

USAID Policy Paper

Health Assistance

(REVISED)

Bureau for Program and Policy Coordination
U.S. Agency for International Development
Washington, D.C. 20523
December 1986

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USAID HEALTH POLICY PAPER

I. Introduction

The goal of USAID's health assistance program is to improve health status in USAID assisted countries as reflected in increased life expectancy. Most health problems in developing countries stem from poor environmental conditions; lack of health care and knowledge; malnutrition; infectious diseases (including diarrheal diseases, respiratory illnesses, measles, tetanus and tuberculosis); and parasitic diseases. Hundreds of millions of adults suffer from chronic illness, but children are the most vulnerable group. Half of all deaths in developing countries occur in the age group of five and under. The most direct way to increase life expectancy and general health status in developing countries is by addressing the health problems of children and their mothers. Thus, within USAID's health assistance program priority will be given to support for child survival and improved maternal and child health.

Child health will be approached primarily through selected child survival interventions-immunizations, diarrheal disease control and specifically oral rehydration therapy (ORT), improved nutrition and adequate birth spacing. These interventions will also provide the basis for building up more comprehensive primary health care systems over time. Priority will be placed on immunizations and diarrheal disease control/ORT, but the choice of which interventions to support will be made on the basis of country-specific conditions.

USAID recognizes that other health interventions in addition to the four listed above can make important contributions to child survival; and that other health problems in developing countries not specific to children or their mothers also need to be addressed. Therefore, other health activities, including primary health care, water and sanitation projects, and vector-borne disease treatment and control, will also be supported where there is a need to meet pressing country specific health problems. Health financing concerns should be addressed in all health projects. However, in some countries improving the financing of health care may be the main USAID activity. Where health programs beyond the four direct child survival interventions are proposed for USAID support, an additional burden of proof will be required to demonstrate their appropriateness.

Because substantial resources will be required to reach developing country goals in health, USAID's policy emphasizes investment in interventions known to be cost-effective. Such interventions are essentially preventive in nature, reducing potential future expenditures by averting diseases and conditions which are very costly to treat. Because of the high cost of curative care, USAID will not generally support curative activities except to deal with common conditions for which prevention is either difficult or even more costly than treatment. Given current technologies, examples are diarrheal disease, acute respiratory infection (ARI), malaria, and certain water-borne diseases. Major investments in the construction of physical infrastructure, the operation of which will increase host country recurrent cost burdens, will not be supported.

II. Background

A. Health Problems and Prospects in Developing Countries

Life expectancy at birth in many USAID-assisted countries is below 50 years. In those countries infant mortality is in excess of 100 per 1000 live births. In addition, many children and adults suffer from chronic, debilitating

diseases. Chronic illness leads not only to early mortality, but also to reduced working time and low productivity. The pattern of mortality in developing countries means that as many as half of all deaths occur among children under five years of age. Some fifteen million children die annually in developing countries due to the cumulative effect of repeated disease episodes exacerbated and catalyzed by malnutrition. Low birth weight renders infants vulnerable from the very beginning of life.

Infant and child mortality are the tragic results of complex interactions between poverty and disease. A variety of development efforts can contribute to reductions in infant and young child deaths, disease and disability. These include: increased income for poor people stemming from general agricultural and economic growth; reduction in hunger as reflected by the percentage of the population receiving adequate levels of nutrient and caloric intake and by reduction in the percentage of children under age five suffering from chronic and acute undernutrition; increased literacy and basic education levels, especially among women; improved health services; and increased use of voluntary planning services.

Global goals for improvement in income and education levels, reduction in hunger, disease and early death, and increased access to voluntary family planning services are established in the Agency's Strategic Plan. Efforts to increase overall economic development will improve the chances for child survival and general health status in the long term. At the same time, selected cost-effective technologies, specifically aimed at infants and children, can have a direct impact on mortality and morbidity at comparatively low cost in a relatively short time frame.

