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UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

PROJECT PAPER
AMENDMENT

HEALTH TRAINING RESEARCH
AND DEVELOPMENT

497-0273

JUNE 1986

USAID/INDONESIA

UNCLASSIFIED

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GLOSSARY

BinKesMas	- Directorate General of Community Health
BKKBN	- National Family Planning Program Coordinating Board
Camat	- District chief administrator
CDD Office	- Sub-Directorate, Diarrheal Diseases Control, GOI
CDD Program	- Control of Diarrheal Diseases Program
CHIPPS	- Comprehensive Health Improvement Program--Province Specific
EA	- Expansion activities
FT	- Field test activities
GOI	- Government of Indonesia
INPRES	- Instruction of the President; MOH procures a major portion of its drugs through this program
IV	- Intravenous fluids
Kabupaten	- Regency (the administrative level below the province)
Kader	- Village-level health volunteer
KAP Survey	- Knowledge, attitudes and practices survey
MIS	- Management information system
MOH	- Ministry of Health, GOI
NA	- New approach activities
Oralit	- One of the commercial brand names of ORS
ORS	- Oral rehydration salts
ORT	- Oral rehydration therapy
Pimpro	- Project manager
PKK	- Community-level women's organization
PKMD	- Village Community Health Development Program
PosYandu	- Integrated village service delivery post
Puskesmas	- Health center
Repelita	- Five-year development plan of the GOI
RRI	- Indonesian National Radio Network
UPGK	- Family Nutrition Improvement Program

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE

C A = Add
C = Change
D = Delete

Amendment Number
Four

DOCUMENT CODE

3

2. COUNTRY/ENTITY

INDONESIA

3. PROJECT NUMBER

497-0273

4. BUREAU/OFFICE

ANE

5. PROJECT TITLE (maximum 40 characters)

Health Training Research & Development

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY
09 30 90

7. ESTIMATED DATE OF OBLIGATION
(Under 'B.' below, enter 1, 2, 3, or 4)

A. Initial FY 78 B. Quarter C. Final FY 86

8. COSTS (\$000 OR EQUIVALENT \$1 =)

A. FUNDING SOURCE	FIRST FY 78			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	2,480	470	2,950	10,450	3,450	13,900
(Grant)	(1,180)	(320)	(1,500)	(9,150)	(3,300)	(12,450)
(Loan)	(1,300)	(150)	(1,450)	(1,300)	(150)	(1,450)
Other U.S.						
1.						
2.						
Host Country		500	500		5,400	5,400
Other Donor(s)						
TOTALS	2,480	970	3,450	10,450	8,850	19,300

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) HE	530B	510		9,450	1,450	3,000	-	12,450	1,450
(2)									
(3)									
(4)									
TOTALS				9,450	1,450	3,000	-	12,450	1,450

10. SECONDARY TECHNICAL CODES (maximum 5 codes of 3 positions each)

560

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code BR BU BW R/H DEL INTR TECH
B. Amount

13. PROJECT PURPOSE (maximum 480 characters)

To strengthen Ministry of Health's institutional capability to plan, implement, and evaluate the recruitment, training, and management of public health personnel; applied research, and community health education.

14. SCHEDULED EVALUATIONS

Interim MM YY MM YY Final MM YY
08 87 04 90

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000 941 Local Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment)

The diarrheal disease component of this project is the focus of this amendment. Efforts will be geared to promoting mothers' and health personnel's acceptance and use of ORS and ORT as the first intervention against the symptoms of dehydration. Education, through mass media communications and social marketing, will be emphasized. Support will be provided to strengthen the MOH's capability to manage complex coordination activities associated with ORT promotion.

17. APPROVED BY

Signature
William P. Fuller
Title
Director
USAID/Indonesia

Date Signed
MM DD YY
06 02 86

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

MM DD YY

2. PROJECT AUTHORIZATION AMENDMENT NO. 4

INDONESIA

Health, Training, Research and
Development Project (HTR&D)
Project No. 497-0273

1. Pursuant to Part I, Chapter 1, Section 104(b) of the Foreign Assistance Act of 1961, as amended, the Health, Training, Research and Development Project for Indonesia (the "Cooperating Country") was authorized on May 1, 1978. That authorization was amended in May, 1980, on August 5, 1983, and on December 27, 1983. That Authorization is hereby further amended as follows:

Paragraph 1, as amended, is further amended to authorize a new Life of Project funding of \$13,900,000, consisting of \$12,450,000 in grant funds and \$1,450,000 in loan funds. The Project Assistance Completion Date, as amended, is extended to September 30, 1990. The additional \$3,000,000 in grant funding herein authorized for obligation through September 30, 1986 is subject to the availability of funds in accordance with the A.I.D. OYB/Allotment process.

2. Except as herein amended, the authorization and its amendments remain in full force and effect.

3. Prior to execution of the Project Grant Agreement Amendment, the Congressional Notification waiting period shall have passed without objection and USAID/Jakarta shall have received a cable notification that funds have been allotted.

Signature: William P. Fuller
: William P. Fuller
Director

Clearances: - O/PH : DDenman DD
- PRO : MBonner MB
- PRO : TMahoney TM
- FIN : RMcClure RM
- A/Dir : JSperling JS

923 5/22/1984
Drafted:LA:GBisson:nb:5/19/86

3. PROJECT RATIONALE AND DESCRIPTION

3.1 Background

3.1.1 Magnitude of the Problem

Diarrheal diseases are one of the most important causes of morbidity and mortality in much of the developing world, especially among small children. In Asia, Africa, and Latin America, for example, at least three to five million children under age five die each year as a direct or indirect result of diarrhea. The primary cause of these deaths is dehydration, which results from a rapid loss of fluids and electrolytes in diarrheal stools.

