

I. PROJECT IDENTIFICATION

1. PROJECT TITLE Maternal Child Health/Family Planning Model Delivery Systems		APPENDIX ATTACHED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 19p
3. RECIPIENT (specify) <input type="checkbox"/> COUNTRY Latin America <input checked="" type="checkbox"/> REGIONAL <input type="checkbox"/> INTERREGIONAL		2. PROJECT NO. (M.O. 1095.2) 932-11-580-610
4. LIFE OF PROJECT BEGINS FY 73 ENDS FY 73		5. SUBMISSION ORIGINAL 6/21/73 DATE <input type="checkbox"/> REV. NO. DATE CONTR./PASA NO.

II. FUNDING (\$000) AND MAN MONTHS (MM) REQUIREMENTS

A. FUNDING BY FISCAL YEAR	B. TOTAL \$	C. PERSONNEL		D. PARTICIPANTS		E. COMMODITIES \$	F. OTHER COSTS \$	G. PASA/CONTR.		H. LOCAL EXCHANGE CURRENCY RATE: \$ US (U.S. OWNED)	
		(1) \$	(2) MM	(1) \$	(2) MM			(1) \$	(2) MM	(1) U.S. GRANT LOAN	(2) COOP COUNTRY (A) JOINT (B) BUDGET
1. PRIOR THRU ACTUAL FY											
2. OPN FY 73	2,500										
3. BUDGET FY											
4. BUDGET 11 FY											
5. BUDGET 12 FY											
6. BUDGET 13 FY											
7. ALL SUBO. FY											
8. GRAND TOTAL											

9. OTHER DONOR CONTRIBUTIONS

(A) NAME OF DONOR	(B) KIND OF GOODS/SERVICES	(C) AMOUNT

III. ORIGINATING OFFICE CLEARANCE

1. DRAFTER PHA/POP/LA, C. Johnson - A. Tinker <i>CJD AT</i>	TITLE Chief - Population Officer	DATE 6/25/73
2. CLEARANCE OFFICER PHA/POP, R. T. Ravenholt <i>RR</i>	TITLE Director	DATE

IV. PROJECT AUTHORIZATION

1. CONDITIONS OF APPROVAL  
 This is a three year contract with financing for contractor core costs and support for the design, implementation and evaluation of family planning service prototypes in up to three countries in Latin America, to be selected and proposed for AID approval.

2. CLEARANCES	
BUR/OFF.	SIGNATURE DATE
PHA/POP, J. Shafer	<i>[Signature]</i> 6/25/73
PHA/POP, E.R. Backlund	<i>[Signature]</i> 6/24/73
AA/LA, H. Kleine draft	6/28/73
PHA/PRS, G. Coleman	<i>[Signature]</i> 6/28/73
BUR/OFF	SIGNATURE DATE
AA/PHA	J.A. Kieffer 6/29/73
GC	<i>[Signature]</i> 6/29/73
PAA/PPC	P.B. [Signature] 6/21/73
3. APPROVAL AAS OR OFFICE DIRECTORS	
SIGNATURE	DATE
<i>[Signature]</i>	6-29-73
4. APPROVAL A/AID (See M.O. 1025.1 VI C)	
SIGNATURE	DATE
<i>[Signature]</i>	6-29-73
TITLE ADMINISTRATOR, AGENCY FOR INTERNATIONAL DEVELOPMENT	

# MCH/FP MODEL DELIVERY SYSTEMS

932-11-580-610.

## I. INTRODUCTION AND BACKGROUND

### A. Problem and Need

The 1973 population of Latin America is now in excess of 300 million and is exhibiting the highest growth rate of any major region of the world, at 2.8 percent per annum. At this rate, the population will more than double by the end of the century.

Mortality has been dramatically reduced in Latin America during the past few decades so that the overall mortality rate now approximates that of North America and Western Europe. On the other hand the crude birth rate for the region, despite a peak and slight decline, still stands as it was at the beginning of the century at 38 per 1000. Apart from further declines in age specific mortality of the youngest segment of the population, there will be few significant changes in the crude mortality rates. Thus it is the fertility variable of demographic growth which is most susceptible to major change. If current problems brought on by excessive population growth are to be alleviated, and future problems avoided, the most obvious need is to lower fertility rates.