Immunization against childhood diseases, including maternal immunization with tetanus toxoids and management of diarrhea with oral rehydration therapy (ORT) can significantly reduce infant and child mortality and form the basis for an effective primary health care program. Children saved from death due to measles or diarrheal dehydration may succumb, however, to the next disease episode especially if nutritional status is low. Concurrent efforts to reduce malnutrition through a focused nutrition package including breastfeeding, feeding during and after diarrheal episodes, good weaning practices, growth monitoring and supplementary feeding programs where appropriate can help prevent this "replacement mortality" effect.

Adequate birth spacing also has a significant impact upon chances for child survival. In developing countries, a child born within two years of a sibling's birth is twice as likely to die as a child born after an interval of more than two years. An older child also has a greater chance of dying if a sibling is born within two years after that child's birth. Lower parity and births that are well spaced and are not at the extremes of the mother's reproductive life protect maternal health and help to ensure an adequate birth weight. (Low birth weight is a major determinant of infant mortality.) Improved maternal health as a result of better nutrition also affects child survival through breastfeeding and the mother's ability to provide better child care.

Other diseases that are major contributors to high infant and child mortality include vector borne diseases (especially malaria), acute respiratory disease, and infectious and parasitic diseases caused primarily by poor environmental conditions. Diagnosis and treatment of these conditions can be important and cost-effective in areas where these diseases contribute heavily to child mortality. Prevention of these diseases requires other kinds of interventions, including vector control, improved housing and provision of

safe water and sanitation.

B. USAID Response to Health Problems

1. Evolution of the Child Survival Approach

The Agency's policy to emphasize child survival interventions in its health assistance program has evolved from USAID and other donor experience in the health sector. Past experience with comprehensive primary health care programs did not provide evidence of improved coverage hoped for, or of improvements in morbidity and mortality rates, particularly in children. The current policy also has been influenced by the availability and accountability of technologies which have a dramatic effect on child survival.

In the 1970s, USAID began to emphasize a primary health care (PHC) approach. The U.S. Government participated in the Alma Ata Conference and was a signatory to the Alma Ata Declaration supporting primary health care. The 1980 USAID policy and program emphasized strengthening PHC systems through training, health education, planning and evaluation, pharmaceutical supply, administrative and logistic support, and operational and applied research. Support for water and sanitation programs, disease control, and improved planning and management also was continued.

The PHC concept was further refined in A.M.'s 1982 Health Policy Paper which emphasized the importance of determining the relative efficiency of alternative health intervention packages and improved management and administration of these programs. Another focus was the promotion of economically viable health programs, emphasizing improved resource allocation, efficiencies, and self-financing. Finally, increased emphasis was given to biomedical research. Raising the health status of children and their mothers was a primary objective of USAID's 1982 health policy, although the approach to health care programs was more comprehensive.

2. Child Survival as the Focus of Primary Health Care-Mid-1980's

USAID has funded activities aimed at child survival for many years through general health service and PHC projects. During the past few years, increased national (including Congressional) and international interest has focused on provision of selected child survival interventions as cost-effective and direct means of improving health and preventing mortality in developing countries. USAID has agreed to assist in the achievement of international child survival targets. These include the development of sustained developing country capacity to provide immunizations to children under five years of age, and ensuring access to ORT by all children in USAID-assisted countries.

USAID's child survival approach is consistent with, but more selectively focused than, the more general PHC approach previously advocated. Initial emphasis on selected child survival interventions will provide the basis for more comprehensive PHC services as other selected health interventions are added gradually. USAID will support not only accelerated delivery of child survival services, but also, and more importantly, investment in institutional development efforts which will ensure sustainability of child survival services within each country.

In addition to the continued emphasis on providing primary care, current policy emphasizes the importance of the secondary and tertiary levels of the health system, particularly the financing and resource management aspects of the health care system as a whole, and their effect on child survival. These

aspects were not fully addressed in the previous PHC-oriented policies. Finally, whereas most PHC projects were concentrated in rural areas, current policy also encourages direct attention to urban health problems.

