development concurrently with this health assessment and strategy effort, and opportunities for cross-sectoral programming will very likely be generated by that process.

The RHP receives congressionally earmarked funding to work in these technical areas: HIV/AIDS, Tuberculosis (TB), Pandemic Influenza, Neglected Tropical Diseases, Maternal and Child Health, Family Planning, and Reproductive Health. The RHP uses funding from multiple earmarks for Health Systems strengthening activities.

The RHP consists both of defined activities or projects implemented through contracts or grants, and extensive direct provision of technical assistance by RHP staff. Contracts and grants are of two types: those that are designed and managed by the RHP team and those that are based in the GH Bureau, which the RHP —b uys into‖ but whose LAC-specific implementation is overseen by the RHP team. The table below shows the activities that make up the current RHP.

<table>
<thead>
<tr>
<th>RHP ACTIVITY</th>
<th>LAC MECHANISM</th>
<th>GH MECHANISM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning and Contraceptive Security</td>
<td>n/a</td>
<td>JSI/Deliver; HPI/The Futures Group</td>
</tr>
<tr>
<td>Maternal/Neonatal Mortality</td>
<td>PAHO Primary Health Care Grant;</td>
<td>BASICS, POPPHI [MCHIP], CDC, USP</td>
</tr>
<tr>
<td>Pandemic Influenza</td>
<td>PAHO Primary Health Care Grant; Links Media</td>
<td>Stop AI, AI Comm, CDC</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>PAHO Primary Health Care</td>
<td>n/a</td>
</tr>
<tr>
<td>Antimicrobial Resistance</td>
<td>PAHO Primary Health Care Grant</td>
<td>n/a</td>
</tr>
<tr>
<td>RHP ACTIVITY</td>
<td>LAC MECHANISM</td>
<td>GH MECHANISM</td>
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<tr>
<td>Global Fund and Other TA for HIV/AIDS</td>
<td>n/a</td>
<td>AIDSTAR One; The Capacity Project.</td>
</tr>
<tr>
<td>Cross-cutting &amp; Health Systems</td>
<td>4th Sector Health; PAHO Primary Health Care Grant</td>
<td>Measure Evaluation; Global Health Fellows; AIM</td>
</tr>
</tbody>
</table>

The RHP currently has a staff of six: a Senior Advisor for Family Planning and HIV/AIDS; a Senior Advisor for MCH and Infectious Diseases; a Senior Advisor for Health Systems Strengthening; a Global Health Fellow for Pandemic Influenza; a Franklin Fellow for Neglected Tropical Diseases; and a team leader who is a Foreign Service Officer.

The work done by the RHP staff is wide-ranging and includes managing RHP activities; providing guidance and support to LAC missions and subregional programs (both from Washington and in-country); providing information to LAC Bureau offices and leadership; coordinating with the Global Health Bureau; maintaining up-to-date technical expertise; tracking regional health trends; participating in technical and policy-making committees; helping to find and develop new funding for health through facilitating public-private alliances and other means for leveraging funding; supporting South-to-South exchanges; and disseminating best practices.

Several of the RHP’s technical activities are implemented under a grant by the Pan American Health Organization (PAHO). The working relationship between USAID and PAHO has been a main feature of the LAC Bureau’s health program for over a decade. The upcoming assessment process will allow a review of the productivity of that relationship and consideration of how it might be more effective.

“Whole of Government Approach.” The Obama Administration is emphasizing a “whole of government approach” to international development, which will require effective coordination among USG agencies in most of the health areas in which the RHP is likely to work. Among other civilian USG agencies now active in international health are the Centers for Disease Control, and Office of Global Health Affairs within the Department of Health and Human Services; the Office of the Global AIDS Coordinator, the Biosecurity Engagement Program, and the Office of Environment and Science within the State Department. In addition, during the life of the 2004–2009 RHP, the Executive Branch initiated far closer coordination between USAID and the Department of Defense. In the Western Hemisphere, there is now regular interaction between the LAC Bureau and Southcom. The RHP has supported a series of Southcom activities, including the multicountry good-will tour of the US Navy hospital ship —Comfort.”

**The Global Health Initiative – the New USG Context.** The magnitude of global health challenges and the established capabilities of U.S. assistance to address health in developing countries were recognized by the Obama Administration in its announcement on May 5, 2009, of the Global Health Initiative (GHI), which budgets $63 billion for USG assistance in international health over six years, from FY 2009–14. Five principles that are to guide program implementation under the GHI are

- Country ownership
- Sustainability and health systems strengthening
- A women-centered approach
- Strategic integration and coordination (among USG health programs; with other development sectors; with other development partners)
- Improved metrics, monitoring, and evaluation.
USAID/W health staff is currently participating in the Administration’s review of the design, organization, and control of all USG international health programs and the distribution of budget resources among USG agencies. The operational implications are yet to be determined. The LAC health team will convey any pertinent new information that arises from this process to the GH Tech team.

Other Administration initiatives which the LAC health team expects to incorporate into the new RHP strategy are the Food Security Initiative and the Global Climate Change Initiative. More information about these initiatives (and perhaps others) will be provided to the GH Tech team over the course of the assignment.

V. SCOPE OF WORK

This assignment comprises three main components, as described below.

(1) Assessment of the LAC Regional Health Program 2004–2009: Completed Activities, Current Environment, and Recommendations for the Future

Part (A) will be a primarily qualitative assessment of the LAC Bureau’s 2004–2009 Regional Health Program (RHP). It will provide an analysis of what did and what did not work well, and why. It will examine the overall design of the RHP, technical approaches selected, implementing mechanisms used, utilization of the team’s own technical advisors, and progress made toward program objectives over the period. The GH Tech team will also evaluate the success of the RHP in partnering with other organizations (especially PAHO), and catalyzing and leveraging the commitment of public and private institutions toward the RHP’s goals. The assessment will take into account the budget and policy constraints within which the RHP must operate.

Part (B) will include an examination of the purposes (the raison d’être) of the LAC Bureau’s health program. A preliminary list of its —routines‖ or dimensions is provided here: (1) support of USAID’s mission health programs and teams in the LAC Region; (2) technical leadership on health issues/conditions that are priorities for Latin America; (3) truly regional programming (that which is best done at a regional level due to economies of scale, etc); (4) promotion of key regional health policies and international partnerships; (5) effective participation in multisectoral or cross-cutting development initiatives of the RSD office; (6) provision of mentoring and training for new USAID health staff and fellows; (7) demonstration of USG commitment to and engagement in the LAC Region. The assessment process may identify additional rationales, or modify these.

Part B will also describe the most important features of the environment in which the LAC RHP now operates, and identify implications and opportunities for the program going forward. Among these features may be USG and USAID policies; budget levels; PAHO’s strategic plans; cross-sectoral approaches being developed in the RSD office; the situation and needs of health programs in the field missions; and the USG’s —whole of government‖ approach.

The assessment document will present a summary and analysis of the extensive information gathered by the GH Tech team via interviews, meetings, and document review. It will provide well-supported recommendations related to both (A) and (B), including how the RHP should be oriented going forward; what in the current program should be preserved, modified, or jettisoned; what could be done more effectively; and what new focus areas (if any) would be appropriate for the 2010–2015 program.

Under this contract, the final Assessment document will be submitted to USAID’s Center for Development Information and Evaluation (CDIE).

Based on findings from the Assessment, the GH Tech team will work with the LAC Health Team to develop a preliminary strategy document for the next LAC regional health program, 2010–2015.

The strategy will describe the appropriate mix and weighting of rationales that should orient the RHP going forward. Working with the LAC health team, the GH Tech team will identify the most important foci for regional intervention and develop program approaches for those areas. Using the “F” framework (including technical elements and sub-elements) as a basis, the GH Tech team will develop a draft results framework for the 2010–2015 strategy, and outline how indicators will be monitored during the life of the strategy. The new strategy will incorporate RSD multisectoral initiatives in which the RHP will collaborate and reflect the “whole of government” approach as appropriate. The strategy will treat the technical assistance supplied by the RHP advisors as an explicit part of the program and plan for its best use.

The draft strategy prepared by GH Tech will be an internal working document. While it must be a high-quality professional document, it will not require final editing and formatting by the GH Tech corporate office.

(3) Active Engagement of the LAC Health Team

The LAC health team itself has the most in-depth familiarity with the RHP overall, including its place in the USAID/Washington bureaucracy and in terms of practical issues that affect its day-to-day implementation. To maximize its access to the insights of the LAC health team, the GH Tech team will design and carry out a process to tap LAC team members as a group and individually at important points in the assessment and strategy development processes.

An important benefit to the LAC health team of this assessment/design process will be the opportunity to entertain new ideas and information relevant to public health and development in the LAC region. The GH Tech team will facilitate sessions for the team to discuss health issues especially relevant to LAC with both GH and external experts. It will also be useful to discuss the role of regional health teams with the health team leaders of the Africa, Asia/Middle East, and Eastern Europe Bureaus. The GH Tech team will arrange a set of meetings developed in consultation with the LAC health team leader.

VI. METHODOLOGY

The work for this assignment is to be done primarily in Washington, DC. Initial meetings between the GH Tech team and the LAC health team will determine the most feasible way to assess RHP impact in the field. If field visits are required, they will be added via a separate agreement with GH Tech.

We propose these key steps for the GH Tech team to accomplish this assignment:

1. The Assessment: detailed planning for how to obtain adequate RHP performance information; document collection and review; oral data collection; regular discussions with LAC health team; summarizing and interpretation of data; writing and addressing any gaps; sharing draft document with the LAC health team for comment; finalizing the document.

Data collection will involve a combination of document review, interviews, and meetings (one-on-one and group meetings with the LAC health team, facilitated roundtables on specific topics with experts, consultations with mission staff, etc.) Whether the RHP can be adequately assessed from Washington will be determined in initial planning meetings.
The assessment will be primarily qualitative, but it should summarize results for major quantitative indicators that reflect changes over the implementation period.

The LAC health team will provide the GH Tech team with core documents prior to the start of the assignment, including RHP project documents, the RHP’s Performance Monitoring Plan and related reports/analyses, Annual Performance Reports (FY05–FY09), and additional project documents and materials to help the GH Tech team gain familiarity with the program vision, structure, and activities.

The GH Tech Team’s full document review should also include recent documents on the health situation in the region; relevant documents on Agency policy and guidance as available; and policy/planning overviews for other major institutions working in the region, especially PAHO. The LAC health team will assist the GH Tech team in identifying a manageable set of pertinent documents; some of the research will be done by the GH Tech team itself.

Recommendations regarding the weighting of program rationales and identification of major environmental factors affecting the RHP will be based on the accumulated information reviewed for the assessment plus guided discussions with the LAC health staff.