Programs directed at reducing fertility, by making accessible the use of family planning methods, are an important first step toward reducing high birth rates. However, an implementation strategy must be devised and tested which will overcome political, social, and cultural barriers to the delivery and utilization of family planning services. At the Third Special Meeting of the Ministers of Health of the Americas in Santiago, Chile, in October 1972, a recommendation was made in the "Ten-Year Health Plan" that Latin American governments adopt the policy of providing family planning services as an integral part of maternal and child health services, rather than as a distinct or separate entity. This community health approach has, as one of its objectives, the achievement of a balanced reduction of excessive fertility, mortality and morbidity through the systematic services being provided. Within Latin America this must be accomplished in a manner culturally acceptable, and economically supportable in the long-run.

Implementation of such integrated family planning services to large segments of a population, particularly the poor and those in rural areas, is hindered by various factors, these being mainly:

- \* the lack of a demonstrated socioeconomic benefit rationale supporting family planning as a priority on a national level;
- \* the lack of organized delivery systems;
- \* significant gaps in the technical expertise needed to design and implement as well as support and evaluate such systems;
- \* the lack of sufficient developmental capital and strategies for mobilizing the resources needed to support delivery systems;
- \* the lack of proper training and supervision of large cadres of auxiliary personnel needed for the maintenance of the system; and,
- \* the lack of adequate management information systems for maintaining effective and efficient services delivery.

An approach to solving these problems and overcoming the related inadequacies lies in the development of a delivery system which integrates family planning services with health services, and which is supported by the appropriate management and administrative capacities, human resources planning and development capacities, evaluation strategies and services methodologies. Many Latin American nations are experiencing a need for technical assistance in the design, implementation and evaluation of prototypes for integrated family planning services. With national government endorsement and commitment, these could provide a basis for replicating such services on a national scale, greatly increasing the numbers of women accepting and continuing to use a contraceptive method.

Although fertility reduction is by no means a panacea for all development problems in Latin America, economic and social progress will be greatly hindered, if

not virtually impossible, without a decrease in the marked growth rates most Latin American nations are now facing. Developmental efforts, both local and those supported by foreign assistance, must address the population phenomenon if they are to succeed.

B. Proposed Project

It is therefore proposed that a project be undertaken to have as its purpose the design, implementation and evaluation of prototypes for integrating family planning services with health services in up to three nations in Latin America. Each would represent the dominant socioeconomic needs characterizing most Latin American countries, resulting from inadequate service delivery systems: high birth rates; high infant mortality and morbidity; and yet at the same time high population increase, rapid urbanization and great economic strain.

The prototypes would be designed, implemented and evaluated over a period of three years, to provide a demonstration area from which appropriate systems, methods and approaches could be considered by the national governments for wide-scale replication. If successful, the project could offer a basis for involving additional Latin American nations in similar family planning efforts.

C. In July of 1971, a grant, under a five-year project, was made to The Family Health Foundation (FHF) to perform four major functions in five countries to be jointly selected with AID, these being to:

1. Build a core of technical experts to provide assistance to counterpart institutions of excellence overseas in the development of family planning service delivery within a health system, preferably MCH.
2. Build expertise within the counterpart institution in the management of this type of integrated approach.
3. Provide AID with five completed feasibility studies documenting the practicability and desirability of implementing a family planning service delivery prototype in each country, each study also discussing the potential for local and international funding, broader replication, etc.

4. Serve as a mechanism for securing funds, beyond AID grant monies, to implement the service program beyond the design stage:

Under the 1971 AID grant, FHF has been developing a core support staff of family planning, health and management specialists who have related to individuals in selected LDC counterpart institutions and government agencies in Brazil, Colombia and Mexico with respect to the design and integrated family planning/health delivery systems for these countries.

The feasibility studies for Brazil, Colombia and Mexico were completed and submitted to AID by FHF in March, 1973. The FHF is currently investigating the possibilities of undertaking a feasibility study and technical assistance in Paraguay. They set forth areas in each country for the implementation of the service delivery {limited operational} prototypes as follows: {1} Brazil: an area in excess of 125,000 population surrounding Montes Claros, in the northern portion of the State of Minas Gerais; {2} Colombia: an area of roughly 110,000 in the Union de Vivienda Popular, a low-income Cali neighborhood; and {3} Mexico: a semi-rural area of approximately 88,000 population and a typical rural area of approximately 50,000 population in the State of Mexico.