III. USAID Policy Objectives

A. Overall Health Goal

USAID's goal in the health sector is to increase life expectancy in less developed countries. Since infant and child deaths are half of the deaths in these countries, USAID will focus on reduction of infant and child mortality and morbidity as the main intermediate objective toward the ultimate health goal

B. Specific Health Sector Objectives

USAID's primary objectives in the health sector are developing countries:

Reduce infant and early child mortality and morbidity;

Reduce maternal mortality and morbidity;

Use child survival interventions as the basis for building a more comprehensive health care system over time;

Ensure that gains made in improving child survival-and health are sustained; and

Develop new, basic, effective technologies and improved systems for delivery of child survival services.

1. Reduction of Infant and Early Childhood Mortality and Morbidity¹

This objective will be achieved primarily through:

Increasing immunization coverage. USAID will collaborate in an international effort to develop sustained capacity to provide immunizations to the world's children, with specific coverage goals defined at the country level;

Reducing diarrheal disease mortality by increased use of ORT and proper feeding during and after diarrheal episodes. USAID has joined other donors and developing countries in a worldwide effort to ensure worldwide access to ORT by those who need it;

Improving nutrition in young children through adequate breastfeeding and improved weaning practices, growth monitoring and targeted supplementary feeding (using PL 480 Title II resources and programs when available); and

Improving birth spacing and maternal health in order to decrease the occurrence of low birth weight infants and increase the survival prospects of children.

¹ The Agency Strategy on Child Survival and additional USAID strategies on Immunization, Control of Diarrheal Disease/ORT, Nutrition for Child Survival and Birth Spacing for Child Survival provide guidance on program strategy and project design.

2. Reduction of Maternal Mortality and Morbidity

USAID will promote birth spacing, child bearing during the safest part of the woman's reproductive life, pre-natal and post-natal care, safe delivery practices and adequate maternal nutrition in order to reduce maternal mortality and morbidity which affects both mothers and their children.

3. Child Survival Interventions as the Basis for Health Care Services

Provision of selective child survival interventions is not an end in itself. Child survival interventions are an effective and focused way to lay the foundation for a more comprehensive health care system with gradual addition of other interventions over time. Incremental strengthening of essential management systems, including improved training and supervision, logistics and information systems are also important elements of a strong health care system.

4. Sustainability of Child Survival Gains

Achievement and maintenance of child survival gains will require:

Promotion of revised national policies which will foster improved health financing through resource mobilization, resource allocation, containment of escalating recurrent costs, and the re-organization of the health services delivery system;

Increased private sector involvement; and

Improved coordination among donor agencies.

5. Development of New Technologies and Improved Delivery Mechanisms

USAID will continue to support biomedical research where there are favorable prospects for early application of new technologies to developing country health problems, particularly those of infants and children. USAID also will continue its leadership in applied/ operations research to address Weaknesses in health technology delivery systems and to improve efficiency. In addition, USAID will continue to address the programmatic obstacles to the effective use of child survival technologies.

IV. USAID Health Program Assistance Activities

A. Child Survival

Priority for USAID health assistance will be given to service delivery and research on selected child survival interventions. Other health interventions described in this paper may be supported, but an additional burden of proof will be required to demonstrate why these programs are proposed rather than, or in addition to, the priority child survival interventions.

1. Selected Child Survival Interventions

In order to achieve USAID child survival objectives, priority will be placed on four interventions which form the basis of the Agency Child Survival Strategy: immunization, diarrheal disease control emphasizing ORT, a focused

nutrition package and birth spacing².

Emphasis will be given to immunization and diarrheal disease control/ORT. Birth spacing and nutrition activities may be carried out simultaneously, or added as immunization and ORT coverage levels improve. In many countries, family planning and nutrition programs are already established and should not be delayed while immunization and ORT coverage levels are raised. As the delivery system is strengthened for each intervention in turn, additional services can be added.

2. Other Child Survival Interventions

A number of diseases not yet preventable by vaccination contribute to high infant and child mortality. Malaria and acute respiratory infections (ARI) are major causes of death and disability. In tropical Africa alone, it is estimated that at least one million infants and children die annually from malaria. New cases of malaria may reach upwards of 300 million worldwide per year, of which at least 100 million are infants and children. The social and economic impacts of this disease have made malaria treatment and control a priority health activity in most countries in tropical Africa, Central America, and a large part of Asia.