2. *The Draft Strategy*: consultation with the LAC health team and other relevant players regarding assessment findings; development and writing of a coherent strategy approach and specific implementing mechanisms; development of a results framework consistent with the Foreign Assistance Framework; —ground-truthing” the approach with key players; and finalizing the draft document.

3. *Engagement of the LAC Health Team*: Initial brainstorming session with the LAC health team to gather ideas and identify experts for the assessment and strategy components; extended interviews with the team members regarding their areas of specialization, their current work, and their views on work needed over the next five years; team meetings to discuss rationales for the RHP and issues for the strategy; team meetings to discuss project objectives, implementation mechanisms, and results; consultation with the team leader at least twice per week during the assignment; review of documents for comment.

The GH Tech team leader will meet and/or communicate with the LAC health team leader on a regular basis throughout the assignment to discuss the progress of the assignment.

**VII. TEAM COMPOSITION, SKILLS, AND LEVEL OF EFFORT**

We propose that the GH Tech team be composed of three experienced international health consultants, one of whom will serve as the Team Leader. The group should be fully capable of organizing large amounts of information and thinking both conceptually and practically about the topics covered in this assignment. As a group, the GH Tech team should have a strong technical background in health; experience in program evaluation and strategy design for USAID health programs; a solid understanding of the Latin American context and familiarity with its national health systems; and demonstrated effective interpersonal and teamwork skills. Together, the team should be well-acquainted with USAID programming approaches in maternal and child health, family planning, infectious diseases, and health systems strengthening.

Each team member should have an advanced degree (Masters or above) in public health or an applicable social science field. Each team member should be able to speak and read Spanish. The Team Leader must have prior experience leading design teams for USAID assignments and have outstanding English writing skills.
Work will be performed between November 2009 and mid-February 2010. A six-day work week is authorized. The distribution of effort within the overall time frame may be adjusted as necessary, based on discussion with the LAC health team leader.

VIII. LOGISTICS
GH Tech will handle all aspects of the travel arrangements for its consultants.

IX. DELIVERABLES AND PRODUCTS
The team will provide the following products and deliverables.

1. Initial Workshop with LAC Health Team – within first week of assignment. Note that additional workshops may be scheduled as needed.

2. Workplan for the three components (Assessment; Strategy; and LAC Health Team Engagement Plan) – within 10 days of beginning the assignment. The workplan will describe how assessment data will be collected, and will advise regarding whether data collection in the field will be necessary. The workplan will include outlines for the Assessment and Draft Strategy documents.

3. Assessment Document – by mid-January 2010. The main body of the report should not exceed 30 pages (single spaced; 1-inch margins; font size 11) excluding executive summary and annexes. LAC/RSD shall receive an electronic version (Microsoft Word format on CD) and 10 hard copies of the assessment report; CDIE shall receive copies as required by the Automated Directive System.


X. RELATIONSHIPS AND RESPONSIBILITIES
GH Tech is responsible for identifying GH Tech-funded team members with the skills and experience described above, negotiating the final team composition with LAC/RSD, and entering into contracts with the team members. GH Tech will provide organizational and administrative support to its team. Other GH Tech responsibilities are included under VII. Logistics, above. The GH Tech team and home office are responsible for maintaining regular communication with the LAC health team leader about the progress of this assignment and apprising her in a timely way of significant problems that may arise.

The LAC Health Team will provide names and contact information for key contacts as well as relevant USAID, host-country government, and partner documents to GH Tech for copying and distribution to the team. To the extent possible, documents will be provided electronically. Team members will cooperate and collaborate with the GH Tech team to arrange meeting times, provide requested information, and review documents in a timely way.

XI. POINTS OF CONTACT
The principal point of contact on technical issues for GH Tech and for the Team Leaders will be the Team Leader of LAC/RSD’s Health Team. In her absence, the Deputy Team Leader will be the point of contact.
XII. ANNEXES

A. USAID Bilateral and Sub-regional Health Programs in the LAC Region

B. Illustrative questions to guide development of the Assessment and Draft Strategy – **THIS ANNEX WAS REVISED OVER THE COURSE OF THE ASSIGNMENT AND IS A SEPARATE APPENDIX IN THE ASSESSMENT REPORT. THUS, IT IS DELETED FROM THE ORIGINAL SOW.**

C. Description of the Regional Health Program from the FY2009 Operational Plan.

ANNEX A. COUNTRIES IN THE LAC REGION WITH BILATERAL (USAID MISSION-BASED) HEALTH PROGRAMS AND MAJOR TECHNICAL AREAS ADDRESSED BY USAID

- **Bolivia** – MCH, FP, HIV/AIDS, TB
- **Dominican Republic** – MCH, FP *, HIV/AIDS, TB
- **El Salvador** – MCH, FP *, HIV/AIDS
- **Guatemala** – MCH, FP, HIV/AIDS
- **Haiti** – MCH (Priority), FP, TB, HIV/AIDS
- **Honduras** – MCH, FP *, HIV/AIDS
- **Nicaragua** – MCH, FP *, HIV/AIDS
- **Peru** – MCH, FP *, HIV/AIDS, TB
- **Paraguay** – FP/RH*
- **Brazil** – HIV/AIDS and TB
- **Jamaica** – HIV/AIDS
- **Mexico** – HIV/AIDS and TB
- **Guyana** – HIV/AIDS

All countries benefit from regional pandemic influenza and antimicrobial resistance monies. All countries also benefit from subregional malaria monies.

*Countries with a Plan for Graduating from USAID Family Planning Assistance.

USAID Subregional Health Programs In the Lac Region

**HIV/AIDS**

- Central American Program (based in Guatemala)
- Caribbean Regional Program (based in Barbados)

**Malaria**

- Amazon Malaria Initiative (based in Peru)

**Infectious Disease & Antimicrobial Resistance**

- South American Infectious Diseases Initiative (based in Peru)
ANNEX C. CURRENT LAC/RSD HEALTH PROGRAM ACTIVITIES

Notes:

- The discussion below is excerpted from the LAC FY 2009 Operational Plan that describes how the LAC Health Program planned to spend the funds allocated to it. It is organized by program element.

- For two other health elements, “Avian and Pandemic Influenza.” and “Other Public Health Threats—Neglected Tropical Diseases,” funding and implementing mechanisms are managed in the Global Health Bureau. The LAC RHP collaborates closely with GH on the application of these activities in the LAC region.

- The LAC RHP staff performs a wide range of tasks beyond managing the activities listed below.

HIV/AIDS

USAID works closely with other U.S. Government agencies under the President’s Emergency Plan for AIDS Relief and with local and international partners to implement prevention, care and support, treatment, surveillance, program monitoring, and evaluation activities. Two countries in the region, Guyana and Haiti, were priority focus countries for the first five years of the Emergency Plan and still receive the largest amounts of HIV/AIDS funding of any LAC countries.

HIV/AIDS remains a major problem in LAC, with the Caribbean experiencing the highest HIV prevalence and Brazil the largest number of cases. HIV/AIDS reduces workforce productivity, which limits the USG’s ability to achieve foreign assistance objectives related to economic growth. HIV/AIDS is a clear USG priority and the impact of the disease has implications for domestic and foreign U.S. security objectives.

The Regional Program’s HIV/AIDS efforts identify, document, and disseminate innovative programmatic HIV/AIDS practices on prevention, treatment, care, and support. Activities improve the success of Global Fund to Fight AIDS, Tuberculosis and Malaria grants; leverage alliances with public and private partners to fight the epidemic; improve the functioning and sustainability of professional training programs; and support missions without HIV/AIDS programs to influence national HIV/AIDS program direction and ensure quality counseling and testing services.

The PEPFAR reauthorization legislation calls for —Partnership Framework” agreements as a way to move from an emergency plan to combat HIV/AIDS to a more sustainable approach characterized by strengthened country capacity, ownership, and leadership. Selected LAC Missions (the Caribbean and Central American Regional programs, the Dominican Republic, Guyana, and Haiti) have been asked to prepare these 5-year joint strategic frameworks for cooperation between the USG and the host government to combat HIV/AIDS and strengthen health systems, with transparency, accountability, and the active participation of other key partners from civil society, the private sector, other bilateral and multilateral donors (e.g., the Global Fund), and international organizations. The Regional Program works with the selected missions to develop and implement these partnership frameworks. However, given this changing structure of HIV/AIDS programming in the region, we will also conduct an assessment to determine how regional funds can best be adjusted so that programming continues to complement local efforts and/or leverage additional support within the region.

Current-year activities will build on efforts begun this past year to develop and disseminate technical briefs, case studies, and other publications including development of a web-based
annotated bibliography on innovative and promising HIV/AIDS practices. As the HIV/AIDS epidemic in the LAC region differs from that seen in many PEPFAR programs, there has been little emphasis to date on many issues which are seen as important to controlling the epidemic in this region. Topics to be expanded on include those related to prevention programs among most vulnerable populations in LAC. These populations include men who have sex with men, commercial sex workers, most-at-risk youth, prison populations, and people living with HIV/AIDS. Findings from this work will be disseminated through regional technical consultations, which it is anticipated will in turn lead to the development of improved policies, programs, and research on the most vulnerable populations.

We will continue to offer technical assistance to country-level HIV/AIDS programs. Selected Global Fund grants that are having difficulties meeting performance targets will receive technical assistance in such areas as organizational development, monitoring and evaluation, and program planning and implementation. We will also continue to expand the reach of the Human Resources for Health Action Framework to develop and implement strategies for an effective and sustainable health workforce. The Regional Program supported the adaptation of this global framework to the LAC region through a successful pilot test in Peru, and the effort will now be expanded to other countries.

**TB**

The LAC Regional Program uses funding in the Tuberculosis element to support activities with the Pan American Health Organization (PAHO) which improve quality of care in the region and employ a “primary health care” approach to strengthening health systems and services. Over the long term, PAHO is expanding prevention, treatment, and care interventions for tuberculosis focusing on integrated training and service delivery; wider service provider networks; strengthened laboratory capacity; and better linkages with other health services, per the primary health care approach. As this is the last year of the current grant agreement with PAHO, the regional program will include the topic of tuberculosis into region-wide assessments to help inform future programming directions.

A major ongoing theme of the program has been the tuberculosis residency program, which enhances leadership in the community of tuberculosis professionals by bringing country-level tuberculosis experts to PAHO for a year to learn about region-wide issues and build capacity and experience contributing to the global state of the art from a regional perspective. The current tuberculosis resident recently completed a descriptive study on tuberculosis in prisons which uncovered critical gaps and poor programs in prisons of the region. With almost 3.5 million prisoners per year in the Americas, this is a huge group of exposed persons in confined quarters, an excellent incubator for propagation of tuberculosis, multi-drug-resistant and extensively drug-resistant tuberculosis. They experience tuberculosis at more than 22 times the rate of the general population of the Americas. A major focus this coming year is publication of the study findings in both the health and judicial system literature, developing an approach to strengthening of prison laboratory services, urging countries to provide directly observed therapy short-course tuberculosis therapy, and more screening of inmates for both tuberculosis and HIV.

