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FOSTER PARENTS PLAN, INC.
MATCHING GRANT
SECOND ANNUAL REPORT
TO THE
AGENCY FOR INTERNATIONAL DEVELOPMENT
GRANT #SOD/PDC-G-0421

August 1982

Foster Parents Plan, Inc.
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Warwick, RI 02887

ANNUAL REPORT TO USAID

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A. SUMMARY

At the end of the second of a three year grant period, PLAN has expanded or established health promoter projects at six Field Offices in four countries, serving both rural and urban populations in Colombia, Haiti, Ecuador and Indonesia. Despite difficulties in locating and training new management and health care personnel, the project, at the end of its second fiscal year, is well into the implementation phase. In Guayaquil, Guaranda, and Tumaco, plans are being made to expand the project into more communities. In Jacmel, Yogyakarta and Tumaco, the emphasis on health promotion has stimulated an interest in notable water projects.

- ... 95 paid community health workers have been trained in the fundamentals of primary health care. Training continues to be upgraded and communication skills improved. Plans are underway in at least two project sites to train a second group of health promoters (HPs) to serve additional communities.
- ... Approximately 6,000 people are now working as unpaid community health volunteers or serving on community health committees under the supervision of trained health workers.
- ... Eleven local staff are in place and trained in the philosophy of primary health care and program management as a result of this grant.
- ... Collaboration with local organizations and ministries of health is excellent in Indonesia and in both posts in Colombia and Ecuador. In Haiti, the cooperation is improving.
- ... Six new health posts have been constructed and three existing clinics improved.

- ... All HPs have been trained to monitor the growth of children using the Road-to-Health Charts. Children under six are being weighed monthly in Yogyakarta and in Tumaco.
- ... Data are routinely being collected on prenatal care, vaccinations and family health. Baseline studies were done in Tumaco, Guayaquil and Bogota. Case studies have been prepared for the Guayaquil and Tumaco projects. A study focusing on Yogyakarta's water project is planned.
- ... The program will be taken over by the local government's Ministry of Health in Bogota, Tumaco and Jacmel. In Indonesia, the present system of collaboration will continue. In Bogota, the program has already become the community outreach department of a private hospital. In Guayaquil, the cost of the program will be assumed by PLAN.
- ... Total USAID expenditures for the first two years are projected to be \$1,222,587; a final year's budget of \$680,585 is planned. These funds were matched by PLAN health program expenditures of a total approximately \$2,333,240 in FY 81 and FY 82. In FY 83, the PLAN health budgets for these Field Offices and an IH match of USAID funds totals \$1,652,655.

PLAN currently has Field Offices in twenty-two developing countries' many of which have or are planning to undertake primary health care projects. As a result of the HMGP, PLAN has developed methodologies for training health promoters, developed strategies for identifying community members who make effective health promoters, and set up mechanisms for monitoring changes in the

nutritional and health status of communities. It has expanded its own programming and, as importantly, stimulated local governments to expand their primary health care efforts. As PLAN programs continue to expand in the primary health care area, the lessons learned from the HMGP will enable PLAN to be more effective in its world-wide programs. As the project moves into its third year, it is expected that 68,000 PLAN-affiliated families and the communities in which they live will have a better understanding of the prevention of illness and will have developed skills for organizing to improve community sanitation. Not only have representatives from these communities been trained to identify and prevent common illnesses, an administrative structure for a responsive primary health care project has been put in place. Members of the community are coming together in committees and general meetings to discuss their problems and ways of solving them. Prior to this project, in at least five of the sites, there had been no health organization committed to prevention and education. In the remaining site, the grant allowed the expansion of an existing Government program.

B. PLAN AND THE MATCHING GRANT

1. Overview of Foster Parents Plan

Foster Parents Plan began in 1937 in response to the humanitarian needs of children orphaned during the Spanish Civil War. Over the past 45 years it has grown to provide services and programs to children and their families in urban slums and remote rural areas in 22 countries around the world.

In addition to Foster Parents Plan, Inc., which was established in the United States in 1937, other national organizations have been incorporated in Canada in 1968, in Australia in 1970, in the Netherlands in 1976 and in the United Kingdom in 1980. In 1973, PLAN's International Headquarters was established to coordinate overseas program activities for the affiliated national Foster Parents Plan organizations. All Foster Parents Plan National Offices are non-profit, non-political, non-sectarian voluntary organizations.

Each National Office functions under its own National Board of Directors. Foster Parents Plan, Inc., the U.S. national organization, is located in Warwick, RI, where executive, marketing, finance and operations staff are based. Approximately 50,000 donors and a growing corps of volunteers are located across the country. The American organization, like its counterparts in other donor countries, is responsible for all national fund raising, public affairs, donor relations, development education, and other domestic activities.

International Headquarters (IH) is located in Rhode Island, where program coordination and accounting staff are officed. Headquarters staff consists of four departments: Executive, Finance, Program and

Administration. An organizational chart of the Program Department is shown on the next page. The primary task of International Headquarters staff is to coordinate and assist the Field staff.

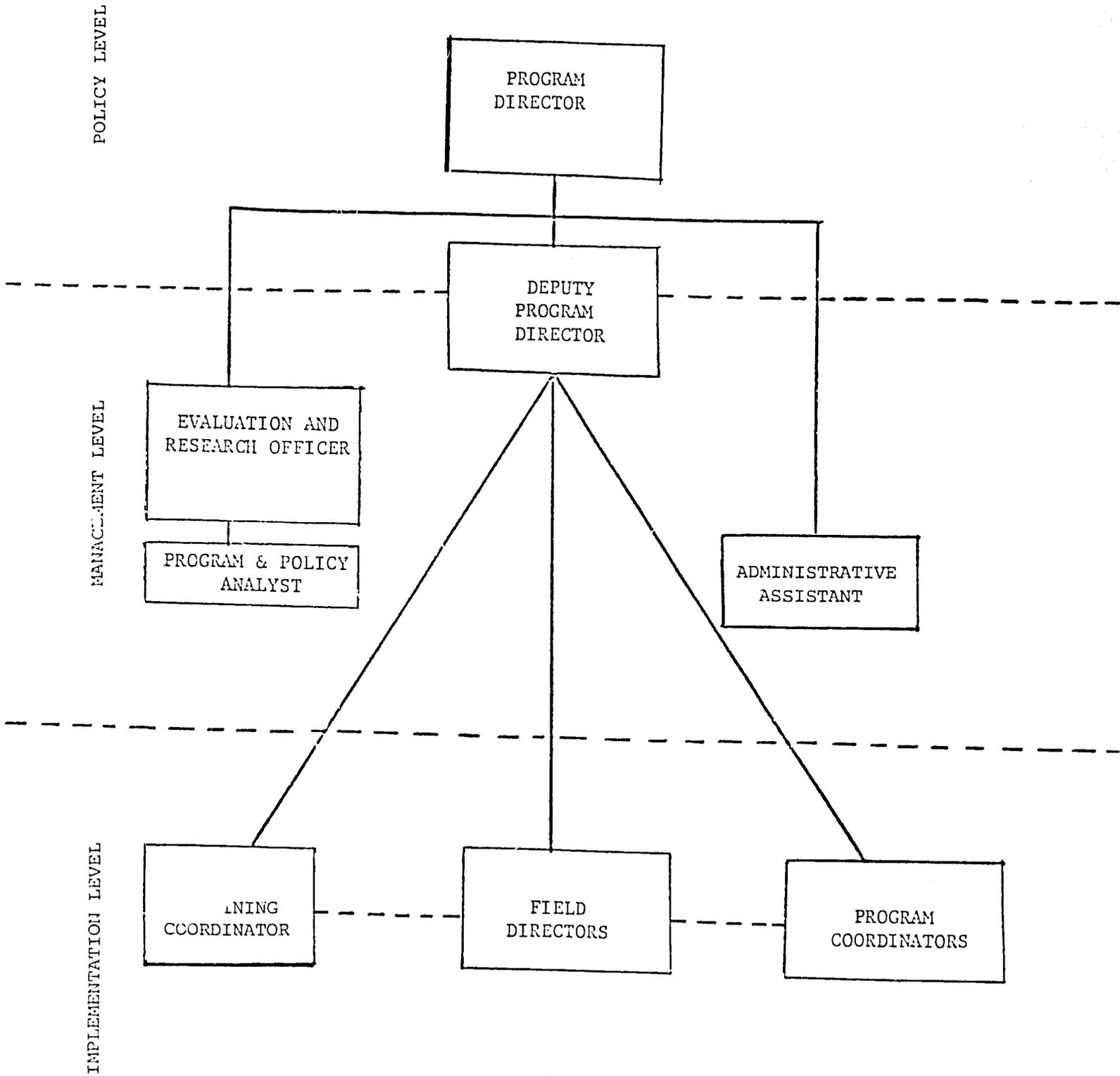
IH supervises the programs in developing countries, coordinates systems between those programs and the National Offices, establishes new National Offices, negotiates with governments of developing countries, and plans programs and enrollments in program countries based on National Office needs. International Headquarters has its own International Board of Directors which is composed of members of the National Boards with voting strength commensurate with the number of Foster Parents each National Office brings to the entire organization.

PLAN programming normally originates at the Field level where staff work with community groups to develop programs to meet both long range and more immediate needs of clients, their families and their communities. Whenever possible, PLAN uses its programming and funds to stimulate the government or other private agencies to provide services to the communities. PLAN, for example, may offer to build a health post on the condition that the local Ministry of Health maintain and staff it. In the case of the HMGP, at all Field Offices, the local government has been stimulated to provide services not previously available to the communities.

Each Field Office is directed by a Field Director (FD). In the larger programs and those with more geographic spread, the FD is assisted by one or more Assistant Directors (AD). FDs and ADs are expatriate members of the International Staff who are subject to assignment at any PLAN Field Office. Most FDs have Field experience in

FOSTER PARENTS PLAN INTERNATIONAL

PROGRAM DEPARTMENT



NOTE: The HEMGP Evaluator who reports to the E & R Officer and the HEMGP Advisor who reports to the Program Director are not shown as they do not appear in the budget and their salaries are paid by USAID through the special health project.

more than one country and often on more than one continent. Aside from the FD and the AD, all other PLAN staff members are hired locally. Depending on the number of Foster Children affiliated with a post, the size of the staff may range up to 150 people. Yogyakarta, with 19,000 FCs, and Guayaquil, with 15,000, are among the largest Field Offices. The core of the Field staff are the social workers who work with client-families or groups of families and assist them in improving their situation. Besides social workers, PLAN Field Offices also have a staff of professional program planning specialists who work in education, community development, health and other specialities depending on local needs.

In addition to the regular programming staff, the HMGP provided funds for the employment of two people to work full-time on the project. The Project Evaluator reports to the Research and Evaluation Officer and is officed at International Headquarters. Her job description includes responsibility for the research and evaluation components of the grant. She assumed her responsibilities in July 1981. Since that time, baseline studies and community surveys have been conducted in three Field sites. In addition to working with Field Staff who conduct those studies, she has written case studies on the projects in Tumaco and Guayaquil. Copies of the case studies and analyses of the data from the surveys is available from IH.