Between 1.5 and 3.5 million children die annually from ARI. Bacterial pneumonias, which account for the majority of deaths in the developing world due to respiratory infection, remain the most treatable. With emerging vaccine technologies, they may also become preventable.

Thus, malaria treatment and control, and diagnosis and treatment of acute respiratory infections are essential to achieving child survival goals in many countries. In countries or regions where such interventions contribute significantly to reduction of infant and child mortality they may be supported. Focused research to develop vaccines for malaria and ARI will be emphasized. USAID also may help countries to improve malaria programs to make more cost-effective use of resources.

Maternal health is important to child survival. Thus, in addition to birth spacing activities, other maternal services such as maternal nutrition and prenatal services may be supported where they can increase the prospects of child survival and reduce maternal mortality.

It also may be necessary to take into account diseases such as USAIDS which may adversely affect current or future gains in child survival. The transmission of USAIDS heterosexually and transmission from infected mothers through the placenta means that increasing numbers of infants will contract the disease. Other diseases which contribute significantly to infant and child mortality may exist or emerge in different geographic settings. Where appropriate cost-effective interventions are identified to address these problems, they also may be supported.

Environmental conditions such as poor water and sanitation can affect child health and mortality. Although not considered direct child survival interventions, certain activities to improve water supply and sanitation can be important complements to priority child survival programs and may be supported when justified on these grounds.

² Family planning service, which are usually funded from the Population account, are considered part of the Agency's child survival effort.

3. The Delivery of Child Survival Services

a. Private Sector Involvement

In countries with high infant and child mortality, the coverage rates for immunization and ORT are often low; and the government infrastructures are lacking or very weak. The use of PVOs and other private sector mechanisms to deliver services, as well as the strengthening of the government service delivery capability, are important to building and sustaining child survival services. Where government infrastructures are weak, PL 480 Title II PVO programs can assist with logistics systems, distribution, and contacts with communities and families.

In the context of child survival, private sector mechanisms include private physicians and other practitioners; private pharmacists and traders, who traditionally dispense pharmaceuticals; private health insurance organizations; and private manufacturers, as well as indigenous and U.S. based PVOs. USAID has had considerable experience in involving the private sector in family planning and health service delivery and, in particular, in the use of social marketing and modern communication techniques in health and family planning. Private sector approaches, social marketing and use of modern communication techniques should be included in child survival programs where appropriate.

b. Sustainability of Services

Strengthening child survival services will require efforts to improve the sustainability of the delivery systems. These efforts in focus primarily on improved allocation of resources, cost containment and organizational reforms in the health sector to ensure sustained levels of recurrent financing for child survival services. Improvements in essential management systems required to implement the child survival service delivery such as improved information systems, training, supervision, drug/vaccine procurement and logistics systems are also necessary.

4. The Selected Country Approach for Child Survival Programs

In order to achieve maximum impact on child mortality and morbidity within budgetary constraints, USAID will give priority in allocation of its resources to selected countries. USAID will support major child survival programs in a number of countries selected on the basis of the:

- Total number of infant and child deaths;
- Infant mortality rates;
- Mobilization and absorptive capacity;
- Government commitment to child survival;
- Availability of funds from various accounts;
- Opportunities for effective donor collaboration, and
- Expectation that USAID will continue to maintain a major program over at least the next five years.

A number of constraints adversely affect the implementation of effective health and child survival programs. Even when external funding is available, a country's capacity to absorb additional resources may be limited. Outdated policies and legal frameworks often inhibit the introduction and delivery of services. Inadequate planning and information systems, lack of infrastructure and insufficient trained personnel also constrain the ability of countries to

effectively program available donor assistance and local funds. The existence of such constraints will be taken into account in Z selection of countries for major child survival programs.

B. Beyond Child Survival

Among USAID-assisted countries, infant and child mortality rates, disease patterns, environmental conditions, economic growth levels, and government policies differ widely. The Agency's priority will be on child survival because infant and child mortality and morbidity are high in the majority of developing countries and in pockets of the populations of all countries. Countries which have not been selected for major child survival programs, but which have health programs, will also be expected to give priority to child survival interventions, although levels of assistance in most cases will be lower.