PAHO’s ongoing tuberculosis work also includes strengthening the laboratory network for technical assistance to national labs, training regional tuberculosis consultants, and working to integrate public and private providers in tuberculosis control activities, including tuberculosis/HIV collaborative activities. As results of several country studies on drug-resistant tuberculosis become available, activities to both publicize and address issues uncovered will continue.
Tuberculosis element funding also contributes to Regional Program Health Systems Strengthening efforts with PAHO, which are co-funded from other elements and described in the key issue for Health Systems Strengthening.

**MCH**

The LAC Regional Program takes an innovative approach to Maternal and Child Health element issues. The Regional Program leads the way for high-impact programming in the LAC setting. However, region-wide, funding in this element is declining. Additionally, this is the last year of the current grant agreement with the Pan American Health Organization (PAHO). Therefore, we will assess the MCH program with respect to unfinished issues at both the regional and bilateral levels to adjust programming to more directly support bilateral efforts and/or help ensure the sustainability of bilateral advances.

MCH work builds on past investments addressing key factors which contribute to maternal and neonatal mortality. Previously, we disseminated research on post-partum hemorrhage prevention and treatment demonstrating that a highly effective, low-cost, and low-skill technique was poorly implemented in four Central American countries. This information galvanized local efforts. We will continue to diffuse this information through professional societies, regional task forces, and PAHO Collaborating Centers. An innovative project on real-time reporting of maternal mortality in Colombia will end its pilot phase and move to countrywide scale-up. By the end of the year, the tools will be available in English and Spanish and shared with the World Health Organization for replication in other regions. We will also begin replication of this innovation in another LAC country. Finally, we will begin to focus efforts on the second highest killer of pregnant women, pregnancy-induced hypertension, through an initial assessment of current situation and practices in the region.

Newborn mortality also remains a concern in the region, as mortality rates have been stagnant for more than a decade. The Regional Program facilitates a three-country initiative to address neonatal infection. Local country hospital teams are connected through bimonthly “webinars” so that countries can discuss technical issues and share “face to face” innovative approaches to the reduction of hospital- and community-based newborn infection. The combination of local in-country contact and use of web-based software has fostered active participation and inter-country healthy competition. As an outgrowth of this effort, the program will support a South-to-South exchange between the three target countries and the Colombia program of constant mother-to-child skin-to-skin contact—“Kangaroo Care” for the high-risk neonate.

Regional efforts have uncovered two unaddressed issues affecting maternal and neonatal mortality: drug quality and overuse of technology. The quality of obstetrical emergency drugs in the LAC region from warehouse to user is unknown. Key drugs used to prevent and treat hemorrhage and pregnancy-induced hypertension are sensitive to heat, humidity, and delay in administration. Anecdotally, high doses of medication are being needed to produce the required effect. There is heightened concern that fake and substandard drugs are prevalent through both public and private sources. Therefore, we plan to begin drug quality studies in one to two countries of obstetric emergency drugs. Results will help to inform future directions within the region and in developing an Agency strategy regarding drug quality. The overuse and misuse of technology is also emerging as a key issue regarding unfavorable outcomes for mother and newborn. Elective use of cesarean sections, repeated ultrasound exams, elective induction of labor, and routine use of regional anesthesia in normal births are a few of the issues causing concern. Complex health systems issues related to the workforce and uninformed clients are a few of the issues leading to these practices. We will conduct an initial literature review on this issue.
Increasing access to and use of high-quality voluntary family planning and reproductive health (FP/RH) services is one of the most effective approaches to reducing maternal mortality.

Historically, fertility declines have preceded economic success in every major country. Preventing unwanted pregnancy ensures that each child is wanted and households have more resources to invest in education and health. The LAC region has experienced a remarkable increase in the demand, offer, and use of family planning, and therefore the Agency has begun a phase-out of several bilateral family planning programs. Currently, six countries are implementing phase-out plans. All six countries will have completely phased out of family planning by 2013. We support this phase-out process by working with international, regional, and national partners to address program sustainability. However, as the phase-out process progresses, we may need to develop new programs to provide targeted support to those countries that have recently graduated. We will assess the opportunities to focus our future programming so that needed support is available for countries with ongoing priority programs, countries in the phase-out process, and those countries that have recently graduated.

Current efforts support countries in the need to secure long-term financing for family planning services and commodities to enable the sustainability of program gains. Our program pioneered this work over the past six years and has made significant progress in increasing the capacity of governments to achieve contraceptive security. In several countries, the program fostered the creation of contraceptive security committees, including representatives from the public, private, and donor sectors. Several of these committees have secured financing for the purchase of contraceptives, and all have improved the logistics for ensuring contraceptive supply. Regional activities ensure that innovations in family planning sustainability (including a more diversified, secure funding base) and lessons learned are widely shared and adapted. We also work with donors and commodity manufacturers to ensure that the lowest possible prices can be obtained across the region. Finally, we work to strengthen governments and civil society to help couples achieve the fertility goals they have set.

This year we will continue to support efforts toward contraceptive security, particularly in the six countries being graduated from family planning. Activities planned include continuing to provide technical assistance to national contraceptive security committees through on-site technical assistance, publications, and regional workshops. We will also provide small grants to 3 to 6 countries to implement action plans that improve equity in family planning. We will enhance communication and information-sharing among regional contraceptive security committees and further efforts to understand the equity dimensions of family planning phase-out through analytical work and policy dialogue to reposition family planning strategies in LAC, with a focus on vulnerable populations.

Finally, our program provides leadership and coordination among donor organizations regarding the future of Demographic and Health Surveys. These surveys and the technical assistance to conduct them are almost wholly funded by USAID, yet the results provide a source of health information for countless national and international organizations. Furthermore, the continued availability of this information is key to monitoring country progress and sustainability post-graduation. Therefore, there is an urgent need to address this issue once USAID funding is reduced in the region. We will continue to develop a “social network” for demographers. This online community, which will be formally launched this year, virtually links together survey demographers to exchange expertise and best practices related to the conduct of population-based health surveys. At best this effort will reduce the need for technical assistance in conducting these surveys but does not completely address the sustainability issues, since the identification of ongoing funding remains a serious constraint.
Health Systems

The Regional Program (RP) funds health systems strengthening (HSS) through the Maternal and Child Health and Tuberculosis elements. The RP supports the PAHO to employ a "primary health care" (PHC) approach to HSS. The PHC approach seeks to integrate family and community-level actions with health systems interventions and to prioritize the extension of basic health services to the entire population. The RP support of the PHC approach includes activities aimed at improving both health systems and vertical interventions for the benefit of the most vulnerable groups. This combination of "vertical" and "horizontal" approaches takes into account the need for quality services along the full continuum of care and is known as the "diagonal" approach to HSS.

In particular the RP works on HSS with PAHO to improve the "steering role capacity" of the National Health Authority (NHA). In the LAC region, the "steering role" is closely associated with health sector governance and includes the ability of the NHA to lead and regulate the health sector while also specifically promoting key principles of effective health systems, such as equity, quality, and responsiveness. In particular, the RP works through PAHO to help countries develop policies and implement strategies which integrate the delivery of services (so that they are not fragmented across independent systems for the public, private, and social security sector or among the primary, secondary, and tertiary levels of care), foment public health capacity and create synergies between targeted programs and systems (the "diagonal" approach). The RP will work with select countries to continually monitor health systems and services through the creation of profiles, improve accreditation of health services, and strengthen the ability of health ministries to lead and regulate the sector. The RP will provide technical assistance (TA) to improve country performance of Essential Public Health Functions. And the RP will provide TA to select countries to integrate service delivery networks.

The RP also supports LAC countries to assess their routine health information systems (RHIS), and develop strategic plans for strengthening them. The assessments begin with the Health Metrics Network (HMN) framework but include in-depth analyses of the organizational and structural dimensions which contribute to weaknesses in RHIS. These efforts have enabled countries to obtain donor and national funding to make the needed improvements to information systems. The RP will work to network countries in the region that are actively working to improve RHIS (supported by either the RP and PAHO or the HMN) to share best practices and other lessons learned. The RP will also continue to provide country-level TA to assess and develop RHIS.

Finally, the RP implements a project to increase the involvement of and funding from private entities in the health sectors through the development of alliances. Specific project activities include identifying and developing public-private partnerships, working with companies to develop and implement corporate social responsibility agendas, supporting cause-related marketing, and developing media and communication alliances to promote public health investment. This project also works to improve the capacities of NGOs and local governments to develop and manage public-private partnerships. Alliances under this project must be multicity in nature and thus have been more difficult to develop. However, the project has signed several memoranda of understanding (MOU). The focus will now move to developing and implementing projects under these MOUs while continuing to seek out regional strategic partnerships.
APPENDIX C. LAC-PHN ASSESSMENT AND STRATEGY DEVELOPMENT

ASSESSMENT TEAM WORKPLAN

(January 4 – February 26, 2010)

- January 4 (Monday): Team Planning Meeting
  - Venue: GH Tech Office
  - Time: 09:00–14:30

- January 5 (Tuesday): GH Tech Team LAC/PHN Workshop planning, etc.
  - Venue: GH Tech Office
  - Time: 08:30–14:00
  - 13:00: Lauren and David meet with Susan to discuss Jan. 6 workshop
  - 14:00 – COB: individual team work

- January 6 (Wednesday: Workshop with LAC/PHN / GH Tech Team
  - Venue: USAID/RRB
  - Time: 10:00–16:00
  - Attendees: GH Tech Team with LAC/PHN Team
  - Host: Susan and LAC/PHN Team
  - Facilitator: David
  - Notes: Lauren and GH Tech Team members

- January 7 (Thursday): 08:30–17:00: reading/working at home

- January 8 (Friday): 08:30–17:00: reading/working at home

GH TECH TEAM BEGINS ASSESSMENT PHASE: JANUARY 11–28

- January 11 (Monday): 08:00 – COB
  - GH Tech Team: work at GH Tech:
    - Complete workplan/schedule and submit to LAC/PHN for review and approval
    - Continue work on reading key documents, data review, meetings, interviews, etc.