- {1} In Northern Minas Gerais, an estimated 200,000 women of fecund age are producing 40,000 live births annually. Fifteen percent of the total population is now under 5 years of age and 43 percent are less than 15 years old. A crude birth rate of 42 per 1,000 correlated with the crude death rate of 15 per 1,000 yields an annual growth rate of 2.7 percent, only slightly less than the overall annual growth rate for Brazil of 3.1 percent. Health needs are great. Seventy percent of the population lack access to even minimal health care, and family planning services are unavailable to a much greater extent. The health sector is disorganized, being characterized by duplication and overlapping of functions and responsibilities, with attendant diffusion of scarce resources. Northern Minas Gerais reflects many of the health problems of all rural Brazil.

- {2} Detailed health and demographic data are very difficult to obtain for the target area of La Union de Vivienda Popular in Colombia, since it began as a squatter settlement and has only recently been included in the city limits and brought into reach of city services and administrative control. It is assumed that the national growth rate of 3.4 percent (based on a crude birth rate of 45 per 1,000 and a crude death rate of 11 per 1,000) would be reflected on a local basis in the target area. Existing information on La Union de Vivienda Popular portrays a rather bleak picture typical of urban squatter areas. Buildings are poor in condition, and health services available in only one health center. City-wide hospital admissions and other morbidity and mortality statistics reveal high rates of fertility and related maternal and child health problems. Infant mortality is 53.1 per 1,000 live births. A small hospital is currently under construction in La Union de Vivienda Popular, but existing health facilities and resources in this neighborhood and throughout the City of Cali are insufficient to meet even MCH needs. Existing services are generally found to be highly curative oriented. Family planning services are available only at Profamilia Centers located near the center of the city or at clinics in nearby barrios, all some miles distant. High risk segments of the community have not been identified and brought into the service system. Rather, those who feel the need for services must seek them out, from within a very fragmented framework of service delivery. The population and health service at La Union de Vivienda Popular typify those of the many semi-urban areas throughout Colombia.
- {3} The Mexican sites are located in the State of Mexico which surrounds the Federal District. The City of Toluca, located 65 kilometers west of Mexico City, is the state capital. Of the 240,000 population of the county, 115,000 live in the city and 125,000 are distributed among the twenty-five rural towns. Fertility and mortality rates typify the conditions of the state and country as a whole, with the crude birth rate of 46.6 per 1,000 and crude mortality

rate of 15.2 per 1,000 resulting in a current annual growth rate of 3.24 percent (migration making up the 0.1 percent difference). The effectiveness of fertility control is highly limited, but lack of available statistics for Toluca make reliable estimations of contraceptive use impossible. A recent publication of the Foundation for Population Studies, A.C. {FEPAC}, however, reports that 96 percent of rural Mexican married women in the reproductive age group were not using a contraceptive method, and that only 1 out of the remaining 4 percent were using a reliable one such as IUD, pills or injections. Because of existing circumstances, most Tolucan women are forced to rely upon public agencies for all their family planning services, which at present are only available in the City of Toluca, at two clinics. Although the rural towns are connected to the city by all-weather roads and bus transportation, for most purposes the towns are relatively self-contained and isolated. Although any woman may use the family planning services of the two clinics for a small fee, few do so. Coverage data do not exist, but only two or three patients are initiated each day in these centers. As with family planning services, health care is available almost exclusively only within the city of Toluca, but is extremely fragmented. Though a medical service framework exists, it must be better coordinated, and must be expanded to reach the population living in the rural towns. The family planning and health service needs of this area are representative of many semi-rural areas of Mexico lacking adequate systems, personnel and facilities to provide for population needs.

The typical rural site is also located in the State of Mexico some fifty miles from Toluca at the municipality of Huixquilucan which consists of 24 localities. Plans are underway by the Government of Mexico to construct 20 Casas de Salud to be staffed by voluntary auxiliaries and supervised by the staff of the health center at Huixquilucan. Contractor and a co-contractor

mutually acceptable to AID and the Government of Mexico would provide the technical assistance necessary to design, test, and evaluate this truly rural model for national replication.