Diarrheal diseases also contribute significantly to malnutrition in children because their intake of food is usually reduced during illness. Although most diarrheal episodes are brief, recurring diarrhea can result in chronic malnutrition. Generally, patients with severe cases are treated with expensive intravenous fluids (IV) in hospitals, creating a heavy economic burden.

In Indonesia diarrheal diseases are considered a major health problem because they are the most common cause of death in children under five years of age. Twenty-five percent of the infant deaths in this country are attributed to diarrhea. Approximately 40 to 60 million people contract a diarrheal disease in Indonesia every year, of which 3% to 10% are treated at health centers. Data collected from 200 hospitals during 1971-1981 showed that 20,000 to 80,000 patients received treatment in hospitals for acute diarrhea each year. There are also approximately 200 cholera outbreaks reported to the central government per year; 1984 showed 18 out of 27 provinces issuing such reports.

3.1.2 Program Background

Oral rehydration therapy (ORT) is a simple effective means of preventing, as well as responding to, dehydration caused by diarrhea of all etiologies in all age groups. ORT consists of:

- The use of home fluids to prevent dehydration. This step, as well the others that comprise ORT, underscores the unique role of mothers in this form of therapy. Mothers must make preventive and curative judgments and perform the actions required for the proper administration of fluids.
- The use of oral rehydration salts (ORS) by mothers or health workers to correct dehydration. Only in severe cases of dehydration should ORS be combined with antibiotics and IV.
- Continuous feeding, particularly breast feeding, and compensatory extra feeding during convalescence.
- The improvement of environmental and personal hygiene.

The control of diarrheal diseases (CDD) using ORT has become an integral part of the national health system in Indonesia. Training related to ORT has been conducted in this country since 1971. The national CDD office, an outgrowth of earlier activities in cholera control, was established in the Ministry of Health in 1981. ORT is a priority intervention for the ministry.

Repelita IV, the national five year development plan for 1985-1989, sets targets for reductions in infant mortality and the increased use of ORT. For example, infant mortality from all causes is expected to drop from 90 per thousand live births in 1984/85 to 70 per thousand by 1988/89. Infant mortality caused by diarrhea is expected to drop from 22 per thousand live births in 1984/85 to 16 per thousand by 1988/89.

Repelita IV also calls for a reduction in case fatality from diarrheal diseases to less than one percent by 1989.

ORT has been administered principally by the public sector through a primary health care approach involving programs of the Ministry of Health (MOH) and the National Family Planning Coordinating Board (BKKBN), and using the primary-level system of health centers, subcenters, and mobile centers. Approximately 70% of the existing health centers currently administer some form of ORT; the government's target is to achieve 100% coverage by 1988/89.

The national CDD office has provided some technical guidance and training to the health centers' staff and village-level volunteers (kader) who administer ORT through these various channels. To a limited extent, the private sector has also participated: some private medical practitioners are now administering ORT and the pharmaceuticals industry provides ORS through commercial outlets. Overall, it is estimated that about 80% of the ORS reaching mothers comes through the public sector, while 20% comes through the private sector.

The number of professional workers trained in ORT has increased from 985 to over 3,500 in the past five years. The national CDD office has assisted in the development of the training materials used in these courses. These efforts have produced significant results. During a five year period (1979-84), the population with access to ORT increased from 41.5 million to 96.3 million. The population which uses ORT has similarly increased from 1.7 million to 9.5 million. The distribution of ORS has risen from 2.3 million liters to 5.6 million liters. And, most important, the case fatality rate from diarrheal diseases has dropped from 4.7% to 1.9%.

In January, 1986, a national conference on ORT/CDD teaching in professional schools was conducted. At that time, all such institutions agreed to review and improve their curricula as they relate to ORT.

At the village level, ORT methods have been part of the training for village health workers since the mid 1970s. BKKBN began ORT training in 1976 as part of its program for peripheral health workers, as did subsequently the Village Community Health Development Program (PKMD), the Family Nutrition Improvement Program (UPGK), and most recently the kader working in the PosYandu (integrated services post) as part of the new Integrated Health Services Program of Repelita IV. Between 1981 and 1983 more than 49,000 village health workers were trained in the use of ORS, and ORT is now a regular part of their curriculum.

Government of Indonesia (GOI) health leaders have been successful in including CDD questions in the national integrated reporting system, e.g., numbers of diarrhea cases and deaths, numbers and sizes of ORS packets used, and source of treatment (health facility or kader). In addition, some health center staff have been trained by CDD staff and provide extra information (amount of IV solution used in treatment and numbers of specimens taken). Finally, special sentinel health centers have been formed by CDD staff to participate in morbidity/mortality surveys and other more intensive data collection activities. These special surveys in morbidity/mortality and treatment are always guided by the CDD national office.

3.1.3 Program Constraints

Despite the priority placed by the government on ORT intervention, only modest progress has been achieved by the national CDD office to date. Before significant breakthroughs can be made in this area, a number of constraints at the national, provincial and local levels, as well as in the private sector, must be overcome. The major constraints identified here relate to mothers' and health professionals' lack of knowledge about ORT, the lack of access to ORT health services, the poor supply system for ORS, and the lack of kader effectiveness.