- January 12 (Tuesday):
  - 09:30–10:15: Susan Brems, GHB: GH Tech Team with Susan:
  - 11:00–12:00: Doug Ball, LAC/RSD: David, Mellen, Susan: @ RSD
  - 13:00 – 14:00: Regional Bureau Reps (AME, AFR, E&E): @ LAC CR: Sharon Carney, GHB/HR: GH Tech Team
- January 13 (Wednesday): See calendar
- January 14 (Thursday): See calendar
- January 15 (Friday): GH Tech Team works @ GH Tech
- January 18 (Monday): Martin Luther King Holiday – USAID and GH Tech closed. GH Tech Team continues work
- January 19 (Tuesday): See calendar
- January 20 (Wednesday): See calendar
- January 22 (Friday): GH Tech Team works @ GH Tech
- January 25 (Monday): See calendar
- January 26 (Tuesday): See calendar
- January 27 (Wednesday): See calendar (Stock-taking: David/Susan @ 1000)
- January 28 (Thursday): See calendar
- January 29 (Friday): GH Tech Team works @ GH Tech. 1\st draft of Assessment due to LAC/PHN for review/comment

**GH TECH TEAM BEGINS STRATEGY DEVELOPMENT PHASE: FEBRUARY 1 – 26**

- February 1 (Monday): LAC/RHP reviews 1\st draft and prepares comments
- February 2 (Tuesday): LAC/PHN reviews 1\st draft Assessment and shares comments at joint meeting with GH Tech Team on February 3.
- February 3 (Wednesday): GH Tech & LAC/PHN Teams jointly review 1\st draft Assessment → GH Tech Team incorporates comments into draft for second iteration
  - Stock-taking: David/Susan @ 1000
- February 4 (Thursday): GH Tech Team incorporates LAC/PHN comments
- February 5 (Friday): GH Tech Team incorporates LAC/PHN comments
- February 8 (Monday): 2\nd draft of Assessment due to LAC/PHN
- February 9 (Tuesday): See calendar
- February 10 (Wednesday): GH Tech & LAC/PHN Teams jointly review 2\nd draft Assessment → GH Tech Team incorporates comments into draft for second iteration
  - Stock-taking: David/Susan @ 1000
- February 11 (Thursday): See calendar
  1. Where are we now? [2004–2009] – The Assessment Report will provide structure and guidance to this section
2. Where do we want to be in the next 5 years [2010–2015]?

3. How will we get there?

4. Will it all be worthwhile?

- February 15 (Monday): President’s Day Holiday – USAID and GH Tech closed – GH Tech Team continues work – incorporates LAC/PHN feedback into draft strategy
- February 16 (Tuesday): GH Tech Team incorporates LAC/PHN feedback into draft strategy
- February 17 (Wednesday): GH Tech submits initial strategy outline/framework to LAC/PHN
- February 18 (Thursday): See calendar
- February 19 (Friday): GH Tech & LAC/PHN Teams jointly review initial strategy. GH Tech Team incorporates comments into draft for second iteration
- February 22 (Monday) (COB): GH Tech Team incorporates feedback into 2nd iteration of new strategy
- February 23 (Tuesday): GH Tech Team incorporates LAC/PHN feedback
- February 24: GH Tech Team refines 2nd draft strategy
- February 25 (Thursday): Final draft strategy submitted to LAC/PHN
- February 26 (Friday): Wrap up loose ends and complete the assignment
APPENDIX D. INDIVIDUALS, MISSIONS & ORGANIZATIONS INTERVIEWED

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<thead>
<tr>
<th>USAID/Washington</th>
<th>USAID Missions</th>
<th>External Partners</th>
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<tr>
<td>Abby Goldstein, LAC/PHN</td>
<td>Alicia Dinerstein, USAID/Bolivia</td>
<td>Anabella Sanchez, JSI/DELIVER</td>
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<td>Beverly Johnston, GH/PRH</td>
<td>Bradley Cronk, USAID/Guatemala (Reg. AIDS)</td>
<td>Caroline Ramagem, PAHO</td>
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<td>Christy Hanson, GH/HIDN/ID</td>
<td>Caroll Vasquez, USAID/El Salvador</td>
<td>Deborah Armbruster, MCHIP Project</td>
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<td>Douglas Ball, LAC/RSD</td>
<td>Connie Johnson, USAID/Nicaragua</td>
<td>Dr. Bremen De Mucio, CLAP</td>
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<td>Ellen Starbird, GH/PRH/DD</td>
<td>Erik Janowsky, USAID/Peru</td>
<td>Dr. Mario Cruz-Peñate, PAHO</td>
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<td>Karen Nurick, GH/RCS</td>
<td>Nancy Alvey, USAID/Mexico</td>
<td>Dr. Priscilla Rivas-Loria, PAHO</td>
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<td>Patricia Paine, USAID/Brazil</td>
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<td>Kerry Byrnes, LAC/RSD/ECON</td>
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<td>Kevin Pilz, GH/PRH/CSL</td>
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<td>Hugo Gonzalez, UNFPA/NY</td>
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<td>Lindsay Stewart, LAC/PHN</td>
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<td>Marcela Suazo, UNFPA/NY</td>
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<td>Maggie Farrell, GH/PRH/SDI</td>
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<td>Maria Cristina Ramirez, UNFPA/NY</td>
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<td>Mary Ellen Stanton, GH/HIDN/MCH</td>
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<td>Mary Harvey, AFR</td>
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<td>Pierre LaRamee, IPPF/WHR</td>
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<td>Beatrix Plaza, MEASURE Evaluation</td>
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<td>Nahed Matta, GH/HIDN/MCH</td>
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<td>Ann Lion, Abt Associates, Inc.</td>
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<td>Nisha Garg, LAC/PHN</td>
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<td>Scott Radlov, GH/PRH/D</td>
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<td>Wilma Gormley, TRG, Capacity + Proj.</td>
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<td>Susan Bachelor, GH/HIDN/ID</td>
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<td>Susan Thollaug, LAC/PHN</td>
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APPENDIX E. DOCUMENTS REVIEWED

KEY DOCUMENTS
Draft 2002 Health Strategic Objective, 598-zzzz, (2002–11–04)

Activity Approval Document (AAD). Latin America and the Caribbean (LAC) Regional Strategic Objective 598-024: Population, Health and Nutrition Policies and Programs Developed and Advanced in LAC, February 2004

LAC Regional Annual Report, 2005

LAC/RSD Health Team Portfolio Review, December 8, 2005 (consolidated Activity Data Sheets)

LAC Regional Annual Report, 2006

Overview of FY 2007 LAC Regional Program, (RSD_OP_Summary_kwedits)

Amendment to LAC Regional Strategic Plan for FY 2007 and FY 2008 (LAC/RSD strategy amendment to AAD, August 11, 2006)

FY 2007 LAC/RSD Health Operational Plan, Sections 3 and 4, January 15, 2007

Health Section Performance Plan and Report Operating Unit, FY2008 (PPR08 – Investing in People)

Health Section Performance Plan and Report Operating Unit, FY2009 (PPR09 – Health)

Extension of the LAC/RSD-PHN Activity Approval Document (AAD) until 2010 (AAD extension 9-07-2007-ks)

LAC Regional Program – Activity Summary Sheets (undated ppt.)

LAC Region Health Programs, September 2009, (LAC PHN fundamentals presentation Sept 2009.ppt)

Summary of LAC Health Trends Analysis – 2005

LAC Health Trends Analysis 2007

Funding LAC Programs: Western Hemisphere Regional Overview (undated)

OTHER DOCUMENTS
A Story to Tell: Better Health in Latin America and the Caribbean, 2005 Overview of Health Program Activities and Achievements in LAC.

LAC Regional Program: Obstacles and Opportunities or Advancing Transformational Diplomacy (undated)

Summary of LAC Key Health Trends (undated)

USAID Principles of Development and Reconstruction Assistance
Regional Health Program FY 2005-2009 Budget Information for Assessment

List of indicators used by LAC/RSD/PHN (PHN Performance Monitoring Plan)

**AVIAN PANDEMIC INFLUENZA (AI):**


STOP-AI LAC activity summary (STOP_AI_LAC_activity_summary_Sep09)

USAID-PAHO Agreement. AID-07-01//Project between USAID and PAHO on Avian Influenza 2007–2009

Avian Influenza. Power point presentation February 2009 (Front Office API Presentation3.ppt)


Leadership During a Pandemic: What Your Municipality Can Do (toolkit). October 2009

Pandemic Influenza, Regional Context. (LAC AA Briefing Paper.doc)

**HEALTH INFORMATION SYSTEMS (HIS)**

LACHEALTHSYS Website (http://www.lachealthsys.org/)


4th Sector Health Annual Report to USAID October 1, 2008 through September 30, 2009

**INFECTIONOUS DISEASES (ID)**

Doi:10.1371/journal.pntd.0000071


Regional Plan for Scaling up Drug-Resistant TB care in Latin-America. Power point presentation PAHO 2009. (DRTBPlan_USAIDNov09_LG[1])

Global Tuberculosis Control: A short update to the 2009 report. WHO 2009 (tbi_8bis)

Elimination of Neglected Diseases and Other Poverty-Related Infections. PAHO 49th Directing Council (2009).

**MATERNAL CHILD HEALTH (MCH)**


Child Survival. Power Point presentation September 2007


Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn and Child Care 2008–2015

**HIV/AIDS**


AIDS Epidemic Update, WHO and UNAIDS, 2009

AIDSTAR-One Project, Field Support Workplan submitted to USAID/LAC Bureau, September 2009

Preliminary Agenda: Technical Workshop on Effective HIV/AIDS Prevention with MARPS: Experiences from Latin America, Antigua, Guatemala, December 8–10, 2009

**FAMILY PLANNING/REPRODUCTIVE HEALTH (FP/RH)**

—Graduation from Population Assistance: Process, Strategy, and Experience to Date at USAID,” Marguerite Farrell, Health Officer GH/PRH/SDI, Chair Graduation Working Group, Power Point presentation to IPPF and UNFPA, January 13, 2010
TECHNICAL NOTE: Guidance for Phase-out of USAID Population Assistance, USAID (undated)


—FP Progress in LAC,” UNFPA (Power Point presentation presented at joint USAID-UNFPA-IPPF meeting, January 13, 2010)

—Is it Time to Phase out Support for Family Planning Programmes in Latin America?” Hugo Gonzalez, RHCS/Health System Advisor for LAC, UNFPA (presented at joint USAID-UNFPA-IPPF meeting, January 13, 2010)

Integration of Contraception in Antenatal, Postpartum and Postabortion Care in the Dominican Republic, Haiti, and Nicaragua, Draft Report, FRONTIERS Project, Population Council (undated)


Facts on Investing in Family Planning and Maternal and Newborn Health, Guttmacher Institute/UNFPA, December 2009