The second person hired under the terms of the grant is the Health Advisor who is responsible for providing technical assistance in the area of health and who reports to the Program Director. Trained in nutrition, she lives in Ecuador and divides her time among the Field sites as needed. She assumed her position in April of 1981.

2. Overview of Finances

PLAN's main source of funds is its Foster Parents. Over 80% of PLAN's income is from the 204,576 individuals and organizations who sponsor children in 22 developing countries. The dialogue between the Foster Parents and Foster Children is the heart of the organization. Letters are exchanged between Foster Parents and Foster Children as a means of communication that would not ordinarily be available to either.

In addition to the individual sponsors of children, some funds come in the form of Designated Contributions. These are usually lump sums from people or organizations who wish to make a contribution whether or not they sponsor a child. These contributions range in size from \$20 through \$10,000. They may be designated for some particular project or Field site or to be used "as needed." For larger projects, PLAN accepts funds from government development agencies.

The following section includes reports from the individual Field Offices involved with the HMGP and outlines their methods and activities to date. Logical frameworks are included for each project and include more detail as to project objectives and the assumptions on which they are based. Budgets for each project are included at the end of the report.

C. REPORTS FROM THE FIELD

BOGOTA, COLOMBIA

The objectives of the Bogota HMGP are to motivate communities to seek solutions to their health problems and to decrease the rate of morbidity and mortality through preventive health measures, especially among the maternal and infant population.

Methods

This is to be done by identifying those families at risk of preventable illness and design and implement a system of home visits to those families by community health workers. The community health workers will also develop a community based health education program and provide primary health care to women of childbearing age, infants, and children. There will be components, also, in dental health and in environmental sanitation.

Activities to Date

1. Twelve health promoters have been selected and trained. Following theoretical training, they are in the process of receiving practical training at a hospital in Suba, the low income suburb of Bogota where the HMGP is being implemented.
2. Training and demonstration materials have been developed and upgraded to be used in the training of future health promoters.
3. A baseline study of the health status and socio-economic conditions of 865 households was completed. These data were analyzed by PAMI, a health research institution affiliated with one of the local universities. The questionnaire was constructed and supervised by local HMGP staff. The data will be used as a basis for future program planning.

4. A risk formula has been devised by which those families who are more susceptible to preventable illnesses can be identified. Six hundred families comprise the target population of high risk households. Health promoters, who will make home visits, provide education and referral services to these families.
5. The program of home visits is currently underway. Until this point the program was concentrated on training the health promoters, on community education and on the collection of data.
6. Arrangements have been made with a private hospital, Hospital Vecinal San Pedro de Claver de Suba, in Suba to take over the management and support of the health promoter project. The salaries of the health promoters and supervisors will be paid by PLAN through the hospital. The hospital will provide supplementary training, office space and back-up for referrals to secondary care. Administrative authority will be shared by PLAN and the Hospital Director.
7. A referral system has been established with the hospital so that the HPs may refer people for curative services, vaccinations, or family planning.
8. Consideration is being given to expanding the program to Bosa, another low-income section of Bogota where PLAN has clients and where health services are limited.
9. Health committees are being formed in five neighborhoods with high population densities and high risk factors. Four committees are now being formed. It is anticipated that the health promoters will be collaborating with more committees in the next year and that the activities of those committees will be strengthened and broadened.

10. Educational talks are given daily to groups in the community. These groups include large community meetings as well as smaller groups of mothers, parents, PLAN affiliates or school children.

NARRATIVE SUMMARY

Program or Sector Goal: The broader objectives to which this project contributes: (A-1)

- To motivate communities to seek solutions to their health problems.
- To decrease rates of morbidity and mortality through preventive health measures, especially among the maternal-infant population.

Project Purpose: (B-1)

- To identify families at risk of preventable illness and design and implement a system of home visits to these families by CHA'S.
- Develop community health education activities.
- Organize health education courses for interested community groups.
- Provide primary health care in the following areas:
 - Maternal { Pre- and Post-natal attention.
Family Planning and Uterine Cancer Screening.
 - Infants and Children { Immunization
Nutrition, Growth and Development
Intestinal parasitism, Oral Rehydration.
 - Dental Health
 - Mental Health
 - Environmental Sanitation.
- Coordinate program activities with secondary and tertiary services provided by the MOH.

Outputs: (C-1)

- In the Field: - To advise communities regarding the organization of Health Committees.
- To offer discussions and presentations concerning community and family health at the household level and to small groups.
 - In coordination with the Cooperative in Suba to design and implement a program wherein the community will assume financial and administrative responsibility for the program over a five year period.
 - To inform community members of the availability of and their rights relative to government health services.
 - To organize and coordinate projects and campaigns concerning vaccinations, dental health, parasitism, environmental health, etc.
 - To support the local health infrastructure through assistance to local hospitals and clinics to help them better meet the anticipated increased demand for their services.
 - Record-keeping and case follow-up among high risk families.
- Administration: - Supervision and coordination of personnel and field activities.
- Coordination with the different Plan department programs to more effectively promote the educational activities, environmental sanitation projects, mental health program, etc.
 - Coordination with public and private organizations to give conferences, help with nutrition dental and parasite eradication programs, vaccination campaigns, etc.
 - Construction, equipping and staffing of Community Health facility.

Inputs: (D-1)

- Financial support from USAID and Plan.
- Development and elaboration of educational and demonstration materials for the CHA'S and the community, including ongoing training for CHA'S.
- Technical support and supervisory staff.
- Assistance from program Coordinator and Program Evaluator.
- Supply of necessary materials for the implementation of the above-mentioned campaigns.

OBJECTIVELY VERIFIABLE INDICATORS

Measures of Goal Achievement: (A-2)

- Levels of community participation and effectiveness in existing community health committees.
- Number of functioning committees where none existed before.
- Projects initiated (as collaborations between PLAN and a given community) to resolve environmental sanitation problems.
- Comparison of the nutritional status of the community at the beginning of the program with that at one year and later.
- Levels of children immunized.

Conditions Expected at End of Project: (B-2)

- An awareness on the part of the community about the concept of preventive health.
- An improvement in personal hygiene, household and community sanitation and diet.
- A decrease in incidence of malnutrition.
- More mothers receiving pre- and post-natal care.
- An increased number of women being screened for uterine and breast cancer.
- Accurate family planning information available to more women and couples.
- Decreased incidence and severity of gastro-intestinal infection.
- More and better utilization of available health services.
- A heightened awareness on the part of community members regarding the importance of being well organized and working together.
- Mechanisms designed for community funding and administration of the program (in collaboration with public and private institutions working in primary health care).
- Well-functioning community health committees.

Magnitudes of Outputs: (C-2)

- To assist and where necessary help to organize one Health Committee in each of the 20 sectors of the area where the program is being implemented.
- Presentation of approximately 400 educational sessions by the CHA'S to small community groups.
- Individualized counseling on the household level among approximately 1800 families which represents about 10,500 persons.
- Formulation of an evaluation and record keeping system.
- Construction, organization, equipment and staff for one community health facility.
- Programs of vaccinations, mental health and parasite eradication with capacity to cover 70% of the pre-school and school age population in the sectors of the city where the program is functioning.
- Special classes for two groups of mothers per sector (40 groups) concerning child growth and development with the goal that these mothers will become informal educators among their friends and neighbors.
- Construction of ten latrines.

Implementation Target (Type and Quantity): (D-2)

- Selection and hiring of technical support and supervisory staff.
- Development of a manual of activities for the CHA'S.
- Coordination of activities with other organizations involved in similar or related programs.
- Implementation of a referral and follow-up system, which involves weekly review of records, referral to Community Health Facility and governmental clinical services.
- Supervision of the CHA'S work both in the home and with community groups.
- Continuous motivation of community groups and organizations which have undertaken health-related projects.

FRAMEWORK

MEANS OF VERIFICATION

(A-3)

- Review, analysis and comparison of data generated by internal record-keeping system.
- Direct field supervision of Community Health Assistants. (CHA)
- Monthly reports by Nurse and Social Worker Supervisors of CHA.
- Regular department and inter-departmental meetings.

(B-3)

- Quarterly progress report to the Field Director which would include a statistical presentation of "the measures of goal achievements".

(C-3)

- Monthly reports from CHA'S, their supervisors and Community Health Facility Staff.

(D-3)

- Monthly budgetary controls.
- Regular supervision of CHA'S.
- Visits from International staff.

IMPORTANT ASSUMPTIONS

Assumptions for achieving goal targets: (A-4)

- That the Community Health Program will contribute to a decrease in maternal-infant morbidity and mortality in real and significant levels which can be taken as indicators of an overall improvement in the health status of the community.
- That the experience gained by the implementation of this program will provide a guide to other Plan departments and other organizations attempting programs which require a high level of community participation.
- That the inadequacies of secondary (clinical) services will not significantly interfere with the achievement of program goals.

Assumptions for achieving purpose: (B-4)

- That the community health committees and other community organizations are capable of and interested in solving their own health problems, and will remain motivated over time.
- That the content and presentation of the health education sessions will be appropriate to stimulate community members to incorporate the information into their daily habits and activities.

Assumptions for achieving outputs: (C-4)

- That sufficient funds exist for the construction of the Community Health Facility.
- That it is possible to development and effectively present applicable and meaningful preventive health information to this community.
- That community members will not confuse the functions of the CHA with those they perceive for clinical practitioners.
- That there will be an effective coordination of activities among the Plan departments of Education, Social Work, and Community Development.

Assumptions for providing outputs: (D-4)

- Secondary and tertiary referral services will be effective.
- That changes in local political leadership will not interfere with the continuing functioning of the program nor with motivation to participate on the part of community members.

TUMACO, COLOMBIA

The objective of the PLAN/Tumaco Health Program has been to promote an awareness of the benefits of good health and to introduce preventive health habits into the daily lives of the urban and rural populations where PLAN/Tumaco has affiliated families. The target population is women of childbearing age and children under six. The emphasis is on preventing common infectious diseases and malnutrition. PLAN/Tumaco has collaborated extensively with the Ministry of Health's efforts to institute and maintain a primary health care program in addition to traditional curative services.

Activities to Date

1. Recruitment and training of 14 health promoters; four to administer the health posts, and to coordinate home visits by the remaining ten.
2. A Program Manager and support staff have been recruited and have been with the project from its inception.
3. In-service and continued upgrading of the health promoters' skills is being provided by the MOH and PLAN. A communication workshop was held. Midwife training is in process.
4. A system of record keeping and monitoring has been established.
5. Baseline data on 782 families in 15 communities adjacent to the health posts were collected.
6. Well-baby clinics have been established at each of the three urban health posts in which children will have their growth monitored and receive vaccinations. The Road-to-Health Chart is being introduced and diet histories are kept. As of June, 450 children were enrolled.