Lack of knowledge of ORT on the part of mothers and health professionals

To be successful, ORT depends very much on the mother's ability to judge whether her child is becoming dehydrated, on her willingness to participate in ORT care, and on her ability to perform complex actions such as mixing ORS. Although mothers' abilities to make these judgments and perform these actions vary widely in Indonesia, the interventions against diarrhea seem to be primarily curative rather than preventive, which can be at least partly attributed to families' negative perception of health. That is, a "healthy" child is perceived as one who is "not sick." Yet in most cases, ORT is essentially a preventive action. Also, Indonesian mothers' use of ORS is very limited. A household survey conducted by Winardi et al. in 1982 reported that less than half of the mothers interviewed knew about ORS and only 14.5% had ever used ORS to treat diarrhea.

Also, as noted in an August 1984 workshop on ORT held in Yogyakarta, the majority of doctors and nurses use ORT only for a limited proportion of diarrhea patients, preferring instead to administer antibiotics, medications such as enterovioform, and intravenous fluids. Tetracycline, for example, is often given to babies with diarrhea, with potentially dangerous side effects on teeth and bone. With some exceptions, even pediatric faculty members are reported to use ORS only rarely for the rehydration of their hospitalized patients. Further, when ORS is available, physicians, kader and other health professionals often give their patients quantities of ORS that are insufficient for adequate ORT therapy.

Lack of access to ORT-related health services

Although the incidence of diarrhea is high among Indonesian children, the treatment of diarrheal diseases, including the promotion of ORT and ORS, is not as strongly emphasized as child weighing, family

planning, and immunization activities in the integrated health services provided at the village level. This lack of emphasis limits the availability of services for treating diarrheal diseases.

When this lack of services is compounded by health professionals' lack of knowledge of ORT, mothers, in turn, lack access to the knowledge necessary to perform actions to prevent dehydration from occurring and to treat their children's diarrhea in the home. Also, the lack of services limits the amount of ORT that is available to the population. This problem is further exacerbated by the lack of availability of ORS in the commercial sector, as discussed below.

Inadequate supply management of ORS at every administrative level

Both the public and private commercial sectors have extensive reach into rural Java and other relatively developed areas of Indonesia. The public distribution system channels pharmaceuticals and other health care products down through the regency to the district level, with the Puskesmas serving as the principal outlet. Products such as ORS, which are an important component of ORT, pass from the Puskesmas to the community level, with the PosYandu serving as the principal outlet. Most rural communities are served by one or more warungs (small shops that sell such goods as sundries, food and OTC drugs), which generally obtain their supplies from wholesalers in nearby cities.

Despite this wide-reaching distribution system, the availability of and demand for ORS are relatively low. A survey conducted in West Java in April 1985 found that most Puskesmas personnel select antibiotics over ORS for the treatment of diarrhea. A review of 773 diagnoses for diarrhea found that only 12% received ORS, while virtually every patient received antibiotic or antiameobic drugs.

A similar attitude seems to prevail in the commercial sector. A check of over 2800 small and large urban area stores conducted in January

1986 found that only 8% stock an ORS product. Further, although 14 manufacturers are licensed to produce ORS in Indonesia, the product is not widely promoted: The principal suppliers seem to have adopted sales to the government as their principal marketing strategy, rather than sales to the public. The high retail markups for ORS, the inability to respond properly to surges in demand, limited government procurement budgets, and the lack of coordinated approaches to procurement and distribution also complicate this problem.

Lack of kader effectiveness

Numerous reports have documented a widespread failure among kader to practice appropriate case management. They often fail to mention feeding or signs of dehydration requiring referral and rarely request the mother to demonstrate whether she has understood the messages that have been given to her. These failings can be largely attributed to two causes, the lack of proper kader training and the overdependence of the health care system on kader as the primary channel of communication to mothers, as discussed below. These problems are made more formidable by the high dropout rate experienced among kader, which creates almost constant training needs as new kader enter the system. In addition, appropriate supervision, which plays a critical role in both training and in making kader feel that they are playing a vital part in the well-being of the community, is lacking. Skilled supervision could provide both the needed motivation and incentives for kader to perform ORT functions more effectively.

Inadequate ORT training program. Although health and family planning personnel, including kader, have attempted to inform mothers about ORT and some formal courses have been conducted for professional staff, training efforts have been inadequate to date. Data from surveys and health facility reports show that: (a) health professionals are often not trained in the proper use of ORT or the importance of other strategies for the case management of diarrhea; (b) many of the health

workers who have actually received training in ORT fail to apply such therapy in an effective manner; (c) recipients of ORT training have not always received uniform instruction; and (d) inadequate stress is given to educating mothers and kader on how to prevent diarrhea and how to practice ORT properly. As a result, there remains a serious lack of parental awareness of the dangers of dehydration and the simple steps for ORT.

Overdependence on a single channel of communication to parents. To date, the conveyance of ORT messages has relied principally upon the interpersonal skills of the kader. This channel has been emphasized because the need for the prevention or treatment of dehydration usually occurs at the patient's home and the kader is almost always a nearby resident in the same village. The utilization of this channel, while obviously important, has revealed many difficulties: Inadequate understanding of ORT procedures by the kader, inadequate monitoring and supervision of kader activities, and a high turnover rate of kader themselves.