TECHNICAL NOTE: Guidance for Approach to Phase-out of USAID Family Planning Assistance (technical note on graduation 08-16-06)

ADDITIONAL DOCUMENTS


Bliss, Katherine E., Health in Latin America and the Caribbean: Challenges and Opportunities for U.S. Engagement, Report of the Center for Strategic and International Studies Global Health Policy Center, April 2009. (CSIS_090420_bliss_healthlatinamer.pdf)

USAID Principles of Development and Reconstruction Assistance (undated)


Anderson G., Waters H., Pittman P., Herbert R. Chu E., & Das K. Non-Communicable Chronic Diseases In Latin America and the Caribbean. Bloomberg School of Public Health Johns Hopkins University, 2009

Water and Sanitation: Protecting the Environment. USAID PowerPoint presentation, September 2009

Inequity Gap by Wealth Quintile in LAC, USAID Power Point, December 2007


Users’ Guide to USAID/Washington Health Programs,” Fiscal Year 2009


Goodwin, M & Anderson, MA. Assessment of Factors Affecting Sustainability of National Population–based Health Surveys in Four Latin American Countries, Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion Division of Reproductive Health, Atlanta, Georgia, 2009

S.1524 – Foreign Assistance Revitalization and Accountability Act of 2009 (S.1524 was introduced by Senators Kerry, Lugar, et.al on July 28, 2009)
APPENDIX F. STANDARDIZED INTERVIEW GUIDES (QUESTIONNAIRES) FOR DATA COLLECTION

I. USAID/WASHINGTON

A. Discussion Topics for Director LAC/RSD

1. Implications for the Agency and LAC Bureau of new Presidential, Congressional and other Initiatives?
2. Implications of these new initiatives on the LAC/PHN workload and staffing?
4. How would you describe LAC/PHN’s current role and functions? Future role and functions under the new strategy 2010–2015?
   a. AAD amendment (p. 11) states LAC/PHN’s primary function as being a “key conduit of information between health programs in the field and in Washington.”
   b. Others have described LAC/PHN’s function as a “pathfinder.”
   c. Others believe its primary function to be the provision of technical assistance.
5. What is the “value added” for housing a technical team in LAC/PHN rather than elsewhere in the Agency or in the field? Esp. given critical senior PHN staff shortages in both USAID/W and the field.
6. Implications for 6 LAC countries to “graduate” or phase out from USAID-funded FP assistance?
   a. How would you, if you would, counter this decision and why?
7. Doug’s view of USAID’s chances of regaining many of its former important functions of policy (PPC), planning, budgetary functions and authorities – regaining from the “F process started in 2006 and the current directions being stated by State and the White House.

B. Other USAID/W Personnel

Interviewer: _______________ Date of Interview: ______
Name of Informant: ___________ Position: ______________
Organization: _______________

1. Are you familiar with the LAC Regional Health Team’s work (LAC/PHN)? If so, do you think it is being effectively implemented? Has it had a positive impact in the region? Does it complement other Agency health sector resources? What are its major achievements? What could/should it be doing differently?
2. Does the LAC/PHN team provide strategic, policy, and/or technical leadership for the region? If so, in what way? If not, should they, and in what ways?
3. The LAC/PHN has many roles, including support to missions, technical leadership on health issues that are priorities for LAC, promotion of key regional health policies and partnerships, and provision of mentoring and training for new USAID health staff and fellows. What do you think are the most important roles for the LAC/PHN team to play?
How well are they doing that? Is there any role they are playing now that another part of the Agency should be responsible for? Is there any area that you would recommend the LAC/PHN add as an additional role?

4. Are there major unmet needs in health programming in the region that could be appropriately addressed through the regional program (rather than, or in addition to, bilateral programs)?

5. Re support to FP: many countries have —graduated”, 6 are on a phase-out trajectory, and 3 USAID-supported FP countries will be continued beyond FY 2013. Do you feel that the programs scheduled for phase out will be sustainable without USAID financial and/or technical support? If so, what evidence do you base this on? What role can/should LAC/PHN play to promote sustainability of FP programs within countries? What, if any, technical assistance will continue to be required to ensure successful phase out?

6. LAC/PHN is developing a Draft Strategy for the Regional Health Program 2010–2015; LAC/RSD is also preparing an overall strategy concurrently. These strategies will take into account the —Whole of Government Approach” and The Global Health Initiative, as well as PEPFAR, Food Security, and Global Climate Change Initiatives. Given this context, what do you think the priorities should be for the LAC/PHN 2010–2015 strategy? What are the important regional health/population/nutrition issues that the strategy can address?

7. Should LAC continue to program a large proportion of its resources through grants to PAHO and field support to CAs? Would you recommend other implementation mechanisms that might be more productive, cost-effective, or more within LAC/RHD’s span of control?

8. How would you evaluate the relationship between Bureau and Global Health staff in working together, supporting one another, getting work done effectively, etc.?

C. Regional Bureaus

1. How do you see the role of the regional bureau health teams vis-à-vis that of the Global Health Bureau?

2. What is your current staffing pattern? What is projected for the next 5 years?

3. What proportion of your team’s time is spent on support to missions, regional responsibilities, and other tasks?

4. What kinds of support/assistance do the Missions in your region want from their Regional Bureau PHN office? How do you respond to their requests?

5. Do you devote much energy to cultivating relationships with other major health players in your region?

6. What is your office’s role in training, supervising, mentoring, and supporting new PHN personnel, especially new Junior Officers?

7. Do you do any cross-sectoral programming at the regional level?

8. What do you see as the 3–4 major challenges for your regional health program? How might they be relevant for LAC?

9. Do you have any observations about the LAC health program, in particular?
10. What is the impact of new Global Health Initiative on workload and priorities of the regional health program? And have the Food Security and Global Climate Change initiatives had an impact on the workload of the regional health program? Has the “whole-of-government” approach had an impact on your workload and effectiveness?

11. For those working in chronic diseases: What are you doing in terms of addressing chronic illnesses and how are you funding it?

D. LAC/PHN Health Team

Interviewer: ________________ Date of Interview: ______

Name of Informant: _____________ Position: ______________

Organization: ______________

1. In your opinion what are the roles that should be performed by the LAC/PHN? Please prioritize what the main activities should be.

2. What percentage or amount of your time is spent in:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
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<tbody>
<tr>
<td>Providing direct technical and programmatic assistance to Missions</td>
<td>including evaluation of mission program performance (PPR review) and program design; assistance may be provided in person or “virtually”).</td>
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<tr>
<td>Development of, coordination of, participation in, and/or follow-up after regional events and processes</td>
<td>(e.g., SOTA, CONCASIDA, PAHO Directing Council, and other multi-country conferences and workshops; includes official “representation” of USAID).</td>
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<tr>
<td>Keeping informed and up-to-date about own technical areas and LAC regional developments.</td>
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<tr>
<td>Advocacy and information-sharing for LAC health priorities</td>
<td>(within LAC, with other AID/W bureaus, interagency, donors, and other external organizations).</td>
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<tr>
<td>Internal LAC/RSD/PHN program functions: strategy and budget development, activity management, and evaluation</td>
<td>(including current activities: PAHO grant, Field Support activities, and Task Order; developing future work).</td>
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<tr>
<td>Responding to “Taskers” from the LAC Front Office, the Administrator's Office, Congress, etc.</td>
<td>(include FOIA requests, FO briefings, and Family Planning Compliance investigation and documentation).</td>
</tr>
<tr>
<td>Administrative/office management functions</td>
<td>(travel, leave, scheduling, personnel and resource planning, staff evaluations, maintenance of records and files, etc.).</td>
</tr>
<tr>
<td>Mentoring/coaching new personnel</td>
<td>(newly assigned FSOs, new AID/W hires, and DLIs).</td>
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<tr>
<td>Coverage for other staff who are out of the office</td>
<td>(on TDYs, leave, etc., include “acting” responsibilities within PHN).</td>
</tr>
<tr>
<td>Other</td>
<td></td>
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</table>

Other
3. What percent of your time is spent providing technical assistance in the field?

4. What percent of your time is spent in meetings? Are scheduled meetings consuming —too much” of your working time? Do you think that some meetings could be scaled back?

5. What is interfering with the performance of your activities?

6. How would you evaluate the relationship between LAC Bureau and Global Health Bureau staff in working together, supporting one another, getting work done effectively, etc.? Any suggestions for improvement?

7. In addition to the new Strategy for the Regional Health Program 2010–2015 that LAC/PHN is developing, LAC/RSD is also preparing an overall strategy concurrently. These strategies will have to take into account the —Whole of Government Approach” and The Global Health Initiative, as well as PEPFAR, Food Security, and Global Climate Change Initiatives. Given this context, what do you think the priorities should be for the LAC/PHN 2010–2015 strategy? What are the important regional health/population/nutrition issues that the strategy can address?

8. What mechanism(s) should be used within the new strategy period to implement programs, manage resources, and achieve results within the regional priorities?

E. Field Missions, LAC Region

Interviewer: _____________________   Date of Interview: _________

Name of Informant: ___________________Position: ________________

Organization: ______________

1. Are you familiar with the LAC Regional Health (LAC/PHN) team and its key program work and activities? If so, do you think the regional health team’s work and activities are being effectively implemented? If so, do you think that work is appropriately complementary to your country strategy/program? If not, why not? Has it had a positive impact in your country or other countries in the region? If so, in what way? If not, why not?

2. Do you call upon the LAC/PHN team for support? If so, what kind of support have you received? How specifically has it helped you? Not helped you?

3. Does the health team provide strategic, policy, and/or technical leadership for the region? If so, how? If not, what more could it do?

4. For the future of the LAC regional health program, what do you think are the most important programmatic/technical roles for the LAC health team to play? Is there anything LAC health is not doing now that you feel they should be doing?

5. Who are the important health sector partners in the LAC region? How important is the partnership with PAHO in your country? In the region overall? How would you characterize their strengths and weaknesses?

6. Re support to FP: many countries have —graduated,” 6 are on a phase-out trajectory, and 3 USAID-supported FP countries will be continued beyond FY 2013. Do you feel that the programs scheduled for phase-out will be sustainable without USAID financial and/or technical support? If so, what evidence do you base this on? Is the role the RHP is currently playing helpful to ensuring successful FP phase-out? What more, if anything, should RHP do to promote successful graduation and sustainability of FP programs?
7. Are there major unmet needs in health programming in the region that could be appropriately addressed through the regional program (rather than, or in addition to, bilateral programs)?