7. Prenatal programs have enrolled 60 participants. Pregnant women are being taught the importance of good nutrition. They are weighed, vaccinated against tetanus and have their blood pressure monitored.
8. Family planning programs have a total of 60 participants. An important aspect of the family planning program is to educate women in the community about the alternative methods available to them. Two complementary aspects of the family planning program are Pap smears and teaching women to do breast self-examinations.
9. Community education programs are expanding in the areas of preventing commonly occurring illnesses such as colds, diarrhea and skin infections. First Aid is also taught.
10. Plans are underway to begin dental health, tuberculosis prevention and hypertension education programs.
11. A library of instructional and demonstrational materials has been started and is continually being upgraded.
12. A system of referrals exists, whereby clients may be referred first to the health posts and, if necessary, to the local hospital.
13. The health program of PLAN/Tumaco is working collaboratively with other PLAN/Tumaco programs such as home building, roof repair, community education, latrine construction and rural water systems.
14. Three health posts have been constructed collaboratively by the health program staff and the communities. In these cases the communities provided the labor; PLAN provided the supervision and materials. One of these is a new health post, two were existing structures which have been remodeled to serve as health posts. It was originally intended that a fourth health post would be constructed in

- the town of Tumaco; however, it has been determined that at this time the need for health posts is greater in rural areas. Plans are underway, however, to construct three health posts in the surrounding rural areas which have even more limited health services than Tumaco.
16. The health promoters have collaborated with the Ministry of Health in an extensive vaccination program in Tumaco and in a community-wide census. About 6,000 vaccinations of BCG, DPT, polio, measles and tetanus were given during the first three months of 1982.
 17. Community health committees have been formed in the urban areas where PLAN has health posts. PLAN is working with existing community organizations in rural areas to determine the health needs of the surrounding rural areas and an effective method by which PLAN and members of the community can collaborate.
 18. Plans are now underway to train a second group of community health workers who will be recruited from and work in the rural areas where health posts are being constructed or already exist under the Ministry of Health's supervision.
 19. The program will be taken over by the Ministry of Health at the end of the AID funding period. This arrangement has been clear since the inception of the HMGP and accounts for the very strong cooperation between the Ministry and PLAN. The health promoters will become salaried by the Ministry of Health and supervised by the head of nursing services at the hospital.

NARRATIVE SUMMARY

Program or Sector Goal: (A-1)

To promote an awareness of the benefits of good health, and to introduce preventive health habits into the daily lives of the urban and rural populations in the areas where PLAM-Tumaco is working. Emphasis is placed on preventing common infectious illness and malnutrition among women of child-bearing age and infants and young children.

To support local Ministry of Health efforts to institute and maintain an ongoing primary health program in addition to traditional curative services.

Project Purpose: (B-1)

- To educate families to prevent common illnesses or to treat them when they occur.
- To support a comprehensive vaccination campaign.
- To promote appropriate nutritional practices for mothers and young children.
- Establish and implement a growth monitoring system which is understood by mothers.
- Introduce and foster attendance in pre- and post-natal attention programs
- Offer family planning education to interested participants.
- Coordinate eventual transition of control and administration of the program from PLAM to participating communities and MOH.
- Establish an ongoing evaluation process (to be assumed by MOH).
- Provide personal and community hygiene and sanitation education and facilities.
- Identify and establish coordination mechanisms for communities to mobilize the various resources available to improve sanitation, malaria and potable water conditions.

Outputs: (C-1)

- Recruitment, education and placement of 14 health promoters: four to administer health posts and coordinate the home visits and community organization and health education activities of the remaining ten.
- Designation of Program manager and support staff.
- Establishment of in-service training and supervision structure.
- Mechanisms developed and in place to assure maximum community participation and coordination with MOH early and throughout the program.
- Establishment of a record-keeping and evaluation system including:
 - a) baseline data collection; b) health post and community activity record scheme, which incorporates road-to-health chart; c) program development in conjunction with community input.
- Development of instruction and demonstration materials, including:
 - a) a resource library for H.P. staff; b) audio-visual equipment and materials; c) practical procedure manual.
- Development of referral system to existing clinical facilities and collaboration with MOH vaccination and screening programs, and other service agencies.
- Integration of preventive health program with PLAM's other program areas.
- Construction, equipping, supplying and maintenance of small health posts from which H.P. staff will work and where communities will meet.
- Installation of public water systems.
- Construction of public latrines with accompanying hygiene and maintenance education.

Inputs: (D-1)

- USAID funding supports: Program staff=Program Manager and Health promoters, development of educational materials for staff and for community, evaluation system, transportation, clinic construction and equipment, and environmental

(C-1)

- sanitation projects. Assistance from Program Coordinator and Evaluator.
- PLAN Matching Funds support; CUSO volunteer nurse as a member of program support staff; participation of other PLAN-Tumaco staff; PLAN clinic (which is one of only two secondary care facilities in the Tumaco Region); support to MOH services and facilities (for example, equipment and medicines for the hospital; housing improvement, education, sanitation and income generating programs as well as a dental health program operated in conjunction with the MOH hospital and a rural and urban family planning program run under the auspices of the MOH.
 - MOH input: health promoter training courses and instructors, vaccination campaigns, medicines, administrative coordination and orientation to community councils.
 - SEM (Servicio de la Erradicación de Malaria) provides malaria screening, treatment and eradication services in collaboration with the program.

Measures of Goal Achievement: (A-2)

Increase in positive health habits at the personal, family and community levels. Expanded and improved MOH primary health program.

Conditions Expected at End of Project: (B-2)

- All impact areas will have health promoter programs focusing on the maternal and child population. A primary health focus will be integral to PLAN's overall development efforts and the services provided by the MOH.
- Increase in the number of women and children vaccinated against Diphtheria, Polio, Pertussis, Tetanus, Tuberculosis, Measles as well as Yellow Fever, Typhoid and Cholera under emergency conditions.
- Improved nutritional status, growth and development of young children.
- Compliance with and attendance at monthly well-child sessions and at pre- and post-natal programs, including an increase in the number of women screened for breast and cervical cancer.
- Increase in practice of family planning.
- Health posts constructed and functioning. Both health posts and promoters will be under MOH administrative authority.
- Potable water systems and public latrines in operation in urban and rural areas.

Magnitudes of Outputs: (C-2)

- 14 health promoters trained and placed in the Field: including three month training course given by local MOH professionals, course planned to develop community organization skills, daily supervision and in-service training by program manager and support staff.
- Program staff: Program Manager (former Peace Corps Social Worker); Health Educator (CUSO volunteer nurse); 1 secretary who also serves as clerk-statistician, 2 health promoters previously working out of PLAN clinic; 12 health promoters; as well as occasional support from PLAN Community Development Department, and Clinic.
- Bi-monthly in-service training system for health promoters, and quarterly personnel evaluation.
- Community health committees formed in four urban areas and two rural communities which meet every two months with health promoters.
- One baseline survey conducted; record system established in all health posts including individual and family histories, regular access to clinic and hospital statistics.
- Formal and informal communication between health promoter and communities to insure community input into program activities and planning.
- Core library and resource center with A.V. equipment established. Practical procedural manual developed.
- Referral mechanism established between health posts and MOH hospital, PLAN clinic, SEM (Servicio de Erradicación de Malaria), Bienestar Familiar (Family Welfare), Seguro Social (Social Security).
- Special Hygiene education in coordination with housing and sanitation projects is in planning.
- 2 health posts constructed and 1 pre-existing post upgraded in the urban area. 2 health posts planned for rural areas. All health posts are or will be equipped with basic examination, and first-aid equipment and materials.
- 6 potable water systems (4 urban, 2 rural) with accompanying public latrines.

Implementation Target (D-2) * See Appendix for more detail.

- Program staff recruited and hired.
- Health promoters received initial training and are actively involved in health education under supervision.

(G-2)

- Practical manual is in draft form. library and resource center stocked, although new materials will be added as they become available.
- Referral and evaluation systems in place.
- Health posts constructed and equipped. Maintenance and supply system in place.
- Environmental sanitation project proposals being received from communities.
- Planning with MOH for turning over administrative authority to them at the end of funding period.

FRAMEWORK

MEANS OF VERIFICATION

(A-3)

- Direct observation and supervision by Program Manager and support staff.
 - Ongoing inventory system for health posts.
 - Attendance and activity records at health posts and community health education sessions.
 - Health promoter performance evaluations.
 - Baseline and follow-up surveys incorporating formal and informal data collection methods.
 - Vaccination records and Road-to-Health Charts.
 - MOH, Seguro Social, SEM and PLAN Clinic statistics and health post records.
-

(B-3)

Same as above.

(C-3)

Program manager reports to Field Director.

(D-3)

Field Director reports to IH.

IMPORTANT ASSUMPTIONS

Assumptions for achieving goal targets: (A-4)

That the preventive health program will show a decrease in commonly occurring infectious disease and malnutrition among urban and rural Tumaco populations.

That the MOH will continue to support the efforts instituted by the preventive health program.

Assumptions for achieving purpose: (B-4)

That through education, Tumaco's urban and rural populations will increased awareness and knowledge of an education on measures to prevent many common illnesses now suffered.

i.e. nutrition, family planning, hygiene.

That the preventive health program will integrate it's services with the established local and regional health care systems, and that communities will be motivated to maintain an active participation.

Assumptions for achieving outputs: (C-4)

Government resources will remain sufficient and for that matter continue to provide financial and material support to our existing health post facilities and staff.

And that PLAN will continue to encourage Preventive Health Programs by continued support of Ministry of Health Secondary Health Services.

Assumptions for providing outputs: (D-4)

Same as C-4

GUARANDA, ECUADOR

The town of Guaranda is an administrative center for a rural area in Bolivar Province about 100 miles north of Guayaquil. PLAN started a sub-office in Guaranda about two years ago. Last year the decision was made to expand the Guayaquil HMGP to that area. From very early on, it was recognized that one of the most serious problems in Bolivar Province is the lack of potable water and sanitary disposal of sewage. As a result, there is a very high incidence of intestinal parasites. The HMGP was extended to this new post at the beginning of this fiscal year and so it started one year later than the other HMGP sites. The Guaranda sub-office is administered by an AD under the supervision of the FD in Guayaquil. Although funds are channeled through Guayaquil, the rural project is set up independently and so is described here as a separate program. Because the PLAN program is new to the area, there was no existing health program or administrative system. The Guaranda HMGP has been developed in accordance with community needs and has been able to start out as a preventive program.

Methods

The methods to be used in Guaranda follow those of the other HMGP projects. That is, community health workers have been recruited from the communities, trained, and supervised by PLAN staff. The situation in Guaranda is somewhat different than in other HMGP sites because it is a sparsely settled rural area in very rugged terrain. The PLAN sub-office has clients in about 60 rural communities high in the mountains as well as in tropical lowlands. Transportation difficulties for health workers and PLAN social promoters, limits the amount of contact with the communities. Social promoters have

living accommodations at four sub-offices in the communities where they work. They attend monthly meetings at the PLAN office in Guaranda and are visited once or twice each month by their supervisors.