## II. PROJECT SUMMARY

### A. Project Goal, Related Verifiers and Assumptions

The goal of the proposed project will be to reduce general fertility rates among target populations. This would be accomplished through the introduction of integrated, effective family planning services. Goal accomplishment will be verified by measures of change in general fertility rates, in numbers of persons accepting contraceptive methods, and continuing family planning users. [Sample surveys on birth rates and family planning practices will be conducted prior to, and during the course of the project. Census data, vital statistics and program data on patient activity will be monitored over the course of the program.] Critical to goal achievement will be that baseline data can be obtained upon which to measure program progress, and that host governments will continue to place increasing priority on the rights of the populations to receive family planning services, and that the governments allocate funds to replicate the prototype system.

### B. Projected Purpose, Related Verifiers and Assumptions

To facilitate achievement of the above goal, the project purpose is to design, implement and evaluate a family planning service delivery prototype, integrating family planning services with health services in each of the designated areas. Once these prototypes are in place, it is expected that each will serve as a demonstration base for program replication on a regional, then national scale, with potential application to other Latin American settings. The degree to which this is accomplished will be verified by the extent to which each limited population group receives high coverage, low-cost family planning services. Quarterly fiscal and semi-annual technical reports will allow continual monitoring of the process, with evaluation to be both internal and external in nature. Several conditions, however, are critical for purpose achievement. These are: {a} that the target

population will adopt and utilize contraceptive practices if they are adequately educated and informed about these and if the family planning services are made available through an integrated health delivery system; {b} that the counterpart universities identified to implement and test the prototype systems continue to have the potential to accomplish the activities involved and to offer expanded support for replication purposes; and {c} that the government and key host agencies will be able to develop and provide the necessary increasing financial and technical support.

Essential methodologies and service delivery system component elements will be introduced in phases, while being adapted and incorporated into operational prototypes applicable to the three national systems. The generic activities of each technical assistance program by year will be:

Year 1 -- The development of initial Limited Services Testing Models, serving smaller units of the population base in each target area. These will be model experimental designs for the testing of models and systems generic to the development, support and evaluation of efficient and effective family planning service delivery incorporated with health services in each area. Each testing unit will serve 10-20,000 persons.

Year 2 -- The methodologies and systems involved will be further tested, refined and extended to serve a larger total proportion of the population base.

Year 3 -- Based on the findings achieved through each Limited Services Testing Model, there will be developed an integrated and representative set of methodologies needed to serve the total population base as a whole in each target area. The resulting methodologies and systems will yield a Limited Operational Prototype serving the combined population base in each target area, or roughly 100,000 persons in each country. The prototype will provide the demonstration area for refining and documenting systems, methods and approaches which may be considered for replication in other parts of the countries and in other Latin American nations.

C. Project Outputs

In line with the above purpose, the following outputs are expected over the course of the project:

1. Trained host country personnel capable of operating and replicating service delivery, human resources development, evaluation and management elements of the proposed prototype.
2. Increased contractor capability to provide technical assistance and administrative/management support adapted to the Latin American Region.
3. Specific manuals for the following aspects of the prototype system:
  - a. Clinic operations, administration and procedures.
  - b. Records, supplies and facilities.
  - c. Patient identification, outreach and maintenance.
  - d. Internal evaluation.
  - e. Cost analysis data collection.
  - f. Patient and community education and information.
  - g. Patient referral.
4. Community household mapping and numbering system; clinic internal record system; patient history forms; mechanisms for updating patient history; patient and worker scheduling and monitoring systems; internal cost analysis system; mechanisms and systems for initiating and updating epidemiographic monitoring on such considerations as disease incidence and prevalence, morbidity and mortality by cause and degree of severity; and pregnancy history, status and outcome as related to clinic attendance and form of contraceptive and follow-up.
5. Internal program monitoring system and annual reporting system for internal and external evaluation.