8. LAC/PHN is developing a Draft Strategy for the Regional Health Program 2010–2015; LAC/RSD is also preparing an overall strategy concurrently. These strategies will take into account the —Whole of Government Approach” and the Global Health Initiative, as well as PEPFAR, Food Security, and Global Climate Change Initiatives. Given this context, what do you think the priorities should be for LAC Regional Health Program 2010–2015 strategy? What are the important regional health/population/nutrition issues that the strategy should address?

9. The GHCS/USAID FY10 budget for LAC/PHN is about $6.5 million (or about 5% of USAID’s health funding for the LAC Region, which is about $131 million). Should LAC/PHN continue to program a large proportion of its resources through grants to PAHO and field support to CAs? Would you recommend other implementation mechanisms that might be more productive, cost-effective, or more within your control?

II. GUIDE FOR PARTNERS (DONORS, LAC-FUNDED CONTRACTORS AND OTHERS)

Interviewer: _________________ Date of Interview: _________________

Name of Informant: _______________ Position: ______________________

Organization: ______________

1. Are you familiar with the USAID LAC Regional Health Program work and activities (LAC/PHN)? If so, do you think they are being effectively implemented? Has it had a positive impact in the region? Does it complement other USAID-funded implementing partners and/or health sector resources?

2. Does the LAC/PHN team provide strategic, policy, and/or technical leadership for the region? In what way? Who are the other important partners in the health sector? In population? In health? In nutrition? Is the LAC/PHN team effectively engaging with these other important players?

3. Are there major unmet needs in health programming in the region that could be appropriately addressed through the USAID LAC regional program (rather than, or in addition to, bilateral programs)?

4. LAC/PHN is developing a Draft Strategy for the Regional Health Program 2010-2015; LAC/RSD is also preparing an overall strategy concurrently. These strategies will take into account the —Whole of Government Approach” and the Global Health Initiative, as well as PEPFAR, Food Security, and Global Climate Change Initiatives. Given this context, what do you think the priorities should be for the 2010–2015 health strategy? What are the important regional health/population/nutrition issues that the strategy can address? What mechanism(s) should be used to implement programs, manage resources, and achieve results within the regional priorities?
APPENDIX G. MISSION PHN OFFICER RESPONSES TO INTERVIEWS

CONSOLIDATED RESPONSES FROM MISSIONS BASED ON QUESTIONNAIRE
Mission response from Honduras, Guatemala, Brazil, Mexico, El Salvador, Nicaragua, Bolivia and Peru.

CONSOLIDATED QUESTIONS 1, 2 AND 3. ACTIVITIES LAC/RSD/PHN PERFORMS
Do you think the regional health team’s work and activities are being effectively implemented? Are they complementary to your country strategy/program? Had a positive impact in your country or other countries in the region? What type of support do you call upon the LAC/health team? Is it helpful? What is working well for advancing health/nutrition/population policies and programs in the region? What is not working so well? Are there missed opportunities?

Consolidated Mission Responses
- Request support for: strategy definition and drafting FP graduation and contraceptive security implementation. Develop a framework for partnerships; contracts; evaluation; budget.
- Interface with Front Office for: policy and strategy, clarification and correction of “policy mistakes” made in GH regarding budget or management decisions; advocacy for programs such as FP and strengthening health systems; liaison with Global Fund-TB.
- SOTAS: Coordination of regional efforts and prepare agenda for regional SOTAs. —State of the art” information.
- Provide TA: increase skills of technical officers in the field (FSNs and DLIs)
- Address country-specific issues: FP graduation, political situation in country that affects health.
- Advocacy with Ministries of Health.
- Locus for communication between GH and Missions on API activities.
- Coverage in the field, TDY.
- Technical leadership in infectious diseases; technical position papers.

CONSOLIDATED QUESTIONS 4, 5, 9, 11, AND 12. ACTIVITIES LAC/RSD/PHN SHOULD DO IN THE FUTURE
For the future of the LAC regional health program, what do you think are the most important programmatic/technical roles for the LAC health team to play? What are you envisioning for future health/population/nutrition programs?
Consolidated Mission Responses

- Advocacy for the region in GH and Front Office regarding policy and budget; advocacy on interpretation of health indicators in the LAC context; unfinished agenda in LAC; identifying GAPs in the region to help budget allocations.

- Advocate for a balanced portfolio in the field (after FP graduation, activities may be very limited to one specific field).

- Strategic leadership.

- Continue funding programs that the mission does not have a budget for, such as infectious diseases, chronic malnutrition in countries not a priority of the Food initiative.

- Venture-capital group: engage in value-added activities, such as combating gender-based violence related to maternal health and unwanted pregnancies.

- Provide grants where Missions can buy in to avoid duplications on programs implemented on the field.

- Filter information sent by GH for what is relevant for our region.

- Focus on health systems strengthening to address broader conditions.

- Communication/sharing: best practices, successful stories in the region, lessons learned.

- Help to maximize effect in budget-constrained Missions, do not have the resources to manage all programs.

- Technical assistance: policy, health sector reform assistance.

- Should (technical) backstop the missions rather than provide TA.

- Advocacy and leadership role coordinating with other agencies: CDC, UNICEF, CAs, DoD.

- Create strategic partnerships with other donors: WB, IDB

- Promote coordination between Missions and other donors in the region; sustainability of ending instruments.

- Keep the Missions informed regularly of policy changes (within agency and with technical areas)

- SOTAs: Engagement of technical experts, research, technology (FP, HIV, Health System Reform); share lessons learned.

- Promote South-to-South interaction.

- Translating GH initiative (food security and climate change, MCH and reproductive health) to the LAC context. Advocate for use of valid model (no PEPFAR). Be the leader among agencies in the GH initiative.

- PAHO: Scale back (smaller grant) and divert to other field mechanisms (direct grant to ministries in region, smaller awards to local organizations, match grants, umbrella grants for the region where Missions can buy in)
CONSOLIDATED QUESTIONS 7 AND 8. PROBLEMS IDENTIFIED/UNMET NEEDS

Are there major unmet needs in health programming in the region that could be appropriately addressed through the regional program (rather than, or in addition to, bilateral programs)?

Consolidated Mission Responses

- Lack of coordination, disagreement between RCS, GH, and LAC/RSD.
- Lack of communication to Missions of agreement with PAHO and activities carried out. As a consequence we have duplicated activities.
- Inconsistent representation of LAC issues in country teams (GH) to support Missions.
- Lack of political leadership in LAC Bureau. No representation in FP.
- Disconnection between regional agreements and bilateral programs.
- Poor coordination between LAC/PHN and CDC: duplication of activities in reproductive health.
- Unmet needs in health: dengue and Chagas are not addressed, avian/influenza pandemic work has not been influential; issue of pockets of need vs. average health indicators; water and sanitation, food security and nutrition, NTD; hepatitis, violence, traffic accidents, gender equity programs; chronic diseases. Continue DHS surveys; gender violence; other emergent epidemics health systems strengthening.
- Inconsistency in sending important documents (waiting for DHS report).
- Need to share lessons learned South-to-South.
- Inconsistent communication with missions.
- GH does not communicate with Mission on AIP.
- Communication problems with CDC. Interagency agreement: We put money in CDC but they were unresponsive.
- Unknown strategy, role, and activities of LAC PHN. Need to talk at next SOTA.
- Too many indicators need to be reported on (after “F” process).
- POPPHI: not effective, poor communication, duplication.
- Relationship with LAC/PHN reactive, not proactive. Need to have strategic leadership.
- GH funds for HIV/AIDS $ 1 million without direct supervision.
- Do not share our plans with LAC. Do not have feedback on our performance plan from LAC.
- Get more support and better communication from GH than LAC PHN on technical issues and regarding Global Health Initiative.
QUESTION 12
Should LAC/RHP continue to program a large proportion of its resources through grants to PAHO and field support to CAs? Would you recommend other implementation mechanisms that might be more productive, cost-effective, or more within your control?

Mission Responses

PAHO strengths:

- Narrow communication with local Ministries of Health (we do not communicate).
- Political: official advisors to ministries. PAHO only valid intermediary with governments, we do not have a bilateral agreement with government, even US NGOs are not registered in the country.
- Focused on providing technical opinion/assistance to Ministries.
- Good technical expertise.
- Good job on TB. We will work with them in reducing accidents and violence.
- Get things done because they have government support.

PAHO weaknesses:

- Do not communicate with or support the Missions. We put money in the Umbrella agreement and they communicated results to RSD, not to us.
- Problems: inconsistency implementing programs, too bureaucratic, everything takes a lot of time.
- Overstated their role (want to monitor us).
# APPENDIX H. COMPARISON MATRIX

## LAC HEALTH TEAM FUNCTIONS WITH:
1. Prototype Regional & Pillar Bureau Functions
2. Regional Bureau Health Team Functions
3. Regional Bureau Health Teams with Global Health
4. Mission Comments on LAC/PHN Functions