Other health interventions can be supported in both selected child survival countries and other countries. However, an additional burden of proof will be required where such programs are proposed to explain why they should be funded.

Activities supported by USAID which may affect child survival but are beyond the four primary interventions include assistance for primary health care, water and sanitation, vector control, health financing, and biomedical and operations research. These health activities will continue to be a part of the USAID health assistance program where warranted on the basis of one or more of the conditions described below.

For example, other health activities may reinforce the impact of the primary child survival interventions on infant and child mortality, or address problems which go beyond child survival. Where government commitment to child survival or ability to implement child survival activities is insufficient, but other health programs can be implemented successfully, USAID may support these other health programs to the extent that U.S. support will further policy reform in the health sector. USAID also may support health activities that are necessary components of other USAID development projects, for example, malaria control in irrigation project areas. Where lack of potable water and sanitation measures are thwarting child survival gains, USAID may help correct those environmental conditions.

In other countries, USAID support for child survival may not be required because low levels of infant mortality have already been achieved. Many, particularly some in the Caribbean, Central America and East Asia, are characterized by moderate income levels and established health systems, but the systems are not cost-effective. In such countries, USAID may want to support health financing initiatives to ensure the maintenance of child survival gains and the financial stability of the health-care system.

In both high and low infant mortality countries there may be a level above which effective utilization of child survival interventions such as ORT and immunization will not rise in the absence of changes in other conditions. Specifically, increasing coverage of immunization, ORT or other child survival services from 60% or 70% to 80% or above may not be feasible in the absence of improvements in environmental, social or economic conditions.

Although priority will be given to specific child survival interventions, the complex interactions between the effectiveness of child survival interventions and other factors should not be forgotten.

Health interventions which go beyond the scope of child survival activities

are described below:

1. Primary Health Care

USAID-supported PHC projects should emphasize child survival. During evaluation and/or redesign of existing projects special attention should be given to increasing the child survival focus of these projects. PHC services should be strengthened and expanded to meet clearly defined country specific health needs through policy dialogue, management improvement and: manpower development support. However, the services should focus initially on phased, selective interventions directed at improving child survival with additional services added incrementally.

2. Water and Sanitation

Urban water and sanitation projects will be funded mainly from the Economic Support Fund (ESF) account. Low cost per capita community water and sanitation projects will continue to be supported through PVO activities. Other community water projects will be considered for fun"g from the Health account on a case-by-case basis. The projects must be justified as cost-effective; have been shown to have an impact on child survival in the proposed setting; and be proposed in conjunction with other child survival interventions.

3. Vector Control

Vector-borne diseases affect over half of the world's population and cause an extraordinary amount of illness and deaths throughout the developing world. Yet programs of vector control incur heavy recurrent costs. In areas where such diseases cause major health problems for children, or where child survival activities may not be feasible in the absence of such support, USAID support for vector control projects may be considered. However, USAID will focus its future activities in this area on biotechnological approaches to prevention of major vector-borne diseases like malaria, onchocerciasis, schistosomiasis, and guinea worm infection.

4. Health Financing

An appropriate health financing system is critical to the ability of a society to sustain and mortality health care must be considered in an USAIDassisted health projects. Thus, health financing activities will be supported as part of child survival programs and in order to establish a sound financial basis for a health care system as a whole. Special attention to health systems finance in middle income countries will be a major part of USAID assistance outside of child survival.³

Host country inability to cover recurrent costs of preventive health care may result from excessive government spending on personal, curative care and-excessive utilization of secondary and tertiary care facilities. Health financing activities should address development of private services, fees-for-service, efficient resource allocation and utilization; equitable distribution of resources, cost containment, and the overall organization of the health system. Excessive reliance on donor funding for costs of primary and preventive health services must be avoided.

USAID should use policy dialogue, design and implementation of health

³ Agency Health Financing Guidelines providing detailed guidance in this area have been issued separately.

projects, and special health financing initiatives as mechanisms for supporting the development of sustainable health care systems. In all countries, projects should address the question of cost effectiveness. This frequently means relating cost savings and the mobilization of new resources to activities, like child survival, which are most cost-effective in improving health status.