New approaches need to be implemented if the kader channel is to become effective. For example, there are other ways to communicate with parents regarding ORT that have not been properly explored. Mass media is a mode that has been used effectively in the Ministries of Health in some other developing countries but remains relatively unexplored in Indonesia. Health leaders lack experience and procedural information about the implementation of mass media. Likewise, the communication of ORT messages through the commercial sector has been virtually ignored by the Indonesian health structure. There are 14 licensed manufacturers of ORS in this country, but none of the products are widely promoted or used to convey ORT messages. Survey results show that dispensers of ORS products in commercial outlets are not prepared to relay ORT messages. Commercial packaging of ORS products is unimaginative, containing only written mixing instructions.

Inadequate management nucleus for planning, coordinating, and evaluating CDD activities

CDD activities, using ORT as the therapeutic approach, are actually applied in the field by various health delivery organizations, such as the Family Planning and Nutrition programs. There are also support organizations that are involved with ORT, such as the Center for Health Education, various donors, offices of government administrators, women's groups, etc. All these organizations must be coordinated if uniform approaches are to be utilized and if national objectives are to be achieved. Inadequate coordination for planning and management activities is a major constraint to ORT success at the present time.

At the national level, the CDD office is unable to function as the pivotal point for coordination. Because it is structurally outside a direct management line to most of the implementers, it simply acts as a technical advisor with no authority to actually direct or control the delivery of ORT services to the people of Indonesia.

Efforts in the past to have an organization other than CDD, that is representative of providers of ORT or professionals involved in ORT application, have failed to have significant impact, principally because such bodies were composed of staff who worked full time for the five primary health care agencies and thus represented sectoral, rather than integrated, interests. At present, there is no effective means for such multi-program coordination.

A CDD infrastructure which is understaffed, underfinanced, and overburdened

The national CDD office is a sub-directorate at the third administrative level in the Ministry of Health, with a professional staff of only five persons. CDD has counterpart staff at the provincial level, but there are no more than thirty CDD specialists among all the

provincial technical units. There are no full-time field staff working solely in CDD; all have additional responsibilities in other areas. Despite these structural limitations, the scope and nature of the tasks for the CDD Program are comparable to the tasks for the Nutrition, Immunization and Family Planning programs. The Immunization and Nutrition programs, operating at the directorate level in the Ministry, have well established programs with field workers down to the health center level. The Family Planning Program, which like CDD must change behavior and distribute commodities at the household level, has an entire agency which rivals the Ministry's capabilities. In contrast, the CDD network itself has limited resources, in both time and funds, to achieve national objectives and encourage country-wide coordination. This network also lacks many aspects of effective management.

The difficulties facing CDD staff are illustrated at the village level where integrated health/family planning posts (PosYandu) are conducted. These posts are periodic gathering points for mothers and a service point for health center workers and kader. ORT is part of the set of services offered and is administered by workers with multiple responsibilities. The results have been only minimally beneficial. Inadequate coordination has been reflected in the training, supervision, and performance of these PosYandu personnel's ORT-related activities.

An inadequate diarrheal diseases data collection system

The ultimate objectives of ORT are to prevent cases of dehydration and to reduce mortality due to severe dehydration in cases that do occur. To measure the achievement of these objectives, as well as to monitor treatment information for the evaluation of ORT efficiency, a disease data collection system is required. The present system is composed of a segment for the routine collection of data (the national integrated reporting system, special CDD health center reporting, and special sentinel area reporting) and a segment for periodically investigating outbreaks or conducting surveys. However, there are

serious defects in this collection system: (a) data reporting is so delayed in the integrated network that any response is inappropriate; (b) there is an inadequate amount of data relating to the appropriateness of treatment method (use of drugs, use of home-based fluids, etc.); (c) a large number of cases are investigated based on erroneous suspicions of cholera; (d) there is a lack of constructive response of health staff to the results of outbreak investigations; and (e) surveys involving the etiology of diarrheal diseases are inadequate.

3.1.4 Donor Assistance

In addition to USAID's contributions to the national Diarrheal Diseases Control Program (e.g., the provision of two full-time advisors -- an epidemiologist and a communications/social marketing consultant -- and the provision of USAID professional staff assistance in the overall development of program management, training and communications activities), other donors have assisted in supporting the GOI program.

The World Health Organization has provided a common forum for policy dialogue and a part-time epidemiologist, as well as recently assigning a full-time management specialist to West Java Province. Its professional staff have also assisted in the development of kader training modules and in program management. UNICEF has assisted through major procurements of locally-produced ORS packets. This organization's professional staff have also aided in the development of province-specific program management, training, and communications activities. In addition, it has been involved in the development of kader training modules and will provide support for the training of some 22,000 kader (see Section 3.2.3.1). UNICEF has also provided a full-time communicable diseases consultant to the program. Last, the World Bank has completed negotiations for a \$33 million loan to the GOI to expand the Nutrition Program which will integrate the five basic health services, including ORT. This program will be another mechanism for integrating health and family planning services and will have a positive impact on CDD initiatives in Indonesia.

The coordination of donor activities will be accomplished through two mechanisms. First, quarterly donor meetings will be held with GOI counterparts in the CDD Program, representatives from BKKBN and the Nutrition Program, and other units within the MOH, notably BinKesMas (the Directorate General of Community Health, which is responsible for managing the country's clinics). In the past, the roles of donors have been identified at these meetings and uniform ORT policies have been established. Second, through the Secretariat for Integration, it is anticipated that donors' cooperative efforts and mutual support will be formalized; longer-term planning will be initiated, and each donor will make a formally agreed-upon contribution to the program. Last, efforts will be made to ensure that donors' activities are complementary and that the duplication of efforts and resources is avoided.