Activities to Date

1. A health department head with extensive experience in community organization has been hired and is currently working to lay the groundwork for the full implementation of the Health Matching Grant. A nurse provides the technical assistance and ongoing training for health promoters.
2. PLAN staff has met with representatives from communities to become familiar with their needs and resources.
3. The Health effort is based on the development of latrines, potable water, and training HPs. Education and community organization are considered critical to all components of effective health improvement.
4. The community health promoters are being trained in conjunction with the Ministry of Health. Other village health workers are being trained by other voluntary organizations in the area.
5. A survey was undertaken of existing clinical facilities starting with those communities in which the community health workers will be located.
6. Research on health needs has been undertaken by the communities. Analysis of the results is being undertaken by a Dutch economist.
7. The training program for the community health workers is now complete. This program trained 32 representatives from all parts of the Province. The training was conducted by a doctor and a nurse from Quito, and in

collaboration with the Ministry of Health. The training was sponsored by PLAN and all those attending were supplied with first aid and educational materials. PLAN will continue the supervision of six of the health promoters. The remaining 26 community health workers will be supported by other social service organizations in the area.

8. Feasibility studies are currently being undertaken in the area to consider alternative methods of providing potable water, health post construction and latrines in the communities where PLAN has affiliated families.
9. PLAN provided each of 26 communities with about \$50 to start a health fund which communities may use as they wish. These funds will be administered by the community health committees to use for health related activities. In the six communities in which PLAN will continue to work the fund is slightly larger (about \$80) but the communities are expected to find mechanisms for financing their health promoter through revolving funds.
10. The health project is jointly funded by Mission Administered Funds from the Government of the Netherlands, which provides approximately \$15,000 for latrines, potable water and medicines. The Canadian Government also contributes \$20,000 to these projects.

GUAYAQUIL, ECUADOR

The purpose of the HMGP in Guayaquil is to provide community health education and thus promote self-reliance in communities for improved health. The objective has been to train health promoters in primary health care and strengthen the secondary and tertiary referral system so that individuals with high risks or those manifesting the symptoms of commonly occurring illnesses may have access to appropriate treatment. Since secondary care facilities are inadequate, the construction of clinics has been an important aspect of the referral system.

Methods

The methods set out in the proposal by which PLAN/Guayaquil expected to achieve its objectives are as follows:

1. In Guayaquil, unlike the other HMGP Field sites, the decision was made to train social workers who were already on PLAN's staff. Health education and health promotion would, therefore, become integrated parts of the services PLAN offers affiliated families and the communities in which they live. PLAN/Guayaquil now has 53 social workers on the staff. Because of the value placed on the prevention of illness, PLAN's medical department is being redirected away from clinical treatment toward preventive health care and community education. The health department is now staffed by a pediatrician, a social worker and a researcher. Outside consultants are being used in the fields of environmental sanitation, nutrition, and informal education techniques.
2. Trained health/social workers are to form community health committees in small neighborhoods in Suburbio, a large low-income section of Guayaquil in which PLAN has worked the longest. These committees will represent about 18,000 families and will provide guidance and assistance in

identifying local priorities and working with other such committees on topics of interest to the larger community. These community volunteers will assist in vaccination campaigns. They will set up community weighing posts for children under six, and provide the mechanism for communication between individuals and families in the community and PLAN.

3. Community mothers' clubs are being organized with 70 to 100 people each. Each community group will operate through a steering committee of six people. Since a typical family consists of more than six people, community volunteers will directly represent over 11,000 individuals in the community and a number several times that large when neighbors and relatives are included. The community health committees will collaborate with PLAN and with government officials for community-wide environmental sanitation projects such as latrine construction, garbage disposal, landfill and mosquito abatement.
4. Community groups hold monthly meetings at which PLAN health/social workers present educational materials relating to nutrition, family planning, accident prevention, dental hygiene, home and personal hygiene, child care, the importance of vaccination, appropriate home remedies and eye check-ups.
5. The establishment of a referral system is central to any health care system. PLAN's health/social workers are trained to detect the symptoms of illness or to identify individuals who are at high risk. A referral system to secondary and tertiary facilities is being established whereby individuals may be referred to private and public clinics. In those areas where these facilities do not exist, clinics are to be built to serve the target population.

Activities to Date

1. Fifteen of the 53 social workers on PLAN staff completed theoretical course work and are currently involved in supervised on-the-job training. These health/social workers are organizing community committees and conducting education sessions.
2. Emphasis is being placed on improving communication and informal education skills and reinforcing technical knowledge. The health/social workers make home visits in the course of their basic social work responsibilities and make referrals to local clinics when appropriate.
3. The supervisory staff of the Health project is designing an ongoing educational program for the health/social workers.
4. A second socio-economic and health status survey of 651 PLAN and non-PLAN families in the community has been conducted.
5. Interview techniques to determine beliefs and practices concerning diarrhea are being developed.
6. A record keeping system has been established so that the health/social worker may follow-up on individuals referred to clinics.
7. Administrative systems for the clinic have been designed. This includes inventory control, accounting systems, purchasing procedures, medical histories and medical statistics.
8. The Health supervisors are overseeing clinic construction and agreements with government or private sector clinics.
9. The Health Department is designing demonstration and teaching materials, protocols for educational sessions and guidelines for the promotion of vaccination campaigns and weighing posts.
10. Consultants in the areas of family planning, informal education and environmental sanitation are being used.

11. The training curriculum, designed for the health/social workers, is being revised so that it may be used for training the remaining social workers on the PLAN/Guayaquil staff.
12. Four health/social workers have identified or organized voluntary community health committees in their respective territories. These four communities will serve as models for the formation of similar committees in other neighborhoods later. Scales for weighing children, Road-To-Health Charts, and educational display materials, are being introduced through these groups. Private homes will serve as neighborhood weighing posts. Depending on the size of the territory and interest of community members, each health/social worker could have between two and four committees in her territory. While the first four committees are involved in their first activities, the other health/social workers are doing educational presentations in their territories on the formation and activities of committees. This process is intentionally gradual and meant to develop an interest in the potential and the responsibilities of a voluntary health committee.
13. The 15 trained health/social workers have been directing regular monthly educational sessions with groups of 12 to 20 community members since January 1982. In April 1982 they began designing mini-programs on related themes for at least two groups of people in their respective territories. A typical program would consist of five or six sessions covering such themes as nutrition during pregnancy and lactation, breast-feeding or personal hygiene. The themes of each session could be based on the group's expressed interest in a topic or could be recommended by the health/social worker. These sessions are intended to be participatory in nature with audio-visual and demonstration aids.

14. A referral system has been established with two pre-existing clinics to receive an average of 200 referrals per month from PLAN health/social workers. One is a government facility, the other is private. The PLAN Health Department has designed improved accounting systems for the pharmacies at both of these clinics. Three other clinics have been constructed by PLAN for the Ministry of Health. Another is being constructed for the private sector. Because there are no laboratory facilities in either of the target areas the Health Department is assisting in setting up small basic laboratories in both new and existing clinics. The clinics make expanded medical services accessible to previously unserved areas of the city and, provide clinic and laboratory services to approximately 60,000 households. These clinics will serve clients referred by PLAN health/social workers. Encouraging use of the clinics is one theme of the educational sessions.
15. An outside consultant completed a month long study of the sewage disposal problems in Guayaquil. A feasibility study of a pilot project for latrine construction was recommended and PLAN/Guayaquil has employed an engineer to undertake the study.

NARRATIVE SUMMARY

Program or Sector Goal: The broader objectives to which this project contributes: (A-1)

The improvement of the health status of PLAN affiliates and their neighbors by providing educational and material support to individuals and groups interested in preventive measures to avoid the common causes of morbidity and mortality in Guayaquil.

Strengthening a national commitment and system devoted to preventive as well as curative health care.

Project Purpose: (B-1)

To stimulate interest in and increase the knowledge of preventive measures to avoid common diseases among PLAN affiliates and their neighbors.

To incorporate a primary health care approach into the overall family/community development activities of PLAN staff.

To respond to organized community level initiatives to improve environmental sanitation conditions.

To contribute to the growth of the health sector infrastructure especially in the area of public health.

Outputs: (C-1)

- A.- Assistance to community members interested in forming clubs, organization or committees for the purpose of improving the health status of family and/or community.
 - B.- Regular informal education sessions in the community directed by trained PLAN staff and focused on: Good Nutrition, Need for vaccinations, Pre- and Post-Natal Care and Family Planning, Home Hygiene and Sanitation, First Aid and Appropriate Home Remedies.
 - C.- Training of community volunteers to regularly 1) monitor the nutritional status of young children by routine weighings under the supervision of PLAN staff; 2) promote special campaigns or mass screenings in conjunction with government programs, and 3) provide first-aid in their respective areas of residence.
 - D.- Construction of latrines, small water treatment systems; also provision of land fill as a mosquito abatement measure.
 - E.- Reinforcement of curative medical service infrastructure: by construction of small outpatient clinics and improvement of pre-existing clinics maintained by the Government.
-

Inouts: (D-1)

Funding supports:

A.- Plan Health Department which serves as a technical support resource for other PLAN departments and community organizations; functions as a training-supervisory unit for PLAN social and health promoters and community volunteers; and is responsible for local level planning and evaluation of program activities and impact.

B.- Development by the Health Department of training materials for health promoters, and demonstration materials for informal health education/promotion among community members

C.- Provision of materials necessary for special campaigns (e.g. vaccinations) or mass screenings (e.g. for tuberculosis).

D.- Training and provision of materials for community initiated environmental sanitation projects.

E.- Construction of small facilities for curative services where none exist and improvement of pre-existing clinic equipment and facilities.

OBJECTIVELY VERIFIABLE INDICATORS

Measures of Goal Achievement: (A-2)

- Vaccination and weight for age records.
- Histories of illness and illness related expenses reported to social workers.
- Histories of hospitalization or clinical attention (including dental) from referral system and clinic records.
- Community level demand for health education and environmental sanitation projects.
- Observed changes in Hygiene and dietary practices.
- Records of activities from community volunteers, and PLAN Social and Health Workers.
- Level of voluntary group formation

Conditions Expected at End of Project: (B-2)

At the end of the funding period it is expected that the populations involved will be motivated and able to identify needs to improve: 1) home and personal hygiene; 2) environmental sanitation conditions; 3) diet; and 4) to take better advantage of clinical services and appropriate home remedies to avoid many of the debilitating or fatal illness commonly suffered. It is also expected that PLAN social workers will be adequately trained in preventive health promotion as an integrated and ongoing part of their community development efforts. And, clinical facilities will be functioning in previously unserved areas.

Magnitudes of Outputs: (C-2)

A.- Community groups of 12 to 20 persons formed in 25 cooperatives in El Guasmo B.- and 20 sections of Suburbio as the object of informal education sessions encompassing approximately 2500 families per year.