6. An internally developed third year annual report, based on the format developed; a report on community impact regarding fertility, mortality, morbidity and patterns of health and family planning facility use; and a documented reevaluation of program planning with designs for implementing the evaluation system in additional areas.
7. Tested and documented management techniques for analysis of institutional/agency needs, and for determining the most feasible programming strategies.
8. Established service delivery program, information/education program, training programs, record keeping systems, and independent evaluation capability.
9. Effective operation of all components in tandem, and documentation of the process through which the management capacity was developed and transferred to host country staff, with a phasing out of external assistance in the management and operation of the program in the designated areas.

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

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

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

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

D. Project Inputs

Project inputs will be of three types: 1) contractor and host country technical assistance staff and support elements financed by AID; 2) contractor technical assistance and host country technical assistance, operational and service delivery elements financed and/or contributed by host governments and communities; and 3) technical assistance, operational and other inputs provided through other sources.

1. AID Financed Contractor and Host Country Technical Assistance Inputs

These will generally fall under five categories:

{a} Contractor Core Management, Administrative and Supportive Staff

The activities of this staff will be project-wide in nature and will include full liaison and coordination with host country governments, United States and International organizations and agencies in program planning, organization, scheduling, fiscal control, staffing and staff management including delegation and coordination of functions, communications and public information, and fund raising. The core staff will direct, coordinate and assist the activities of the other technical assistance inputs, and will provide specific backup in the development of management, administrative and systems aspects of the project in the field. Talents to be included will be professionals with medical, health, administrative, research, language translation, and country specific expertise. Clerical and secretarial support for this group is included under this category.

{b} Contractor Technical Assistance Teams

Persons under this category would accomplish

task-directed support in the four following components of technical assistance: 1} Human Resources Development {Training}; 2} Services Delivery; 3} Evaluation; 4} Management, and 5} Documentation Support. They would undertake preliminary work in the United States, by component, essential to field provided technical assistance: and, they will assist host country professionals and officials in the design, application and adaptation of generic materials, models, curricula and program sub-systems needed for the design, implementation and evaluation of each prototype.

Technical Assistance in the areas of family planning and health services delivery and management will be complemented significantly by inputs from contractor staff as indicated earlier under that heading.

{c} Host Country Technical Assistance Teams

In-country technical assistance teams formed by host country personnel will serve as counterparts to contractor technical assistance personnel in the areas of Human Resources Development, Services Delivery, Evaluation and Management. These persons will provide the program the necessary insights and techniques for organizing local resources to meet needs within the social, political, economic, religious and cultural dimensions of each prototype setting. These persons would provide the initial manpower base through which an increased host country capacity can be developed.

{d} Commodities

These will include materials for the preparation of manuals and media to be used in the program, equipment in support of specialized aspects of technical assistance such as demonstration equipment to be used in-country for manpower training and public information.

Requirements of contraceptives and medical equipment will be outlined in each country specific project and the sources of procurement identified.

2. Host Country Financed/Contributed Technical Assistance and Operational Inputs

Support from host countries will include technical assistance staff, facilities, equipment, and other aspects of support to the operational activities of the project. The latter will include staff for services delivery, and backup medical facilities for referral purposes. Funds will be provided by the host countries, in some cases from AID health loans, and other sources. Host countries' input commitments will be identified in each specific country proposals submitted.

3. Technical Assistance and Operational Inputs Provided Through Other Sources

Ford and Rockefeller Foundations have been approached to provide additional support for technical assistance. These other inputs will be identified in the country proposals.

BUDGET SUMMARY

I. Core Support Costs

	<u>FY 1974</u>	<u>3 Year Total</u>
A. Personnel	\$ 221,667	\$791,767
B. Travel	45,000	122,000
C. Consumables	14,500	39,500
D. Equipment	10,000	27,000
E. Other	19,403	45,189
F. Overhead	<u>86,556</u>	<u>285,794</u>
TOTAL	\$ 397,126	\$ 1,311,250

II. Country Specific Costs For Three Countries

A. FHF Technical Assistance	\$ 600,000
B. Host Country Personnel	200,000
C. U.S. Consultants	37,000
D. Host Country Consultants	11,000
E. Travel	94,000
F. Consumables	8,100
G. Equipment	7,000
H. Other	18,000
I. Overhead	<u>213,094</u>
TOTAL	\$ 1,188,694
GRAND TOTAL	\$ 2,500,000

AID 1920-20 (1-72)