3.2 Project Amendment Description

3.2.1 Objectives of the Amendment

The goal of the Health Training, Research and Development Project is to make health programs more effective and responsive to the health needs of the poor in terms of both coverage and quality. This Project Amendment is intended to contribute to attaining this goal by reducing the diarrheal diseases case fatality rate among children under five years of age. The project purpose is to strengthen the public health planning, research and education capabilities of the Government of Indonesia in such a way as to contribute to the achievement of the program goal. In addition, the project will seek to overcome the constraints listed in Section 3.1.3, the primary constraints being the lack of mothers' and health professionals' knowledge of ORT, the lack of access to ORT-related health services, the poor supply system for ORS, and the lack of kader effectiveness.

This Project Amendment has three short-term objectives that are prerequisites to achieving both the program goal and the project purpose:

- To improve the knowledge, attitudes, and practices (KAP) of mothers, kader, and health personnel regarding ORT.
- To strengthen the capability of the Ministry of Health to manage complex coordination activities that relate to ORT.
- To strengthen the capability of the national CDD office to manage support systems related to ORT interventions (i.e., the disease information system, monitoring and evaluation, logistics, and central office operations).

3.2.2 Project Strategy

To achieve the objectives outlined in Section 3.2.1, three broad strategies have been developed for application during the 24-month Project Amendment period.

First, new approaches (NA) will be introduced directly into the CDD Program in order to overcome identified constraints to ORT success. These new approaches will be immediately applied in the national CDD Program. An example of such an approach is the development of a Secretariat for Integration, described in detail in Section 3.2.3, to help overcome the problems of coordination. The results from such a broad strategy can have an immediate country-wide impact.

Second, those parts of ongoing activities that have already demonstrated their potential for expansion will be further developed. These expansion activities (EA) do not require an emphasis on new approaches, but they do need amplification and continued evaluation. One example is the expansion of classes in clinical training that will be conducted to improve the knowledge, attitudes and practices of health professionals. Another example concerns the International Center for Diarrheal Diseases Research in Dhaka, Bangladesh (ICDDR/B). In 1983, 19 Indonesian health professionals were sent to ICDDR/B for clinical and

case management training in diarrheal diseases. This project will continue, using ICDDR/B for additional training. Results from this strategy can likewise have an immediate country-wide impact.

Third, experimental approaches will be field tested (FT) to determine if broader application at a later date is both feasible and warranted. For example, three new training modules will be produced for kader but will only be utilized in pilot areas located in one or two provinces. Any province in which these experimental approaches are field tested is labeled an Intensification Area. Although the Project Amendment activities conducted using this strategy will only take place within the local provincial boundaries of the Intensification Area, if they show potential for national impact, they will be expanded at a later date.

Reference to an Intensification Area during this and subsequent sections usually refers to West Java Province. This province has already been selected to demonstrate the effects of special communications activities (both interpersonal and mass media). However, it should be understood that a province outside of West Java, especially one of the provinces where a CHIPPS (Comprehensive Health Improvement Program - Province Specific) project site already exists, can also be the location for field testing. Therefore, these provinces are also called an Intensification Area.

All of these strategies provide the means for the three short-term objectives to be achieved. The first provides the opportunity for new ideas or creative approaches to be introduced directly into the national program. The second builds upon and continues to learn from activities already proven to be beneficial. Finally, the third opens the way for experimental approaches to be tested and analyzed.

All project inputs in Section 3.2.3 will be categorized by either "Intensification Area," i.e., being implemented in an Intensification

Area, or by "national," i.e., being implemented by the national program. They will also be further delineated by the type of strategy they will employ: NA (new approach), EA (expansion activity), or FT (field testing in an Intensification Area).

3.2.3 Project Activities

The project activities identified in this section are presented in terms of the three short-term objectives for this Project Amendment, as identified in Section 3.2.1. Unless otherwise stated, all the activities discussed here will be funded as part of this USAID Project Amendment.

3.2.3.1 Objective 1: Improve the Knowledge, Attitudes and Practices (KAP) of Mothers, Kader and Health Personnel Regarding ORT

The project activities that will be undertaken to meet this objective fall into two broad categories: training and communications. These two types of related activities are intended to help resolve three of the current program constraints identified in Section 3.1.3. The training activities are directed toward addressing the constraint of inadequate ORT training programs for kader and health professionals. The first two activities will be conducted in an Intensification Area; the remainder are national-level activities. The communications activities are intended to overcome the constraints of mothers' and health professionals' lack of knowledge about preventing and treating diarrhea, and the present system's overdependence on a single channel of communications to parents. The first four of these activities, which will be conducted in an Intensification Area, are intended both to improve the interpersonal and teaching skills of the kader, and to increase the awareness of families regarding the treatment of diarrheal diseases. The three national-level activities are designed to improve the KAP of health professionals.

Training Activities

Activity 1. Develop and field test three training modules on communications and the CDD Program for kader -- (FT)

During the three-month launch and 18-month expansion phases, three modules will be developed, written, and refined. These teacher aids will be part of a continuing teaching effort that will be carried out for 15 to 30 minutes prior to the monthly PosYandu session. One module will concern improving the interaction of kader with mothers and two modules will explain the relevant aspects of the CDD Program to kader. Support will be sought from other donors for the completion of an additional 21 modules that are related to other integrated programs. Together, these 24 modules will serve as tools for retraining (repetition is important for kader performance) and orientation for replacement kader (the turnover rate for kader is high).

During the expansion phase, these three modules will be field tested in several PosYandu in at least one Intensification Area. Based on the field test results, the modules will be revised if necessary.