C.- From these 45 "communities," volunteers will be trained to monitor weights of pre-school children, promote vaccination programs, and provide first-aid to their neighbors. These volunteers could potentially provide services to as many as 9,000 families.

D.- 1000 Latrines appropriate for the unique physical conditions of Guayaquil may be built by PLAN affiliated families, and practical demonstration courses in their construction will be open to all community members.

Designs for small water treatment systems are under study. Such systems would serve 200 to 400 households.

E.- 6 outpatient clinics staffed and equipped by the Provincial Health Ministry are under construction in areas where no medical services exist and access to existing or emergency services is very difficult or impossible. In addition, a pre-existing clinic is being equipped with a laboratory capable of doing parasitological, basic hematology and urine examinations for an at-cost fee.

Implementation Target (Type and Quantity) (D-2)

A. Health Department Staff: Health Educator (a medical doctor), Research Assistant. (a sociologist), Program Coordinator (a social worker with health-related experience.), Secretary. Assisted by International Coordinator and Program Evaluator.

- Training curriculum established and implemented.
- Development of AV and other teaching and demonstration materials.
- Referral system set up for affiliates requiring medical attention.
- Ongoing assessment of program functioning through direct observation by Health Department staff, analysis of baseline data, and periodic formal and informal evaluation methodologies.

B. Curriculum designed for training PLAN Social Workers and Community Development Promoters. Groups of 15 employees trained at a time. Training lasts four months. Education sessions and demonstrations are held in the community with small groups.

C. Liasons established with government and private agencies involved with public health (two examples are the Provincial Ministry of Health which sponsors frequent vaccination campaigns and APROFE, a private organization devoted to family planning education.).

D. An Analysis of the sanitation technology appropriate to the area will be undertaken in June 1982. Community members will be taught construction and maintenance methods. Materials will be supplied upon community request according to the protocol of the FCDP or the Home Improvement Program. Hygiene education to accompany environmental sanitation projects.

E. Three small clinics have been completed and await staffing and equipment from the Provincial Ministry of Health. Three more similar clinics are planned pending appropriate response by the government to the first three. The facilities of a pre-existing clinic is being upgraded through the addition of basic laboratory equipment.

FRAMEWORK

MEANS OF VERIFICATION

(A-3)

Analysis of baseline data and information generated by methods under A-2

(B-3)

Regular reports to PLAN International Headquarters from Field Director.

(C-3)

Regular status reports from the Health Department Staff and International Coordinator to the Field Director.

(D-3)

Same as C-3.

IMPORTANT ASSUMPTIONS

Assumptions for achieving goal targets: (A-4)

That exogenous influences (eg. inflation, political unrest) will not diminish nor negate any improvements in health status resulting from this project.
That there is continued corroboration on the part of government health officials.
That current government emphasis on preventive and educational aspects of public health will not succumb to the tradition and professional demand for curative facilities and services.

Assumptions for achieving purpose: (B-4)

That the preventive health program will be able to integrate its services with the established local and regional health care system.
That communities are interested in identifying and working toward meeting their basic health and nutrition needs.
That a community can participate effectively in the identification of basic health problems and can develop and implement solutions to these problems. That community involvement in health activities will enhance community participation in other self-help development efforts and vice-versa.

Assumptions for achieving outputs (C-4)

Existing and future community organizations do not factionalize to the point of paralyzing cooperative preventive health activities.
Preventive health activities may serve to unite factions.

That perceptions of professional status among medical professionals will change sufficiently to create an attitude of acceptance and enthusiasm among Ecuador's health professionals.

Assumptions for providing outputs: (D-4)

Government resources will remain sufficient to maintain clinic facilities and provide vaccination and other mass programs at sufficiently low cost for utilization by economically marginal populations.

JACMEL, HAITI

The objective of the Jacmel HMGP has been to support the Government of Haiti's Rural Health Promoter Project. The target population consists of mothers and children under six. Since one of the critical health issues in the Jacmel area is the lack of available water, PLAN/Jacmel provides backup to the Health Promoter Program through the development of potable water resources by digging wells, protecting reservoirs and tapping springs.

Methods

The methods include:

1. Training, equipping, and supervising rural HPs and supporting them financially.
2. The expansion of PLAN's water projects.

Activities to Date

1. The Government of Haiti assumed technical responsibility for the program in Jacmel earlier than expected. Thus, PLAN is keeping a low profile, working through the Government to strengthen and encourage this arrangement.
2. Jacmel now has over 30 trained and supervised HPs who are employed by the Ministry of Health. Their salaries are currently paid by PLAN from HMGP funds.
3. The HMGP is only one component of PLAN Jacmel's overall preventive health effort.
4. Over the past several years 900 prefabricated latrines have been distributed throughout PLAN communities. These were developed in consultation with Government health engineers and are installed and used by the families themselves.

5. Family planning is a priority for PLAN/Jacmel. A full-time family planning specialist gives frequent lectures to PLAN families and distributes material under the supervision, and with the cooperation of the Government Family Planning Department. As PLAN's health program officer, she also works with community groups on health activities.
6. All PLAN/Jacmel social workers have received one week of training in basic health and family planning provided by the Government Department of Health.
7. All PLAN/Jacmel social workers participated in a two-day seminar in preventive dental health.
8. Over the past four years PLAN/Jacmel has engaged in a "Project Habitat" focusing on health related improvements to client-family homes.
9. The 30 trained rural HPs work under the supervision of Government-appointed supervisory team that consists of a physician, a nurse auxiliary, and a sanitarian.
10. In consultation with the Government, PLAN provides the HPs with their salaries and needed supplies, such as scales for weighing children and vitamins.
11. The HPs provide minor curative services, but the emphasis is on preventive health education.
12. Before PLAN's potable water activities were initiated, the only potable water available had to be purchased at a price of about 40¢ a gallon. In the rural areas water had to be carried long distances from polluted streams, rivers and canals. Now that more

families have access to potable water, the health agents will be encouraged to deal with questions such as the use of water, storage, and community sanitation.

13. PLAN has supported well-drilling projects for a local school and a hospital.
14. Because of the difficulty of providing long-term maintenance and operating costs for drilled wells which require electric pumps or generators, alternate methods and careful planning for follow-up have been required.
15. In 1980 PLAN/Jacmel assisted in the development of a gravity water system in which a spring was tapped and brought through a pipe and a public fountain system to communities lower in the mountains. Because this project was a success the distribution was extended to serve several more communities along the road. There are currently 11 fountains in operation covering a distance of 10 km. and serving a population of over 6,000 in the communities adjacent to the fountains. Additionally, a large number of people travel this road from further communities and, thus, use the water resource. One major hotel in town transports water from this system as do PLAN offices.
16. An important aspect of PLAN/Jacmel's HMGP has been collaboration and careful planning through the communities. Agreements have been signed by PLAN and community councils in those communities where water projects are planned whereby PLAN will provide materials and skilled labor, while the communities themselves will provide local materials and manual labor.

17. Other communities are developing similar potable water projects.
One drilled well will soon be serving several communities totalling 3,000 people in an area where there is no potable water currently available.
18. A combination of well/rain water system and spring tapping systems projects are being scheduled for implementation to assure all communities a source of potable water.
19. PLAN/Jacmel's projects emphasize rural areas because the Government of Haiti, with support from the World Bank, is in the process of replacing the town of Jacmel's water supply system. Thus, the availability of HMGP funds has permitted PLAN to respond to interest from the surrounding communities in improving their water systems.
20. PLAN/Jacmel now has made potable water available to 10,000 people in rural regions where no Government plans for potable water existed.
21. PLAN will continue to pay HPs salaries through the end of the next fiscal year, at which time their salaries will be assumed by the Government of Haiti. PLAN will continue to provide HPs with appropriate support, if needed, from regular funds after the termination of the HMGP.

Project Title: Foster Parents Plan, Inc. and USAID Health Matching Grant Project
JACMEL, HAITI: Logical Framework: Feb. 1982 - Kim G. Glenn, PLAN Asst/Director

NARRATIVE SUMMARY

Program or Sector Goal: The broader objectives to which this project contributes: (A-1)

The sector goal is to improve the overall health status of affiliated PLAN families and their communities in the Jacmel region of Haiti emphasising maternal/infant care.

Project Purpose: (B-1)

The purpose of this project is to initiate and support the Haitian Government's Department of Health (DSPP) Rural Health Agents Program in the Jacmel Region.

Outputs: (C-1)

As provided for in the design of the DSPP Rural Health Agents Program, implemented elsewhere in Haiti and under the guidance of "Management Science Services", AID contracted consulting firm, Rural Health Agents will be operating in the Jacmel Region Communities focusing on monitoring infant/maternal health and educating the population in Primary Health concerns.

Basic supportive sanitation systems, especially potable water, will be initiated.

Inputs: (D-1)

Facilitative funding for Health Agents Salaries will be provided.

Transportation support will be provided.

Sanitation systems projects will be funded and implemented.

PLAN staff will collaborate with Health Agents.

OBJECTIVELY VERIFIABLE INDICATORS

Measures of Goal Achievement: (A-2)

Significant drop in incidence of death among PLAN/Jacmel families, especially in the 0 - 5 age group and especially where apparent cause can be classified as "preventable" R.G. dehydration, umbilical Tetanus, Water borne disease and disease preventable by immunization.

Base-line data and progress data collected and reported by the Health Agents according to DSPP Health Agents Program comprehensive reporting system.

Conditions Expected at End of Project: (B-2)

DSPP Rural Health Agents Program will be firmly established, and fully supported by the DSPP in the Jacmel Region with basic Sanitation systems in place and functioning.

Magnitudes of Outputs: (C-2)

35 Health Agents will be working in the Jacmel Region.

Each PLAN Community will have an adequate source of potable water.

Implementation Target (Type and Quantity): (D-2)

Funding for Health Agent's Salaries will be provided through September 1983 at the same wage-level as other DSPP Health Agents in Haiti.

At least one vehicle will be purchased and operated in support of the sector goal through September 1983.

Potable Water projects will be implemented and completed emphasising spring-capping/delivery systems and hand-dug wells but also including drilled wells and appropriate pumping-delivery systems.

Health Agents and PLAN staff will confer and jointly participate in meetings with client-families and dealing with specific health concerns.

MEANS OF VERIFICATION

(A-3)

PLAN/Jacmel's monthly report of deaths and apparent cause of death among client families.

DSPP compilation of Health Agents Reports.

(B-3)

The number of Health Agents working in the Jacmel Region fully supported by the DSPP and the communities being served with basic sanitation systems, especially potable water.

(C-3)

- Same as above.

(D-3)

Funds for Salaries paid to and signed for by the Health Agents.

Vehicles operating.

On-site projects visits and evaluation by PLAN staff.

Reports of meetings with client families by PLAN staff and regular communication between PLAN's Health Co-ordinator and the Health Agent's Supervisory Team.