5. Research

USAID will continue to invest in basic and applied research to develop new technologies for child survival and to improve the delivery and effectiveness of existing technologies. Continued priority will be on improvements in diarrheal disease control and immunization. Research activities will include development of a malaria vaccine, improvements in measles, pertussis and other vaccines; more cost-effective systems for service delivery; better evaluation techniques; and improved techniques for diagnosing diseases with severe impact on child survival.. USAID also will support basic research on the next generation of child survival needs, such as new vaccines, low birthweight, acute respiratory infections, the role of micronutrients in child health, and maternal nutrition. Finally, the Agency is giving special attention to research on improved approaches to financing health care, including operations research and pilot activities to involve the private sector in the delivery of critical health services.

V. Funding

Funding for USAID child survival programs and for other health activities will come from the DA Health Account, the Child Survival Fund (for child survival activities only), the ARDN account (for nutrition activities not funded from the Health Account), the Population Account (for family planning activities), ESF, Sahel Funds and local currency generations from PL 480 and ESF. PL 480 Title II food resources also will be increasingly used to achieve child survival objectives.

VI. Donor Collaboration

Achievement of internationally agreed targets for child survival through immunization, ORT, and other critical health interventions will require careful donor coordination. A number of multilateral and bilateral donors are contributing to this effort, but maximum impact will only be achieved through collaboration at both international and country levels. In areas where the U.S. has a comparative advantage, such as communications and social marketing and biomedical and operations research, USAID should take a leadership role.

VII. Evaluation

USAID must satisfy several different requirements for information and data through the monitoring and evaluation of its child survival and other health programs. Data are needed for: 1) reporting to Congress on progress in meeting targets for immunization; 2) reporting on progress in achieving designated CRT and immunization coverage targets; 3) reporting on the implementation of the Agency's child survival activities and health programs as required for all USAID projects; 4) evaluation of the impact and cost of selected child survival projects; and 5) operations research to improve the delivery, acceptance and effectiveness of child survival interventions. A standardized system for collecting information on projects has been developed, and the capacity for monitoring and evaluation should be incorporated into all project plans. USAID will collaborate with WHO, UNICEF and other donors in monitoring progress toward meeting international goals for immunization and

ORT.

Evaluation of health projects which are not directly aimed at child survival will be especially important, since these projects will have been approved on an exceptional basis and future projects will be competing with child survival activities for scarce health funds.

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The following reports have been issued in a series. These documents with an identification code (e.g. PN-AAM-323) may be ordered in microfiche or paper copy. Please direct inquiries regarding orders to:

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<u>Title-Policy Determination</u>	<u>Date</u>	<u>Fiche#</u>
PD #1-Narcotics	August 5, 1982	PN-AAM-443
PD #2-Mixed Credits	September 29, 1982	PN-AAM-444
PD #3-Voluntary Sterilization	September 1982	PN-AAM-445
PD #4-Title XII	October 5, 1982	PN-AAM-446
PD #5-Programming PL 480 Local Currency Generations	February 22, 1983	PN-AAM-591
PD #6-Environmental and Natural Resources Aspects of Development Assistance	April 26, 1983	PN-AAN-375
PD #7-Forestry Policy and Programs	May 16, 1983	PN-AAN-376
PD #8-Participant Training	July 13, 1983	PN-AAP-273
PD #9-Loan Terms Under Pl, 480 Title I	September 27, 1983	PN-AAN-753
PD #10-Development Communications	February 17, 1984	PN-AAP-616
PD #11-Using PL 480 Title II Food Aid for Emergency or Refugee Relief	July 26, 1984	PN-AAQ-159
PD #12-Human Rights	September 26, 1984	PN-AAQ-161
PD #13-Land Tenure	May 9, 1986	PN-AAQ-166
PD #14-Implementing USAID Privatization Objectives	June 16, 1986	PN-AAQ-167
PD #15-Assistance to Support Agricultural Export Development	September 13, 1986	PN-AAV-460