Activity 2. Launch and expand kader ORT training in the Intensification Area -- (FT)

During a three-month pre-launch phase, special training materials will be developed, written and printed for kader. These materials will center on teaching health staff and kader ORT treatment. During the three-month launch phase, these materials will be used to train kader in one kabupaten in teaching mothers to prevent dehydration using home fluids, food and breast feeding and how to give ORT for the treatment of dehydration, and in teaching mothers to watch for signs of dehydration and to seek assistance when dehydration occurs. Kader and other health staff will also be taught how to treat dehydration using ORS.

During the 18-month expansion phase, 52,000 kader in West Java will be trained using materials refined during the launch phase. USAID will support the training of 30,000 of these kader, and UNICEF will support the training of some 22,000 kader.

Activity 3. Provide support for the further development of clinical courses in ORT at five central or provincial hospitals -- (EA)

These hospitals are already equipped with rehydration units that also function as teaching centers and already have technically skilled personnel in ORT. Improvements will be made in candidate selection, curriculum (to include increased time in practical case management), methodologies for the establishment of ORT activities at the health center/village level, and post-course follow-up. The number of courses provided will be increased during the two-year Project Amendment period and efforts will be initiated to monitor the impact of these changes.

Activity 4. Support the development of rehydration centers at kabupaten hospitals -- (EA)

This support would include all costs relating to the training of staff (two individuals from each hospital, chosen from among the administrator, responsible physician, head nurse, and the kabupaten chief medical officer), development of training materials, and the conduct of any ORT courses needed to train the kabupaten's Puskesmas staff. The training would be centered on clinical diarrhea case management emphasizing ORT and the practicalities of establishing and supervising such centers at their hospitals. A follow-up workshop will be held where trainees will present their progress reports and clinical data. It is anticipated that one hospital in West Java will be selected for this activity; another nine hospitals in other provinces will also be selected.

Activity 5. Improve ORT-related curricula at three medical schools -- (EA)

These schools will be assisted, through individual consultancies, in incorporating practical and experiential community-based teaching about ORT programs and program management into their present community medicine or social and preventive medicine curricular components. Planning workshops and other training activities will be used to train faculty members in the use of ORT materials and techniques.

Activity 6. Support a national workshop for nursing school faculty -- (NA)

The workshop will emphasize development approaches, skill in communication with community members, and the ability to alter knowledge and behavior. Support will be provided to enable faculty members to visit Indonesian programs with strong ORT activities that emphasize appropriate community CDD activities.

Communications Activities

The four Intensification Area activities discussed below will be implemented when the first phase of the province-wide study of mothers' and health providers' KAP is completed. Another KAP study may be conducted in West Sumatra (a CHIPPS province) or another province. Further, the success of these activities will depend on the integration and coordination of the distribution of Oralit-200, training, and mass media communications. These activities have already begun.

A staged roll-out is planned for the Project Amendment's communications activities (a three-month West Java pre-launch, a three-month launch phase, and an 18-month expansion phase). The launch phase will first target Garut Kabupaten, which represents about 5% of the province's population. During the expansion phase, activities will be extended to greater Bandung, then to the remainder of the Sunda-speaking area, and then to the remainder of West Java Province.

Activities in this area will concentrate on both primary audiences (caretakers of children under five years of age and kader), and secondary audiences (provincial to Puskesmas-level MOH staff, camat, intersectoral forums, village chiefs, PKK leaders, and traditional birth attendants). Secondary audiences will be reached through the national activities (activities 5 through 7) described below, as well as by spillover from the Intensification Area communications activities.

Although the Intensification Area activities are also intended to reach national-level audiences, the expansion of project activities will be conducted by the CDD Program after this two-year project is completed. Thus, national expansion is not included under this Project Amendment.

Activity 1. Design communications materials -- (FT)

The messages of these campaigns will be centered on preventing dehydration when a child has diarrhea, treating dehydration, and seeking assistance from fixed facilities if a child's condition does not improve. The materials will be designed for three, or perhaps four, media types.

- Printed messages. These will include an identification sign to be placed on the home of each kader, a training manual for each kader, an interactive home therapy graphic to be used at community weighing posts, a kader certificate, kader trainer kits, and kader instruction bags. In addition, for secondary audiences, a CDD plan will be prepared for provincial leaders and a physician's notebook will be written for physicians.
- Radio. Radio spots on ORT will be carried on Radio Republic Indonesia (RRI) and private stations. Longer messages, in the form of special programs aimed at kader, will be carried on RRI.

- Television. A 15-minute training movie for kader will be prepared, as will 5-minute programs and 60-second spots aimed at mothers' participation in ORT.
- Unconventional media. Mobile film units, puppetry, the postal system, or other types of unconventional media may be used if the communications and development studies described in activity 6 indicate that they are feasible vehicles for conveying ORT messages.

Activity 2. Conduct a formative evaluation of the communications materials developed -- (FT)

Before the design of the prototype materials is complete, the materials' communication concepts will be evaluated. Also, the results of surveys, the KAP study, and the communications and development studies will be incorporated into the final design. The materials will then be refined, pre-tested and field checked.

Activity 3. Produce and distribute or broadcast communications materials -- (FT)

Based on the results of the formative evaluation, refinement and field tests, the written materials will be printed and distributed, and the radio and television materials produced and broadcast, according to the staged roll-out described above.

Activity 4. Conduct development and communications studies -- (FT)

First, USAID will support a full feasibility study, including detailed recommendations and a five-year budget, on the social marketing of ORT in the commercial sector. This study will aim to establish ways of increasing this sector's involvement in terms of: its provision of financial or other resources to public sector communications activities,

its provision of ORT at prices acceptable to the majority of the population, and reducing dependence on the public sector's provision of ORS.