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

Life of Project:  
From FY 74 to FY 77  
Total U. S. Funding 2.5 million  
Date Prepared: 6/2/73

Project Title & Number: MCH/FP Model Delivery Systems #932-11-580-610

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><b>Program or Sector Goal:</b> The broader objective to which this project contributes:</p> <p>Reduce general fertility rates through the provision of improved and integrated family planning services to the target population in up to three Latin America countries.</p>	<p><b>Measures of Goal Achievement:</b></p> <p>Declining general fertility rates and increasing number of acceptors and continuing family planning users.</p>	<ol style="list-style-type: none"> <li>1. Sample surveys.</li> <li>2. Census</li> <li>3. Vital statistics</li> <li>4. Program data</li> </ol>	<p><b>Assumptions for achieving goal targets:</b></p> <ol style="list-style-type: none"> <li>1. Host governments place increasing priority on right of population to family planning services.</li> <li>2. Baseline data will be developed by which to measure progress.</li> <li>3. The governments replicate the prototype system and allocate the funds to do so.</li> </ol>
<p><b>Project Purpose:</b></p> <p>To design, implement, and evaluate a family planning service prototype in up to three countries providing a demonstration base for replication on a regional, then national scale, with potential application in other Latin American countries.</p>	<p><b>Conditions that will indicate purpose has been achieved: End of project status.</b></p> <p>Three limited operational prototypes completely installed in designated regions at high coverage and low cost.</p>	<ol style="list-style-type: none"> <li>1. Internal and external evaluation</li> <li>2. Technicians reports</li> </ol>	<p><b>Assumptions for achieving purpose:</b></p> <ol style="list-style-type: none"> <li>1. Target population will adopt contraceptive practices if informed and services are made available to it through an integrated health delivery system.</li> <li>2. Universities identified to implement system have institutional potential to expand support to national scale.</li> <li>3. Government and key host agencies will provide necessary increasing financial and technical support.</li> </ol>
<p><b>Outputs:</b></p> <ol style="list-style-type: none"> <li>1. Trained host countries personnel capable of operating and replicating family planning delivery system.</li> <li>2. Increased contractor capability to provide technical assistance and administrative/management support adapted to the Latin American region.</li> <li>3. Specific manuals prepared in various aspects of the prototype system; data bank.</li> <li>4. I/E program, training programs, record keeping systems, independent evaluation.</li> </ol>	<p><b>Magnitude of Outputs:</b></p> <ol style="list-style-type: none"> <li>1. Numbers of host countries professional and auxiliary personnel trained</li> <li>2. Percentage of target population receiving family planning services.</li> <li>3. Operations manuals and training curricula designed, documented and disseminated.</li> <li>4. Data bank in operation and evaluation system fully functioning.</li> <li>5. Numbers of contractor staff qualified to provide technical assistance.</li> </ol>	<ol style="list-style-type: none"> <li>1. Reviewing evaluation of implementation against plan</li> <li>2. Performance evaluation of trainees on job</li> <li>3. Technicians reports</li> <li>4. Site inspections</li> </ol>	<p><b>Assumptions for achieving outputs:</b></p> <ol style="list-style-type: none"> <li>1. Host government will have institutional capacity to undertake task.</li> <li>2. Personnel respond to training opportunities.</li> <li>3. Prototype delivery system culturally acceptable and economically supportable for host government in the long-run.</li> <li>4. Host country conditions allow recruitment selection and training of personnel who will respond favorably to training and job responsibilities.</li> </ol>
<p><b>Inputs:</b></p> <ol style="list-style-type: none"> <li>1) Contractor and host country technical assistance staff and support elements funded by AID;</li> <li>2) Contractor technical assistance and host country technical assistance, operational and service delivery elements financed and/or contributed by host governments and communities; and 3) technical assistance, operational and other inputs provided through other sources.</li> </ol>	<p><b>Implementation Target (Type and Quantity)</b></p> <p>See budget and prop.</p>		<p><b>Assumptions for providing inputs:</b></p> <ol style="list-style-type: none"> <li>1) Contractor provides technical assistance, commodities and training.</li> <li>2) Host country provides technical assistance counterparts, personnel, facilities and funds.</li> <li>3) Other donors provide contributions as committed or proposed.</li> </ol>