<table>
<thead>
<tr>
<th>(1) Prototype Regional and Pillar Bureau Functions</th>
<th>LAC/PHN Functions for LAC Bureau</th>
<th>(4) Mission Comments on LAC/PHN Functions</th>
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</thead>
<tbody>
<tr>
<td>Assistant Administrator (AA) -- Front Office* -- Mission Directors and Program Offices report to Regional Bureau AAs; thus a Regional Bureau is the primary focus for Missions.</td>
<td>Responding to &quot;taskers&quot; from the LAC Front Office, the Administrator's Office, Congress, etc. (include FOIA requests, FO briefings, and Family Planning Compliance investigation and documentation)</td>
<td>Interface with Front Office for: Policy and strategy; clarification and correction of &quot;policy mistakes&quot; made in GH regarding budget or management decisions; advocacy for programs (FP, strengthening health systems).</td>
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<tr>
<td>Administrative Management Support (AMS).</td>
<td>Administrative/office management functions (travel, leave, scheduling, personnel and resource planning, staff evaluations, maintenance of records and files, etc.)</td>
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</tr>
<tr>
<td>Strategic Planning and Policy.</td>
<td>Internal LAC/RSD/PHN program functions: strategy and budget development, activity management, and evaluation (including current activities: PAHO grant, Field Support activities, and Task Order; developing future work)</td>
<td>SOTA Courses: Coordination of regional efforts and prepare agenda for regional SOTAs. State of the art information.</td>
</tr>
<tr>
<td>Budget – Regional and Country Budget Allocations.</td>
<td>Coverage for other staff who are out of the office (on TDYs, leave, etc., include &quot;acting&quot; responsibilities within RSD.</td>
<td>Advocate for a balance in portfolio in the field; after FP graduation, activities may be very limited to one specific field.</td>
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<tr>
<td>Program Management</td>
<td></td>
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<tr>
<td>Technical Assistance and Support.</td>
<td></td>
<td>Coverage in the field, TDY.</td>
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<thead>
<tr>
<th>(2) Key Functions of Regional Bureau Health Teams</th>
<th>LAC/PHN Functions</th>
<th>Mission comments on LAC/PHN Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advise Front Office on health issues.</td>
<td></td>
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<tr>
<td>Provide TA and strategic support to Missions.</td>
<td>Providing <strong>direct technical and programmatic assistance to Missions</strong> (including evaluation of mission program performance (PPR review) and program design; assistance may be provided in person or 'virtually')</td>
<td>Provide TA: Increase skills of technical officers in the field (FSNs and DLIs). Should (technical) backstop the missions rather than provide TA. Keep the missions informed regularly of policy changes (agency and with technical areas).</td>
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<tr>
<td>Participate in Mission strategy development, budget allocation recommendations, strategy approvals, and annual report reviews.</td>
<td><strong>Advocacy and information-sharing</strong> for LAC health priorities (within LAC, with other AID/W bureaus, interagency, donors, and other external organizations)</td>
<td>Strategy definition and drafting (FP graduation, contraceptive security); Develop a framework for partnerships; contracts; evaluation; budget.</td>
</tr>
<tr>
<td>Liaise with other USG agencies, Capitol Hill, NSC, OGAC, DOD, and other donors.</td>
<td><strong>Development of, coordination of, participation in, and/or follow-up after regional events and processes</strong> (e.g. SOTA, CONCASIDA, PAHO Directing Council, and other multicountry conferences and workshops; includes official 'representation' of USAID).</td>
<td>Advocacy and leadership role coordinating with other Agencies: CDC, UNICEF, CAs, DoD. Create strategic partnerships with other donors: WB, IDB. Promote coordination between missions and other donors in the region.</td>
</tr>
<tr>
<td>Support PHN activities in Regional Offices and non-presence countries.</td>
<td>Keeping informed and <strong>up-to-date about own technical areas</strong> and LAC regional developments</td>
<td>Address country specific issues: FP graduation, political situation in-country. Advocacy with Ministries of Health. Continue funding programs that the mission doesn’t have a budget for, such as infectious diseases, chronic malnutrition in countries not priority of Food initiative. Help to maximize effect in budget constrained missions; don't have the resources to manage all programs. Promote south to south interaction.</td>
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<tr>
<td>Examine regional health issues, horizon issues, and demonstration activities.</td>
<td>Technical leadership; Technical position papers. <strong>Engage in value-added activities such as combating gender-based violence related to maternal health and unwanted pregnancies.</strong></td>
<td>Liaison with Global Fund-TB. Locus for communication between GH and Missions (API activities). Filter information sent by GH, only what is relevant for our region.</td>
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<tr>
<td>Work with Global Health Bureau counterparts on technical issues.</td>
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<tr>
<td><strong>Communication/sharing:</strong> Best practices, successful stories in the region, lessons learned.</td>
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<td><strong>Mentoring/coaching new personnel</strong> (newly assigned FSOs, new AID/W hires, and DLIs)</td>
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<td><strong>Others</strong></td>
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<td><strong>(3) Regional Bureau Health Team Interaction with Global Health Bureau</strong></td>
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<td><strong>LAC/PHN Functions</strong></td>
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<tr>
<td><strong>Mission comments on LAC/PHN Functions</strong></td>
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<tr>
<td>As members of the PHN Sector Council</td>
<td>“Translate” GH initiative (Food security and climate change, MCH and reproductive health) to the LAC context. Advocate for use of valid model (no PEPFAR). Be the leader among agencies in the GH initiative</td>
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<tr>
<td>GHB staff act as County Leads for LAC countries – Bureau Health Team representation.</td>
<td>Advocacy on interpretation of GH indicators in the LAC context. Identify gaps in the region for budget allocations.</td>
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<tr>
<td>Reviewing missions’ operational plans, strategies, etc.</td>
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<tr>
<td>Supporting mission programs through email, conference calls, and TDYs</td>
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### Bureau for Latin America and the Caribbean (LAC)

#### SPO’s Main POCs

As of January 7, 2010

#### CARIBBEAN (CAR)
- **Director**—Kermit Moh
- **SPO**—Lacy Kilraine
- **F**—George Rowland

- Barbados-Eastern Caribbean
  - Robert Boncy
  - Mission Director—James Gooqin

- Dominican Republic
  - Debbie Banks
  - Mission Director—Richard Gough

- Guyana & Non-Presence
  - Robert Boncy
  - Mission Director—Carol Homing

- Haiti
  - Dan Riley & Belinda Bernard
  - Mission Director—Carleen Dei

- Jamaica
  - Robert Boncy
  - Mission Director—Karen Hilliard

- Caribbean Basin Security Initiative (CBSI)
  - Debbie Banks & Robert Boncy

#### SOUTH AMERICA (SA)
- **Director**—Karen Anderson
- **SPO**—Joyce (Peru, SA Regional)

- Bolivia
  - Karen Anderson
  - Mission Director—Ken Ellis

- Brazil
  - Darren Manning
  - Mission Director—Jeff Bell

- Colombia
  - David Johnston
  - Mission Director—Ken Yamashita

- Ecuador
  - Darren Manning
  - Acting Mission Director—Daniel Sanchez-Bustamante

- Paraguay
  - Mike Karbeling
  - Mission Director—Rosemary Rakas

- Peru & SA Regional
  - Mike Karbeling
  - Mission Director—Paul Weisenfeld

- Venezuela
  - OTI—Ben Rempell
  - SPO—Joyce Kim

#### CENTRAL AMERICA & MEXICO (CAM)
- **Director**—Azza El-Ab
- **SPO**—Joyce Kim
- **F**—Karen Nelson

- El Salvador & CAM Regional
  - Emily Hogue
  - Mission Director—Larry Brady

- Guatemala
  - Ken Seifert
  - Mission Director—Wayne Nilsestuen

- Honduras
  - Ken Seifert
  - Mission Director—William Brands

- Panama
  - Julie Ciccacore
  - Mission Director—Littleton Tazwell

- Nicaragua
  - Emily Hogue
  - Mission Director—Rodger Garner

- Mexico
  - Julie Ciccacore
  - Mission Director—Rodger Garner

- **CAR**
  - **Director**—Kermit Moh

- **SPO**—Lacy Kilraine

- **F**—George Rowland

- **CUBA**
  - **Acting Director**—Kim Rosen
  - **PO**—Danielle Reiff
  - **SPO**—Joyce Kim
  - **F**—Karen Anderson

- **LPA**
  - Barbara Bennett
  - Sande Reinhardt
  - Kathy Morris (CNs)

- **GC**
  - Warren Leishman

- **OMA**
  - Charles (Spencer) Abbot

- **State/WHA/PPC**
  - Jennifer Ceriale
  - Teresa Fralish

- **OMB**
  - Chief—Christa Capozzola
  - ESF & DA—Erica Navarro
  - GHCS-USAID & DCA—Adam Ross

- **DOCs**
  - Barbados—Sophia Cave
  - Bolivia—Walter Mur
  - Brazil—Hector Cerpa
  - Colombia—German Acevedo
  - Dominican Republic—Norma Paredes
  - Ecuador—Alexandria Panahal
  - El Salvador—Karen Azucena
  - Guatemala—Wende Duffon
  - Guyana—Wyndee Oudkerk
  - Haiti—Karine Roy
  - Honduras—Samantha Croadsdale
  - Jamaica—Karen Hilliard
  - Mexico—Cristina Prado
  - Nicaragua—Jan Howard
  - Panama—Eliana Stanziola
  - Paraguay—Gabrila Frutos
  - Peru—Maria Arce

#### OFFICE OF THE ASSISTANT ADMINISTRATOR/LAC (AA/LAC)
- **Acting AA**—Janet Ballantyne
- **Acting DAA**—Ted Landau
- **EMT**—Andrew Luck
- **F—Dep. Director**—Robert Goldberg, Jane Zimmerman (WHA)

#### STRATEGY AND PROGRAM OFFICE (SPO)
- **Acting Director**—Robin Brinkley
- **Strategy**—Chris Cushing
- **Budget**—Sharon Nichols

#### REGIONAL SUSTAINABLE DEVELOPMENT (RSD)
- **Director**—Doug Ball
- **Program Officer**—Stephanie Budzina
- **SPO**—Joyce Kim
- **F**—George Rowland

- **Health**
  - Susan Thollaug

- **Democracy**
  - Eric Kite

- **Environment**
  - Anne Dix

- **Economic Growth**
  - Tracy Quilter

- **Education**
  - Ebony Bostic

#### LAC/RSD REGIONAL HEALTH PROGRAM ASSESSMENT 2004–2009
## APPENDIX J. LAC/RSD/PHN TEAM ROLES AND RESPONSIBILITIES

### CURRENT LAC/RSD HEALTH PROGRAM ACTIVITIES (ANNEX C SOW)

<table>
<thead>
<tr>
<th>RHP ACTIVITY</th>
<th>Funding</th>
<th>RHP Staff</th>
<th>LAC MECHANISM</th>
<th>GH MECHANISM</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Family Planning and Contraceptive Security</td>
<td>Child Survival and Health Account</td>
<td>Senior Advisor</td>
<td>n/a</td>
<td>JSI/DLIVER; HPI/The Futures Group</td>
<td>Currently 6 countries have initiate phase out activities that will be completed by 2013</td>
</tr>
<tr>
<td>2  Maternal/Neonatal Mortality</td>
<td>Maternal and Child Health ??</td>
<td>Senior Advisor</td>
<td>PAHO Primary Health Care Grant</td>
<td>BASICS, POPPHI [MCHIP], CDC, USP</td>
<td>This is the last year of current grant agreement with PAHO</td>
</tr>
<tr>
<td>3  Infectious diseases</td>
<td>Funded from Global Health Bureau</td>
<td>Senior Advisor &amp; Technical Advisor (Global Health fellow)</td>
<td>PAHO Primary Health Care Grant; Links Media</td>
<td>Stop AI, AI Comm, CDC. Managed in the Global Health Bureau</td>
<td></td>
</tr>
<tr>
<td>4  Pandemic Influenza</td>
<td>Child Survival and Health Account</td>
<td>Senior Advisor</td>
<td>PAHO Primary Health Care</td>
<td>n/a</td>
<td>This is the last year of current grant agreement with PAHO</td>
</tr>
<tr>
<td>5  Tuberculosis</td>
<td>Child Survival and Health Account</td>
<td>Senior Advisor</td>
<td>PAHO Primary Health Care</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>6  Antimicrobial Resistance</td>
<td>Child Survival and Health Account</td>
<td>Senior Advisor</td>
<td>PAHO Primary Health Care Grant</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>8  Cross-cutting &amp; Health Systems</td>
<td>Funded through The Maternal and Child Health and TB elements</td>
<td>Senior Advisor</td>
<td>4th Sector Health; PAHO Primary Health Care Grant</td>
<td>Measure Evaluation; Global Health Fellows; AIM</td>
<td></td>
</tr>
<tr>
<td><strong>Other Public Health Threats; Neglected Tropical Diseases</strong></td>
<td><strong>Funded from Global Health Bureau</strong></td>
<td><strong>Franklin Fellow for Neglected Tropical Diseases</strong></td>
<td><strong>Managed in the Global Health Bureau</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>------------------------------------</td>
<td>--------------------------------------------------</td>
<td>----------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other Infectious Diseases</strong></td>
<td><strong>USAID/Peru Mission</strong></td>
<td></td>
<td><strong>Amazon Malaria Initiative. South America Infectious Disease Initiative</strong> (Both subregional activities included in the RHP included at the beginning of the period being assessed but were transferred to the USAID/Peru Mission in 2008 and have been evaluated separately.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6</th>
<th><strong>Alliances and Exchanges (4 sector Health)</strong></th>
<th><strong>Team Leader</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td><strong>PAHO Grant</strong></td>
<td><strong>Deputy Health Team Leader</strong></td>
</tr>
</tbody>
</table>
### COUNTRIES IN THE LAC REGION (ANNEX A SOW) WITH BILATERAL (USAID MISSION-BASED) HEALTH PROGRAMS AND MAJOR TECHNICAL AREAS ADDRESSED BY USAID