Second, USAID will support several communications development studies that will assess specific aspects of the ORT communications system and develop tests for new techniques before attempting to use them on a province-wide basis. These would include, but not be limited to, studies of the child-caretaker communication network, ORS and home fluids use, ORS mixing ability of mothers, the feasibility of providing incentive or reward systems for kader, kader training by radio, ORS packaging, liquid ORS, village communication media, reaching kader by mail, kader communication aids, diarrheal diseases processes, provider-mother communications, pricing, pharmacists, consumer marketing, retailers, manufacturers and distributors, and learning from mothers.

Activity 5. Hold an annual ORT conference for health professionals -- (NA)

This national conference will be held to stimulate interest in ORT and CDD activities, particularly through publicizing operational studies conducted in Indonesia, as well as clinical studies and information from other countries. USAID will provide financial and technical support for conference planning, the rental of facilities, publicity, printing, and travel and per diem for selected participants.

Activity 6. Conduct a feasibility study for the development of the Information Center for Diarrheal Diseases -- (NA)

This national center, which will be located in an institution engaged in library-like activities, will collect, catalogue, and distribute operational and clinical materials to program planners, implementors, and evaluators, and will prepare updated annual bibliographies. USAID will provide financial and technical support for the center to the extent of funding a full feasibility study including detailed recommendations and a five-year budget.

Activity 7. Develop a CDD newsletter -- (NA)

USAID will provide technical and financial support for the planning, editing, publishing, printing and distribution of this national newsletter, which is intended to publicize the value of ORT as a primary health care activity being integrated into the country's health services. The newsletter, which will be intended for a professional medical audience, will include clinical and operational aspects of ORT-related activities in Indonesia and other countries. Editorial policy will be set by the CDD Working Group, and printing and distribution will be contracted. It is intended that after a start-up period, the newsletter will be financed through subscribers (physicians, medical and public health schools, etc.).

3.2.3.2 Objective 2: Strengthen the Capability of the MOH to Manage Complex Coordination Activities that Relate to ORT

The three national-level activities described for meeting this objective are intended to help overcome the constraint identified in Section 3.1.3, the inadequate management nucleus for planning, coordinating, and evaluating CDD activities. The first two activities are intended to improve the management nucleus within the MOH and the CDI Program, respectively, and will be based in Jakarta. The second will also require field testing in an Intensification Area. The third activity, which is also designed to enhance the integration of CDD activities, will be directed from Jakarta but will be implemented principally in an Intensification Area.

Activity 1. Develop a new body within MOH, as part of the Task Force for Integration: The Secretariat for Integration -- (NA)

As mentioned earlier, the CDD infrastructure by itself does not have the capacity to form the nucleus for the management of coordination.

Thus, resources outside their infrastructure must be sought. As an answer to this need, there is agreement by all Director Generals within the MOH for the creation of a Secretariat as part of the Task Force for Integration. It will consist of a Secretary and three to four administrative assistants and secretaries. The purpose of its formation is to provide an objective analysis of integration issues from a source outside of primary health care programs. Members of the Secretariat will work full time for this organization and will thus not represent sectoral interests. It hopefully will be a neutral voice that identifies problems, seeks solutions to those problems through collaboration, and provides recommendations for improvements directly to the Director Generals. The CDD Program will be one of the principal beneficiaries of the formation of this Secretariat.

More specifically, the Secretariat will: (a) Monitor planned integration activities, identify discrepancies in any technical or operational policies, messages, definitions, etc., and provide recommendations for resolution of these problems. Successful integration requires such uniformity; (b) monitor availability and utilization of funds earmarked by the MOH for use in integrated activities and recommend ways to improve financial efficiency. Various sources of funds often lead to gaps and overlaps in funding; and (c) evaluate past and ongoing integration field activities and recommend ways to improve performance.

Activity 2. Improve the CDD management information system (MIS) -- (EA)

The MIS for CDD, which monitors essential indicators of the program's activities in the field, represents an opportunity for integration. The characteristics of the present system (data points, indicators, data flow) are not specifically designed to provide information for management decision making. As this system is refined, monitoring, supervision and, therefore, performance will be improved. These improvements will provide a clearer understanding of avenues for improved coordination.

The MIS will be changed to a more specific ORT-related information system, with the intention of aiding internal management. For example, data points will be designed to link with specific management actions. All modifications to the MIS will be thoroughly field tested in an Intensification Area before being entered into the system. Once refined and approved, special training for managers in the use of the new MIS will be necessary at every administrative level.

Activity 3. Initiate activities designed to enhance CDD integration into the primary health care system -- (FT)

CDD cannot function in Indonesia as a vertical program, but must promulgate ORT as a basic part of the integrated primary health care services system. The major challenge facing the national CDD Program is to understand how to coordinate properly with existing delivery systems and secondary organizations related to ORT. This project activity will support those efforts that lead to a clearer understanding, and includes: (a) Operational studies in the field to determine how to bring PosYandu activities into a more coordinated effort with CDD. Information dissemination has been generally ineffective for several reasons: there is confusion and noise at the post, growth monitoring conducted by nutrition workers at the PosYandu is generally unresponsive to the connection with ORT, and case management has been limited to only those few persons who happen to be suffering from diarrhea at the time of the PosYandu; (b) trial inclusion of CDD activities with the Expanded Program of Immunization's (EPI) expansion of training for the PKK; and (c) trial inclusion of an acceptor-rate concept for ORT into the health center microplanning system, bringing CDD activities more into the character of family planning efforts.