## APPENDIX TO PROP

### I. Staffing

(a) <u>Number</u>	(b) <u>Specialized Field</u>	<u>Annual Salary</u>	<u>Duration of Assignment</u> (Man-Months)
1	Project Director	36,000	34
1	Deputy Project Director	34,500	34
1	Finance Specialist	30,500	34
1	Epidemiologist/Evaluation	30,500	34
1	Bio-Statistician/Evaluation	21,000	34
1	Administrative Assistant	14,000	34
4	Secretaries, preferably bilingual	40,000 (4)	34
3	Translators	36,000 (3)	34
1	Program and Reports Officer	28,000	34

### Scope of Technical Services - Technicians

Core costs to support the staff at FHF in New Orleans during FY 1974 will provide funds for the 14 full-time staff members listed above. This includes management, professional/technical, administrative/clerical and language specialist staff, who, during FY 1974, will prepare specific country assistance proposals as described in the PROP for submission to the project manager for review and approval.

Since the purpose of this project is to develop, implement, and evaluate pilot family planning and health services delivery systems, the rationale for core costs is to support the country specific pilot projects. Therefore, no separate budget item is included for core costs in FY 1975 and FY 1976. Each of the country-specific pilot projects will include in its budget an amount for core costs for FY 1975 and FY 1976, not to exceed one-third of the total amount provided for annual core costs in FY 1974. This is to insure that the core support costs are directly related to the country-specific pilot projects; if fewer than three pilot projects are developed, core support costs will be decreased accordingly. For example, if only two country projects are approved, core costs would be decreased by one-third.

### II. Special Provisions

1. International and domestic travel may be undertaken as necessary to meet program objectives. All requests for international travel, specifying the purpose of the travel, must be submitted by the contractor to the project manager in writing at least two weeks prior to initiation of the proposed travel; the project manager must give written approval for international travel before the travel begins. Domestic travel must be approved in writing in advance by the project manager. All sub-contracts must be approved in advance by AID/W.

2. Changes in approved budget items, in core staff or country project staff levels or salaries must be requested by the contractor in writing to the project manager and all approvals by the project manager must be in writing to the contractor. Requests must be submitted at least two weeks before any proposed change is to become effective.

3. No funds will be authorized for commitment or expenditure by the contractor for specific country projects until the following conditions are met and agreed to by the project manager in writing:

a) Contractor must submit to the project manager a country specific work plan and schedule, a detailed budget outlining the personnel and financial resources required by fiscal year, the objectives to be attained in the pilot project with estimates of family planning acceptors to be served, the local and other external resources contributing to the project, and the host government institutions with whom the contractor will work.

b) The project manager has secured approval of the project from the AID Mission, the host government, the Bureau for Latin America, and the Bureau for Population and Humanitarian Assistance.

4. Key personnel must be approved in writing by the project manager prior to employment under this contract. The contractors will submit a curriculum vitae for all key personnel to the project manager. For FHF core staff, the following positions are considered key personnel: project director, deputy project director, finance specialist, epidemiologist, biostatistician, and program and reports officer. Key personnel for technical assistance teams will be determined by the project manager at the time of approval of country projects, and the contractor will be informed in writing.

5. The contractor may provide the technical services of third country nationals upon written request to and written approval by the project manager.

6. All specific products, such as clinic manuals should be submitted to AID Monitor along with monthly reports for AID comments/suggestions prior to final publication.

### III. Reports

1. The contractor will submit a monthly report providing the following:
  - a) A narrative summary of progress in meeting the objectives of this contract, problems encountered and proposed actions to solve the problems.
  - b) A summary of all financial commitments, obligations, actual expenditures, and remaining uncommitted funds by budget category.
  - c) A summary of man-months of services provided for all approved categories of manpower and all travel undertaken during the month.

d) When country projects are undertaken, the monthly report should include a brief summary of activities undertaken and completed in each country, with statistics on the number of family planning acceptors served.

2. The contractor will submit an annual report by June 1 beginning in 1974, summarizing progress to date in meeting project objectives and highlighting the major problems encountered. The report should include a financial summary.

The format of the monthly and annual reports will be developed by the contractor and the AID project manager and approved in writing by the project manager to the contractor.