<table>
<thead>
<tr>
<th>USAID Missions</th>
<th>Health programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolivia</td>
<td>MCH (Priority), FP, HIV/AIDS, TB</td>
</tr>
<tr>
<td>Dominican Republic</td>
<td>MCH, FP *, HIV/AIDS, TB</td>
</tr>
<tr>
<td>El Salvador</td>
<td>MCH, FP *, HIV/AIDS</td>
</tr>
<tr>
<td>Guatemala</td>
<td>MCH (priority), FP, HIV/AIDS</td>
</tr>
<tr>
<td>Haiti</td>
<td>MCH (Priority), FP, TB, HIV/AIDS (Focus)</td>
</tr>
<tr>
<td>Honduras</td>
<td>MCH, FP *, HIV/AIDS</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>MCH, FP *, HIV/AIDS</td>
</tr>
<tr>
<td>Peru</td>
<td>MCH, FP *, HIV/AIDS, TB</td>
</tr>
<tr>
<td>Paraguay</td>
<td>FP/RH*</td>
</tr>
<tr>
<td>Brazil</td>
<td>HIV/AIDS and TB</td>
</tr>
<tr>
<td>Jamaica</td>
<td>HIV/AIDS</td>
</tr>
<tr>
<td>Mexico</td>
<td>HIV/AIDS and TB</td>
</tr>
<tr>
<td>Guyana</td>
<td>HIV/AIDS (Focus)</td>
</tr>
<tr>
<td>Ecuador</td>
<td>MCH for water and sanitation</td>
</tr>
</tbody>
</table>

*Countries with a Plan for Graduating from USAID Family Planning Assistance.

### USAID SUBREGIONAL HEALTH PROGRAMS IN THE LAC REGION

<table>
<thead>
<tr>
<th>Health programs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
<td>Central American Program (based in Guatemala)</td>
</tr>
<tr>
<td></td>
<td>Caribbean Regional Program (based in Barbados)</td>
</tr>
<tr>
<td>Malaria</td>
<td>Amazon Malaria Initiative (based in Peru)</td>
</tr>
<tr>
<td>Infectious Disease &amp; Antimicrobial Resistance</td>
<td>South American Infectious Diseases Initiative (based in Peru)</td>
</tr>
</tbody>
</table>
Figure 2. Working List for Family Planning “Graduation” USAID/LAC Region

<table>
<thead>
<tr>
<th>Country</th>
<th>Last Year of Contraceptive Donations (shipments)*</th>
<th>Proposed Last Year of FP Technical Assistance Funds (Activities)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolivia</td>
<td>None Planned</td>
<td></td>
</tr>
<tr>
<td>Ecuador</td>
<td>2003</td>
<td>2001</td>
</tr>
<tr>
<td>Guatemala</td>
<td>2008</td>
<td></td>
</tr>
<tr>
<td>Honduras</td>
<td>2007</td>
<td>FY2011 (2012)</td>
</tr>
<tr>
<td>Mexico</td>
<td>2000</td>
<td>2000</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>2008</td>
<td>FY2011 (2012)</td>
</tr>
<tr>
<td>Paraguay</td>
<td>2009</td>
<td>FY2010 (2011)</td>
</tr>
<tr>
<td>Peru</td>
<td>2004</td>
<td>FY2010 (2011)</td>
</tr>
</tbody>
</table>

*Does not include condoms for HIV programs

** Note that these are planning dates and may be modified.

Figure 3. USAID Family Planning Funding in the LAC Region, by County FY 2001–FY 2009
## APPENDIX K. LAC/RSD/PHN TEAM WORKING GROUPS/MEETINGS

<table>
<thead>
<tr>
<th>#</th>
<th>Priority Ranking*</th>
<th>Working Groups/Committees</th>
<th>When Meet</th>
<th>Team</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5</td>
<td>Global Health Initiative: Health Systems Workgroup</td>
<td>Weekly (or more + significant pre/post work)</td>
<td>Health</td>
<td>Kelly Saldana</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>Global Health Initiative: MCH/FP workgroup</td>
<td>Weekly (or more)</td>
<td>Health</td>
<td>Peg Marshall</td>
</tr>
<tr>
<td>3</td>
<td>5</td>
<td>QDDR: Leading and Supporting Whole-of-Gov’t Solutions</td>
<td>Weekly (or more + significant pre/post work)</td>
<td>Health</td>
<td>Susan Thollaug</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>Crisis Management Committee for Pandemic Flu</td>
<td>Biweekly</td>
<td>Health</td>
<td>Peg Marshall, Abby Goldstein</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>Improving Government Acquisition</td>
<td>Daily (in October)</td>
<td>Health</td>
<td>Kelly Saldana</td>
</tr>
<tr>
<td>6</td>
<td>4</td>
<td>Global Health Initiative: Update meeting</td>
<td>Weekly</td>
<td>Health</td>
<td>Health Team</td>
</tr>
<tr>
<td>7</td>
<td>4</td>
<td>Population Health &amp; Nutrition Sector Council</td>
<td>Monthly</td>
<td>Health</td>
<td>Susan Thollaug/Kelly Saldana</td>
</tr>
<tr>
<td>8</td>
<td>4</td>
<td>Sector Council Budget Committee</td>
<td>Seasonal</td>
<td>Health</td>
<td>Susan Thollaug/Kelly Saldana</td>
</tr>
<tr>
<td>9</td>
<td>4</td>
<td>F Investing in People</td>
<td>Occasionally</td>
<td>Health</td>
<td>Susan Thollaug/Kelly Saldana</td>
</tr>
<tr>
<td>10</td>
<td>4</td>
<td>F Humanitarian Assistance Group</td>
<td>Occasionally</td>
<td>Health</td>
<td>Susan Thollaug/Kelly Saldana</td>
</tr>
<tr>
<td>11</td>
<td>4</td>
<td>Field Support Working Group</td>
<td>TBD</td>
<td>Health</td>
<td>Susan Thollaug/Kelly Saldana</td>
</tr>
<tr>
<td>12</td>
<td>4</td>
<td>Family Planning Compliance</td>
<td>Biweekly</td>
<td>Health</td>
<td>Lindsay Stewart</td>
</tr>
</tbody>
</table>
## LAC RSD Participation in Working Groups - Health Only

<table>
<thead>
<tr>
<th>#</th>
<th>Priority Ranking*</th>
<th>Working Groups/Committees</th>
<th>When Meet</th>
<th>Team</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>4</td>
<td>PEPFAR Core Team for the Dominican Republic</td>
<td>Biweekly conference calls, occasional meetings</td>
<td>Health</td>
<td>Lindsay Stewart</td>
</tr>
<tr>
<td>14</td>
<td>4</td>
<td>PEPFAR Advisor to the Caribbean and Central American HIV/AIDS Programs</td>
<td>Biweekly conference calls, occasional meetings</td>
<td>Health</td>
<td>Lindsay Stewart</td>
</tr>
<tr>
<td>15</td>
<td>4</td>
<td>Newborn Working Group</td>
<td>Occasionally</td>
<td>Health</td>
<td>Peg Marshall</td>
</tr>
<tr>
<td>16</td>
<td>4</td>
<td>Pregnancy Induced Hypertension Working Group</td>
<td>Occasionally</td>
<td>Health</td>
<td>Peg Marshall</td>
</tr>
<tr>
<td>17</td>
<td>4</td>
<td>Post-Partum Hemorrhage Prevention and Treatment Working Group</td>
<td>Occasionally</td>
<td>Health</td>
<td>Peg Marshall</td>
</tr>
<tr>
<td>18</td>
<td>3</td>
<td>Health Systems Indicators</td>
<td>Occasionally</td>
<td>Health</td>
<td>Kelly Saldana</td>
</tr>
<tr>
<td>19</td>
<td>3</td>
<td>Family Planning Graduation</td>
<td>Occasionally</td>
<td>Health</td>
<td>Lindsay Stewart</td>
</tr>
<tr>
<td>20</td>
<td>3</td>
<td>Family Planning/HIV/AIDS</td>
<td>Occasionally</td>
<td>Health</td>
<td>Lindsay Stewart</td>
</tr>
<tr>
<td>21</td>
<td>3</td>
<td>Post Abortion Care</td>
<td>Monthly</td>
<td>Health</td>
<td>Lindsay Stewart</td>
</tr>
<tr>
<td>22</td>
<td>3</td>
<td>Youth Working Group</td>
<td>Occasionally</td>
<td>Health</td>
<td>Lindsay Stewart</td>
</tr>
<tr>
<td>23</td>
<td>3</td>
<td>Working with Most-at-Risk Populations on HIV/AIDS</td>
<td>Occasionally</td>
<td>Health</td>
<td>Lindsay Stewart</td>
</tr>
<tr>
<td>24</td>
<td>3</td>
<td>Global Health Initiative: Metrics shadow group</td>
<td>Weekly, or more</td>
<td>Health</td>
<td>Kelly Saldana</td>
</tr>
</tbody>
</table>

*Priority Ranking: Rank from 1 to 5- with 5 being Required/Agency priority, 3 being Tech Working Group, and 1 being Voluntary.

**APCC: Agency Policy Coordination Committee**
For more information, please visit http://www.ghtechproject.com/resources