IMPORTANT ASSUMPTIONS

Assumptions for achieving goal targets: (A-4)

That exogenous factors (i.e. inflation, political instability, natural disasters such as hurricanes) will not negate health status improvements.

That local food and/or economic resources are and remain adequate for families to establish and maintain a minimum level of basic health conditions.

Assumptions for achieving purpose: (B-4)

The DSPP is willing and able to implement and support a Rural Health Agents Program in the Jacmel Region.

Assumptions for achieving outputs: (C-4)

Appropriate collaboration will be available from relevant government and community organisms.

Assumptions for providing outputs: (D-4)

Same as above.

YOGYAKARTA, INDONESIA

The objective of the Health Matching Grant Project in Yogyakarta is to improve the health, nutrition, water supply and sanitation conditions of PLAN families and their communities in Yogyakarta Province. The target population is rural and consists of pregnant and lactating women, and children under five.

Methods

The project is achieving its objectives by collaborating with the Indonesian Government's primary health care program in training, equipping and supporting community health promoters so that there is an increased awareness of local health, nutrition, water supply and sanitation problems. This is done in three ways.

1. By working through community health promoters and community volunteers to facilitate the development of self-reliant primary health care.
2. By facilitating the improvement of health conditions with corollary programs in potable water, sanitation and home improvement.
3. By collaborating with the Government of Indonesia's primary health care project. Plan has worked with the government to train 2,000 community health promoters (HPs). PLAN's contribution to the training constitutes about 30% of the total resources for training health promoters in the communities where PLAN works. Five hundred weighing and nutrition posts have been established. Approximately 32,000 children are currently being weighed at these centers.

Activities to Date

1. Program planning, collaboration with Government and the local University, staff training and program supervision conducted by two PLAN medical doctors.
2. Extensive two-month training has been carried out for 18 PLAN medical workers (nurses and midwives) who work with Government staff in 32 community health centers and with community members to implement the programs.
3. Together with staff of 32 community health centers, PLAN medical workers have given five day training courses to approximately 2,400 HPs who work in the rural communities. Topics include child weighing, filling and checking Road-to Health Cards, recording and reporting, referral, nutrition, menu selection, food preparation, vitamin A and iron/folic acid usage, immunization, oral rehydration, prenatal care, teaching and motivation techniques, hygiene and sanitation.
4. PLAN supplements the Government's efforts to provide supplies for the HPs to enable them to establish weighing and nutrition posts in their communities. These include weighing scales, teaching posters, recording and reporting forms, notebooks and pens, reference booklets, oral rehydration mix, vitamin A, iron/folic acid pills, cadre uniform and starter funds for cooking demonstrations and child feeding.
5. Weighing and nutrition posts have been established and are running in 638 rural communities. The weight of approximately 40,000 children under five years is monitored. One fifth of these are from PLAN families. Prenatal monitoring and distribution of

iron/folic acid pills and oral rehydration mix also takes place at the posts. Some posts have also become a focal point for support of family planning services provided by the Government.

6. At these posts, children are weighed once a month. If a child is not gaining weight, an HP speaks to the mother about likely reasons for the problem and ways to improve the child's condition. The mother and child may be included in feeding and nutrition education activities. In more serious situations the child may be referred to Government community health centers for treatment.
7. For the past year PLAN staff have checked the Road-to-Health cards of approximately 7,500 under-fives from PLAN families, on a monthly basis. They check for weight gain, immunization, vitamin A dosage, and discuss the health status of the children with their mothers.
8. During and after monthly weighing sessions, talks, discussions and sometimes slide/sound shows on preventive health and nutrition topics presented by the HPs with periodic support and input from PLAN medical workers. PLAN provides the slide/sound shows and the necessary equipment. To date, 101 slide/sound shows have been presented. These activities are directed by the HPs with periodic support from PLAN medical workers and community health center staff.
9. To emphasize the importance of good nutrition and to improve the food selection and preparation, cooking, feeding and nutrition education sessions are organized by the HPs. These sessions are most useful in areas where the weighing and nutrition posts have recently begun operation or where there is a high incidence of malnutrition. Nutrition posts are held weekly or bi-weekly for 16

to 24 weeks. Mothers and health promoters select nutritious, economical menus of locally available foods. Mothers and HPs purchase the food, prepare it and feed their under five children together. The emphasis is on education, motivation and practical activities for the mothers in order to improve their families nutritional and health status.

10. The major roles of the PLAN health promoters include giving supervision, advice, moral and professional support and generally stressing the importance of the program activities at the nutrition posts. It is time-consuming to visit hundreds of rural communities, often under difficult road conditions, but it is seen as critical to starting the program off on a strong footing. PLAN attempts, with the support of the local community health centers, to visit each new post once a month for the first three months and every second or third month thereafter for the first year of operation. In program areas where the establishment and operation of the posts appears more difficult, more frequent visits by the medical workers and often visits by the PLAN or Government doctors are necessary.
11. Community health center staff and HPs have monthly meetings for administrative and program purposes. Four meetings per year are used for supplemental training at the community level.
12. PLAN medical workers give training four times per year at meetings of school health teachers in conjunction with the Department of Health. The aim is to dovetail the efforts in health and nutrition in the communities and the schools. PLAN provides teaching posters, health manuals and some supplies.

13. Rabbit, fowl, fish and other small animal raising and home garden projects are underway in areas where nutrition is poor and physical conditions permit.
14. In addition to the primary health care activities described above, PLAN supports closely related projects in potable water, sanitation and healthy homes. The Government of Indonesia is actively developing water supply facilities in rural areas but the extent is limited by budgetary constraints. In dry, hilly areas, the water supply is a particularly serious problem. Illnesses such as diarrhea, gastroenteritis, intestinal parasites and typhoid are still frequent due to an inadequate clean water supply. At the beginning of 1982 PLAN conducted a survey of 15,000 client-families as to their source of drinking water and its distance from their homes. Over 35% take water from ditches, polluted rivers or open wells. In some areas water must be purchased during the middle/late dry season. In an effort to improve this situation PLAN supported the construction of 442 wells, 14 moderately large gravity water systems and seven water storage tanks on a test basis. For community-level water projects the local leaders or project committees are responsible for obtaining Government approval and support when possible. They also supervise the implementation of the projects. Depending on the socio-economic conditions of the area, community members contribute some of the necessary capital and construction materials such as stone, sand or wood and in most cases provide all the unskilled labor. This is also true for latrine and bath house construction. In the past

year, 689 latrines and 42 public bath house/well/latrines were constructed. PLAN provides construction drawings and technical advice when needed.

17. Education and motivation activities are underway and are being further developed so that the water and sanitation facilities may be properly used and maintained.
18. PLAN also supports improvements made in the homes of PLAN clients. Slide/sound shows and discussions cover home improvements that can be made for health reasons. Solid foundations, cement floors, windows for light and ventilation, good roofing and separation of cooking, living and animal stabling areas are the main topics. PLAN provides a portion of the materials for such improvements while the clients provide their portion of the materials and the necessary labor. In the past year PLAN/Yogyakarta has helped improve 1,563 homes.

NARRATIVE SUMMARY

Program or Sector Goals: The broader objectives to which this project contributes; (A-1)

The sector goal is to improve the health, nutrition, water supply and sanitation conditions and status of affiliated FLAN families and communities in the Province of Yogyakarta, Central Java, Indonesia. Primary emphasis is on pregnant women, mothers, and children under 5 years of age, particularly in rural areas.

Project Purpose: (B-1)

The purpose of the project is to help train, equip and support village health workers and families in FLAN working areas so that there is an increased awareness of local health, nutrition, water supply and sanitation problems, and ways to improve the situation with a minimum of outside financial input over the long term. Thus, the purpose is to facilitate the development of self-reliant primary health care at the village level that is linked with the development in other sectors, most important being potable water supply and sanitation.

Outputs: (C-1)

- Trained village health workers in all FLAN affiliate communities.
- Weighing and nutrition posts for pregnant women, mothers and children under five established in all FLAN affiliate communities. Complete materials and supplies for these posts.
- Weighing of under 5's and nutrition education programmes every month in every community.
- Supplementary feeding and extra education/motivation for identified high risk cases.
- Programmes to encourage and provide basic immunization, oral rehydration, iodized salt, Vit. A supplements, iron/folic acid supplements and referral of serious cases, in co-operation with the Department of Health.
- Education on water supply and sanitation and the construction of wells, gravity water systems, latrines, and bath houses in cooperation with Dept. of Health and communities.

Inputs: (D-1)

- Personnel, funding and material input for planning, implementation and evaluation of project.
- In cooperation with the Dept. of Health, local university and consultants, develop teaching methodologies, produce teaching materials, select and purchase the most appropriate materials, supplies and equipment for field use.
- In cooperation with those listed above, carry out training of village health workers, provide them with our support and supervision and then facilitate continued support and supervision by local official and health centre staff.
- Set up, support and monitor mother/child health and nutrition status based on weight/age cards and physical examinations.
- Set up, support and supervise intervention for health problem cases and high risk cases identified by the above.
- Survey potable water and sanitary facilities and design possible improvements with communities and help fund the purchase of materials and supplies to implement these improvements. Education and motivation on water supply and sanitation will be important aspects of our work in this sector.

OBJECTIVELY VERIFIABLE INDICATORSMeasures of Goal Achievement: (A-)

- Number of village health workers trained and supplied.
- Number of weighing and nutrition posts established in villages.
- Number of women, mothers and children under 5 receiving services from health workers.
- weight/age criteria for nutrition status.
- Coverage of immunizations, Vit. A and Iron/Folic acid.
- Numbers of high risk and problem cases receiving attention and referral.
- Continuing support and permanence of the established health posts.
- Pre and post survey on potable water sources and sanitary facilities.

Conditions Expected at End of Project: (1-2)

- All PLAN working areas will have an equipped weighing and nutrition post in operating every village, run by trained village health workers.
- All PLAN under 5's will have a Road to Health card completed monthly.
- Complete coverage for immunization and Vit. A for under 5's, Iron/Folic acid and prenatal care for all pregnant PLAN mothers.
- Improved education and oral rehydration capacity via the nutrition and weighing posts, school health programmes and PLAN health posts.
- Support and supervision of the newly established village posts by local health officials.
- Improved intersectoral cooperation between health and other sectors such as Agriculture and water resources.
- Improved access to potable water and sanitation facilities in PLAN working areas.
- Improved facilities in the local health centres to handle referrals.
- An equipped and staffed health post operating in PLAN's 12 field offices.
- Increased awareness about goiter and use of iodized salt.

Magnitudes of Outputs: (C-2)

- Approximately 500 weighing/nutrition posts with 2000 trained village health workers.
- Approximately 8075 PLAN and 25,000 non-PLAN under 5's using the posts.
- Pre and post natal care and education for 1500 PLAN and 4,500 non-PLAN women.
- Complete immunization and Vit. A for 8075 under 5's.
- 12 PLAN health posts operating.
- Support for 32 community health centres.
- Potable water/latrines/bath house development dependent on community participation, needs and variable costs, but in all PLAN Yogya working areas.

Implementation Target (Type and Quantity) (D-2)

- Investigation and assessment of severity/prevalence of local health problems with emphasis on mother/child that can be improved with preventive interventions.
- Investigation and assessment of available health resources of government and PLAN.
- In co-operation with the Department of Health and local university etc. design programme that complements and supplements those of the government that can give greatest benefit to the population in the PLAN working areas.
- Hire and train PLAN staff to give training, support and supervision.
- Develop a training programme for the village health workers.
- Let community health centres select and train village health workers.
- Purchase and distribute supplies and materials to the village weighing/nutrition posts.
- Immediate and regular supervision of work carried out in the new posts.
- Monthly (later bi-monthly) monitoring by PLAN staff of all Road to Health cards on weight/age, Vit. A, and immunization.
- Monthly reporting and evaluation of above and other statistics.
- Implement referral and follow up system for high risk and identified health problem cases.
- Analysis of baseline data from Road to Health and other statistics and field visit information.
- Development and implementation of follow up efforts to deal with problems identified in the analysis mentioned above.
- Regular up grading, support and additional training from PLAN and health centre staff.
- Survey of water and sanitation resources and planning based on findings.
- Implementation of water/sanitation projects based on survey and community needs and input. These projects will include new wells, well repairs, gravity water systems, water and pit latrines, and bath houses.

LOGICAL FRAMEWORK

MEANS OF VERIFICATION

(A-7)

- Field visits to weighing/nutrition posts by FLAN and health centre staff.
 - Reporting by village health workers on under 5's receiving services each month. Weight/age, vaccinations and Vit. A recorded on Road to Health card.
 - Cards checked monthly (later bi-monthly) by head village health worker, health centre and FLAN staff.
 - Monthly reporting by FLAN health worker on a variety of health indicators.
 - Completion reports and field visits on water/sanitation projects.
 - Monthly meetings on reporting and planning for FLAN health workers and health department.
-

(B-7)

Same as above

(C-3)

Same as above

(D-3)

- Monthly report sent to IHI on funds spent and funds requested according to budget category.
- Monthly report made in field by FLAN staff on the status of projects underway and on completion when finished.
- Visits to project sites by local FLAN and International staff.
- Visits to projects in the field and reports written by IHI Project Evaluator (Shirley Emsard) and by IHI Assistant Health Project Coordinator (Carol Stepick).

IMPORTANT ASSUMPTIONS

Assumptions for achieving goal 1 costs: (A-1)

- That exogenous factors such as agricultural failure, severe new economic problems or political instability will not negate improvement resulting from this project.
 - That the Department of Health will maintain its present and increasing emphasis on mother/child health care.
 - That development programmes in other sectors supported by PLM and the government will enhance the benefits of the health programme.
 - That health conditions and status can improve without fundamentally realigning the economic, social and political structures in the country.
-

Assumptions for achieving purpose: (B-1)

- That the PLM health programme can be successfully integrated with those of the government and local communities.
 - That motivated and capable health workers for PLM and the communities can be found and properly trained to carry out their health functions.
 - That the communities' members, particularly mothers and village health workers, are willing to attend and take responsibility for the health programme.
 - That the health programme can be effectively run at low cost (virtually self sufficient).
 - That the efforts of the PLM and village health workers can motivate the community population to make efforts to improve their own health status.
 - That improvements in water supply and sanitation directly compliment improvements made in nutrition.
-

Assumptions for achieving outputs: (C-1)

- That materials, supplies and equipment for weighing/nutrition posts and for water/sanitation projects can be developed, purchased and distributed.
 - That village people will volunteer to become village health workers.
 - That the Department of Health will assist in training, support and supervision.
 - That high risk and health problem cases can be properly identified and that intervention is effective. (Intervention meaning increased education and motivation as well as medication etc.)
 - That there is active community input: financial, material and labour in water/sanitation projects.
-

Assumptions for providing inputs: (D-1)

- Our input in personnel, funds and material will compliment and not replace or substitute for input from the health department or communities.
- Materials, supplies and equipment needed for the project are available or can be produced in time for an acceptable price.
- Suitable additional PLM health workers can be hired and trained adequately.
- Staff transportation is adequate for health workers from PLM and community health centres to make frequent field visits to the weighing/nutrition posts.

D. EVALUATION

The evaluation of the HMGP has proceeded at two levels. All Field sites have developed mechanisms for recording activities being performed and monitoring the health of certain target populations in the communities they serve. At the same time, IH monitors progress of the project at all posts through Field visits by IH staff as well as through reports prepared in the Field as part of PLAN's usual project evaluation.

Setting up record keeping systems and training health promoters to keep records and use them is an ongoing process. In most posts, it is only in the past six months that Field activities have been underway since most of the first two fiscal years were taken up with the selection and training of the health promoters. In all posts, scales are available and the regular weighing of babies will be the fundamental aspect of the well-baby clinics. Four Field Offices are using some version of the Road-to-Health Chart to determine the level of malnutrition and record the progress of individual children. It is planned to use these charts more extensively and to give them to the mothers to keep. This is already being done in Indonesia. In Tumaco, Road-to-Health Charts are kept at the health posts. Health promoters are learning to prepare monthly reports on the number of clients enrolled in various programs and to report the percentage of children weighed each month who have gained or lost weight.

Baseline data were collected in Tumaco on 782 families in the communities adjacent to the three new health posts. In Bogota, a survey of 865 families in Suba was conducted and the data were analyzed by a research firm in Bogota. These data were used to develop

a risk formula for identifying those families to be targeted for home visits by the health promoters. In Guayaquil, a second baseline study was conducted. This study, similar to the one conducted during the last fiscal year, covered 651 PLAN and non-PLAN families. The results of the two studies are appended to this report.

The Project Evaluator has visited all the Field Offices during the fiscal year and has worked with Field staff to develop suitable research methodologies and data collection procedures. The next step in this process is to improve the Field staff's ability to use the data they collect to more effectively set short and long-term goals.

Two case studies have been prepared over the projects in Guayaquil, Ecuador, and Tumaco, Colombia. These reports were disseminated to all HMGP Field sites and to program staff at IH. A third case study, focusing on water projects in Yogyakarta, will be written later this year.

E. LESSONS LEARNED

The HMGP has enabled PLAN to focus closely on primary health promotion in four countries, thus enabling real growth in the knowledge of the design and implementation of such programming. Lessons learned varied from Field Office to Field Office. They also were different at the International Headquarters level and the Field level.

1. Community health promoters are at the core of this project. It is around their selection, training and supervision that PLAN has gained considerable insight that is of value to our other Field Offices. Some of these findings follow:
 - a. Community acceptance of the HPs is critical to their effective functioning. Members of the community should be involved in their selection and evaluation.
 - b. Although allowances must be made for personality, in general, female HPs are more effective in working with pregnant women and infants.
 - c. Mothers and community members with limited education can make good, reliable, enthusiastic HPs, even when they work without pay.
 - d. The individuals chosen to become HPs have often not had any public roles before. An important component of their training must be to build their confidence that they can take on new and different roles.
 - e. The training of HPs should be conducted in the manner in which it is expected to be taught. Innovative, participatory, highly visual (films, demonstrations, models) methods are preferred.

- f. Interpersonal skills, including the ability to listen to people in the community, should be a component of the training.
 - g. Training should be both theoretical and practical. It is best to begin with a short core curriculum and begin practical work in the community from very early on. This allows the HPs to develop community relations skills and build confidence while they are learning.
 - h. Supervision of the HPs is very important. The relationship between the supervisor and the HPs must be open and positive. Especially early in the project, moral support and encouragement by the supervisor is important.
 - i. It is very easy for the HPs to slip over into diagnosis and cure. Supervisors must be continually on guard to be sure they are first class educators, not mediocre nurses.
 - j. Regular supplemental training must be a part of all HPs routine in order to maintain standards and expand their skills.
 - k. The routine collection of simple data and record keeping should be incorporated into the training program from the beginning, not added on after initial training is finished.
2. Often change is a slow process. Although PLAN has been designing, implementing and evaluating humanitarian and development programs for a long time, sometimes one can forget that real change can be slow. There are two levels of change involved in this project. The first was a planned transition from a basically curative program to a preventive program. It was more difficult to create a consciousness of prevention

and control over health than was anticipated. For most people in the communities where PLAN works, and sometimes even among the staff, curative medicine is a much higher priority than is prevention. The first component of any preventive health program must be to develop the consciousness. This level of change has now been accomplished.

The second level of change is the individual and community behavioral changes whereby greater responsibility for good health is assumed. This, of course, is the focus of health education. The process is slow when real community participation and development is sought.

3. The Governments in all Field Offices but one were eager to collaborate with PLAN on this program. The HMGP enabled PLAN to collaborate and integrate its primary health programs more quickly than expected. Change can be fast.
4. Materials have been developed in these locations which are of benefit to the communities and beyond.
 - a. The HMGP in Jacmel developed the first Road-to-Health Charts in Creole. Yogyakarta has developed extensive materials in collaboration with the Government and its program. Guayaquil has just completed its own materials, using those from Yogyakarta for reference.
 - b. In the one Field Post where mothers have kept their children's Road-to-Health Charts, it has been shown to be a useful educational device. Loss has been less than 1%.

- c. The routine collection of simple data presented in the form of wall charts can be an effective programming and evaluation tool.
5. Teaching materials have been one focus of the HMGP Health Advisor. In her work in each of the HMGP Field Offices she has advised PLAN staff and even Government training staff about curriculum content. As in all development work, caution, diplomacy and patience are necessary when introducing change, the Health Advisor has certainly shown this is possible. Her assistance has been valuable throughout the program, for PLAN health staff and the health promoters.
6. The contribution of the Project Evaluator has been most timely since PLAN has been working on its own evaluation process for the past several years. Her advise and guidance will not only affect HMGP, but has a spin-off effect on the overall evaluation process of the agency in other areas of our work, as well as in health.

F. IMPACT OF HMGP ON PLAN

The implementation of the HMGP has represented progression of program development for PLAN. The original proposal was written in collaboration with the Field Directors in those HMGP Field Offices. Ideas had been solicited from many Field Offices but these five had viewed such a primary health care thrust particularly appropriate for their communities. Later there were some personnel changes so that the project is now being implemented by a different group of Field Directors. IH has been much more deeply involved in this project than with ongoing Field programs; indeed it put the proposal together and has worked with the changing Field staff in its adaptation and implementation.

New systems of reporting had to be established, accounting procedures for fiscal years that differed from PLAN's had to be set up, and guidelines as to what items could and could not be purchased with HMGP funds had to be formulated. Collaboration with Washington has been excellent and helpful during this period of adjustment.

The presence of two full-time staff working only on primary health care has served to stimulate PLAN's health care efforts at other Field sites to emphasize preventive measures. Clinics are difficult to administer and they are costly. Because of this, and because the illnesses affecting most PLAN clients are preventable, the long-range solution to improved health is health education, cleaner water and better sewage disposal. This preventive approach, combined with primary health care, (i.e., the diagnosis and treatment of illness before it becomes serious) is considered by most FDs to be a more appropriate role for PLAN.

This year all PLAN Field Offices were required to conduct evaluations of their health sector programs which increasingly emphasize the preventive over the curative. Field Offices have also, in most cases, aligned their other program priorities to support the primary health care effort. Projects for home improvement, sanitation and water are more effective when developed in conjunction with the community health education component of the HMGP.

Since any program seeking to improve health must include clean drinking water and the sanitary disposal of sewage, the HMGP has stimulated discussion of appropriate technology for improved latrines, energy sources, and water systems. PLAN has collaborated with WASH, the Washington-based Water and Sanitation for Health resource agency, in collecting background materials for Field staff interested in special topics. WASH also worked with PLAN in providing a speaker (on Health Care) for the August, 1982 conference of African Field Directors. In at least four of the Field Offices, HMGP funds are being directed to water and latrine projects in the final fiscal year.

G. BUDGETS

HEALTH MATCHING GRANT PROJECT

USAID FUNDS

Three-Year Costs * - FY 81, FY 82, FY 83

	<u>FY 81</u>	<u>FY 82</u>	<u>FY 83</u>	<u>TOTAL</u>
Bogota	19,062	106,948	80,000	202,010
Tumaco	25,017	145,577	116,000	186,594
Ecuador	33,494	202,250	118,257	354,001
Haiti	57,774	70,000	27,300	155,074
Yogyakarta	37,462	100,000	122,800	260,262
Bolivia	-	-	83,000	83,000
IH	40,082	125,000	100,819	265,901
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Subtotal	212,891	749,775	648,176	1,610,842
Overhead **	57,482	202,439	32,409	292,330
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Total	270,373	952,214	680,585	1,903,172

* Actual expenditures for FY 81.
Projected expenditures for FY 82 and FY 83.

** Overhead is presented as follows:

- 1) FY 81 at 27% as renegotiated by the USAID auditor and PLAN Finance through 6/30/81.
- 2) FY 82 at 27% provisional from 7/1/81 until amended.
- 3) FY 83 at 5%. This new rate is proposed tentatively by Foster Parents Plan Inc. to cover its overhead costs. Foster Parents Plan International chooses to use all its USAID funds in 1983 in direct programs.

HEALTH MATCHING GRANT PROJECT - PLAN/USAID

PROJECTED EXPENDITURES - USAID FUNDS - FY 82

<u>Field Post</u>	<u>Budget</u>	<u>Projected</u>
Bogota	139,962	106,948
Tumaco	130,537	145,577 *
Haiti	70,000	70,000
Yogyakarta	100,000	100,000
Guayaquil/Ecuador	165,250	165,250
Bolivar/Ecuador	<u>37,000</u>	<u>37,000</u>
Ecuador Total	202,250	202,250
Bolivia	87,000	-
IH	97,530	125,000
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Subtotal	827,279	749,775
Overhead	<u>83,000</u>	<u>202,439</u>
Total	910,279	952,214

* Authorized increase in funds to Tumaco for rural expansion.

** Overhead was budgeted at the provisional 10% rate. Later this rate was provisionally renegotiated to 27%, hence the increase.

Increased rate accepted by AID; \$168,000 to be added to grant to cover higher overhead costs of two years.

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HEALTH MATCHING GRANT PROJECT - PLAN/USAID

Fiscal Year 1983 Budget *

<u>Field Post</u>	<u>PLAN Health</u>	<u>USAID</u>	<u>Total</u>
Bogota	106,082	80,000	186,082
Tumaco	151,260	116,000	267,260
Haiti	75,966	27,300	103,266
Guayaquil	189,187	90,000	279,187
Bolivar	<u>10,510</u>	<u>28,257</u>	<u>38,767</u>
Ecuador Total	199,697	118,257	317,954
Yogyakarta	490,778	122,800	613,578
Bolivia	513,300	83,000	596,300
IH	115,572	100,819	216,391
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Subtotal	1,652,655	648,176	2,300,831
Overhead at 5%	<u>-</u>	<u>32,409</u>	<u>32,409</u>
Total	1,652,655	680,585	2,333,240

PLAN and USAID FY overlap. PLAN budget year is July 1, 1982 to June 30, 1983. USAID is October 1, 1982 to September 30, 1983.

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HEALTH MATCHING GRANT PROJECT

FIELD HEALTH BUDGET - FY 83 *

BOGOTA

<u>PROJECT</u>	<u>PLAN MA&S</u>	<u>USAID</u>	<u>TOTAL</u>
Salaries & Related	33,156	58,000	91,156
Laboratory, Lab Tests, & x-rays	10,632		10,632
Mother/Child Care	758		758
Clinic Equipment		5,000	5,000
Clinic and Office Supplies		8,000	8,000
Existing Health Facility Support	5,000		5,000
Transportation		3,500	3,500
Preventive Dental	3,500		3,500
Pre and Postnatal Care	606		606
Training		500	500
Health Promotion		5,000	5,000
Health Community Organizing	6,509		6,509
Mental Health	8,136		8,136
Garbage Collection/Disposal	1,123		1,123
Health Related Home Improvement/Repair	34,962		34,962
Vehicle	1,700		1,700
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Total	106,082	80,000	186,082

* PLAN Fiscal Year Budget July 1, 1982 to June 30, 1983
 USAID Fiscal Year Budget October 1, 1982 to September 30, 1983

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HEALTH MATCHING GRANT PROJECT

FIELD HEALTH BUDGET - FY 83 *

TUMACO

<u>PROJECT</u>	<u>PLAN MA&S</u>	<u>USAID</u>	<u>TOTAL</u>
Salaries and Related	86,094	56,000	142,094
Travel	9,760	3,000	12,760
Consultant		2,000	2,000
Clinic Construction		20,000	20,000
Clinic Renovation		5,000	5,000
Clinic Equipment		10,000	10,000
Clinic Supply		8,000	8,000
Existing Health Facility	35,406	4,000	39,406
Community Health	9,500		9,500
Pre and Postnatal Care		1,000	1,000
Health Promoter Training		2,000	2,000
Latrines	5,500		5,500
Potable Water	2,000		2,000
Other		5,000	5,000
Family Planning	3,000		3,000
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Total	151,260	116,000	267,260

* PLAN Fiscal Year Budget July 1, 1982 to June 30, 1983
 USAID Fiscal Year Budget October 1, 1982 to September 30, 1983

HEALTH MATCHING GRANT PROJECT

FIELD HEALTH BUDGET - FY 83 *

GUAYAQUIL/ECUADOR

<u>PROJECT</u>	<u>PLAN MA&S</u>	<u>USAID</u>	<u>TOTAL</u>
Salary and Related	8,187	26,000	34,187
Laboratory, Lab Tests, & x-rays	6,000		6,000
Travel		1,300	1,300
Consultants		5,000	5,000
Health Service Delivery System	45,000		45,000
Medicines & Drugs		2,000	2,000
Clinic Construction		8,000	8,000
Clinic Equipment		4,000	4,000
Clinic Supplies		3,500	3,500
Field Support		16,000	16,000
Health Services Support		11,000	11,000
Health Promotion Training		700	700
Supplies for Environmental Sanitation		10,000	10,000
Health Related Home Improvement/Repair	130,000		130,000
Other		2,500	2,500
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Total	189,187	90,000	279,187

* PLAN Fiscal Year Budget July 1, 1982 to June 30, 1983

USAID Fiscal Year Budget October 1, 1982 to September 30, 1983

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HEALTH MATCHING GRANT PROJECT

FIELD HEALTH BUDGET - FY 83 *

BOLIVAR/ECUADOR

<u>PROJECT</u>	<u>PLAN MA&S</u>	<u>USAID</u>	<u>TOTAL</u>
Salaries		7,900	7,900
Consultant		357	357
Travel		900	900
Health Promotion		11,200	11,200
Field Support		7,900	7,900
Health Facilities	6,000		6,000
Latrines	1,000		1,000
Potable Water	3,510		3,510
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Total	10,510	28,257	38,767

* PLAN Fiscal Year Budget July 1, 1982 to June 30, 1983
 USAID Fiscal Year Budget October 1, 1982 to September 30, 1983

HEALTH MATCHING GRANT PROJECT

FIELD HEALTH BUDGET - FY 83 *

JACMEL/HAITI

<u>PROJECT</u>	<u>PLAN MA&S</u>	<u>USAID</u>	<u>TOTAL</u>
Health Salaries and Services	12,226		12,226
Feeding Programs & Rehabilitation	3,424		3,424
Medicines and Drugs	4,219		4,219
Clinic Renovation	24,051		24,051
Existing Health Facility Support	8,000		8,000
Mobile Health Clinic	2,410		2,410
Community Health Promoter Honoraria		27,300	27,300
Potable Water	<u>21,636</u>	<u> </u>	<u>21,636</u>
Total	75,966	27,300	103,266

* PLAN Fiscal Year Budget July 1, 1982 to June 30, 1983
 USAID Fiscal Year Budget October 1, 1982 to September 30, 1983

HEALTH MATCHING GRANT PROJECT

FIELD HEALTH BUDGET - FY 83 *

YOGYAKARTA

<u>PROJECT</u>	<u>PLAN MA&S</u>	<u>USAID</u>	<u>TOTAL</u>
Feeding Programs & Rehabilitation		30,000	30,000
Dental Care Curative	4,000		4,000
TB Control	17,000		17,000
Referral to Specialists	7,500		7,500
Hospitalization	30,000		30,000
Existing Health Facility Support	10,000		10,000
Community Health Promoter Honoraria	250		250
Preventive Dental	6,000		6,000
Family Planning	4,000		4,000
Health Promotion Training		15,800	15,800
Latrines/WCs	60,000		60,000
Potable Water	180,528	77,000	257,528
Health Related Home Improvement/Repair	171,500		171,500
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Total	490,778	122,800	613,578

* PLAN Fiscal Year Budget July 1, 1982 to June 30, 1983
 USAID Fiscal Year Budget October 1, 1982 to September 30, 1983

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HEALTH MATCHING GRANT PROJECT - PLAN/USAID

"IH" HEALTH AND EVALUATION BUDGET

FY 83

	<u>USAID</u>
Salary and Related	52,000
Travel Expenses	
Health Staff	18,350
Evaluation Staff	10,000
Other	5,000
Supplies/Equipment	
Health Staff	200
Evaluation Staff	200
Other	200
Data Analysis	10,000
Translation.	2,500
Other	<u>2,369</u>
	100,819 *

PLAN'S MATCH

PLAN's evaluation and research division includes two full-time staff members in addition to the HMGP project evaluator. Additionally, thirteen other IH staff in Program and Finance participate in the HMGP direction, monitoring, and support. The USAID \$100,450 are matched or exceeded by PLAN's contribution to salary, offices, and travel of these staff members.

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