3.2.3.3 Objective 3: Strengthen the Capability of the National CDD Program to Manage Support Systems Related to ORT Interventions

The three project activities required to achieve this objective relate to management, disease information, logistics, and program monitoring/evaluation. The activities described below will attempt to overcome three of the constraints identified in Section 3.1.3: A CDD infrastructure which is understaffed, underfinanced, and overburdened; an inadequate diarrheal diseases data collection system; and the inadequate supply management of ORS at every administrative level.

The first project activity is a national, Jakarta-based activity. The second and third activities will be conducted in an Intensification Area.

Activity 1. Improve the management capabilities of the CDD infrastructure
-- (EA, NA)

This activity encompasses seven components. The first four components are EA activities; the last three are NA activities.

The first component is to develop practical, realistic work plans and activity schedules for CDD Program activities during the period of Repelita IV.

The second is to develop a CDD work plan for the Repelita V period. This document will allow for the systematic expansion of diarrheal diseases control activities to all kabupaten in the context of the integrated health services delivery system. A modular approach will allow for the inclusion of reasonably detailed task analysis and work planning modules.

The third is to develop improved supervision of CDD activities at every administrative level of the CDD infrastructure. Training will be conducted to enhance these skills. This is an especially delicate task because CDD managers must usually work through their counterparts to promote the achievement of objectives. Supervision activities will be

conducted in the various provinces, but special attention will be provided to Intensification Areas where unique supervisory demands are made. Financial assistance from other donors will also be sought for this component.

The fourth is to develop and utilize program indicators at every administrative level for improved monitoring.

The fifth component is to conduct training. Training might include, for example, workshops for CDD leaders to promote their communication skills and/or to improve the program's internal organization, and holding a national meeting for project managers of CDD activities. Such a forum would improve liaison between central leaders and provincial-level managers, in addition to cross-sectoral organizations concerned with ORT.

The sixth would be to revitalize the central-level Working Group. This group of program advisors has not functioned for the past year. It will be restructured to include representatives from other ministries, bureaus and donors, as well as organizations such as laboratories and medical schools that have an interest in ORT activities. This group will provide an automatic channel of communication with other MOH and non-MOH participants in CDD. The Working Group will serve as a forum for discussion of CDD-related problems, it will make recommendations for solving problems, establish priorities, and review the monitoring and evaluation of program data conducted by national CDD staff.

The seventh component is the development of a centrally-based position within the CDD infrastructure in order to provide a more rapid field analysis of CDD issues. This local consultant, who will be functionally positioned in the national CDD office for 18 months, would make frequent field visits and provide first hand, third party observations. With the careful selection of field sites, the person in this position would become a type of roving troubleshooter. His or her primary responsibilities will be to identify issues, and assist in

project implementation, monitoring and evaluation. In FY 87/88, the MOH will evaluate the activities of this consultant to determine if future DIP budgets should include the extension of this position.

Activity 2. Improve the CDD disease information system -- (NA, EA)

The CDD infrastructure uses an information system that includes data about diseases as well as program operations. Data about program operations comprise the management information system (see Activity 2 in Section 3.2.3.3), while morbidity/mortality data comprise the disease information system discussed under this activity.

This activity has four components. The first three are NA activities, and the fourth is an EA activity.

The first is to initiate new approaches to participation in the routine reporting system. In this component, attempts will be made to incorporate more CDD-specific recording and reporting tools as part of this system. In addition, more rapid feedback to disease reports will be provided to field offices.

The second is to integrate CDD and EPI sentinel reporting sites. In this component, training will be provided to incorporate more specific information on diarrheal diseases and ORT at the sites, as well as to make the reporting procedure more efficient.

The third is to conduct various operational studies. Such studies will include: (a) Determination of the minimum data needed to identify coverage problems or clinical aberrancies; (b) identification of relevant questions to allow collection of clinical information from villages, rather than only from the health center level; (c) identification of new systems for information flow to expedite the movement of surveillance program data to decision making points; (d) determination of methods to measure intervention effectiveness rather than CDD activity outputs; and

(e) surveillance of field and hospital-based tests to determine the etiologies of diarrheal diseases.

The fourth is to recommend improvements to outbreak investigation procedures. New guidelines for improving the outbreak investigation system will include ways to determine the basic quality of knowledge and case management capability that exists in a locality and methods to enhance knowledge and skills in certain ORT procedures through meetings, public education, and distribution of materials. When the guidelines are approved, the training of health personnel will be required.

Activity 3. Improve the supply management of ORS -- (NA, EA)

This activity has five components. The first and fourth components are EA activities; the remaining components are NA activities.

The first is to provide technical assistance to MOH decision makers who are responsible for procuring drugs through INPRES. At present, INPRES drug funds are used to purchase an unwarranted amount of IV solutions and antibiotics. Thus, comparative costs for IV, antibiotics and ORS will be developed. Then, seminars and discussions will be held for MOH and INPRES personnel to educate them on the cost differences and therapeutic implications of diarrhea-targeted products.

The second is to develop an information sharing system among the public suppliers of ORS. This system will be initiated to share information on procurement plans and distribution schedules among the programs that supply ORS. Such information should lead to increased efficiency, and perhaps lower procurement prices.

The third is to develop a simple management information system (MIS). The purpose of this component will be to monitor stock levels and offtake of ORS at various points in time within the public system.

The fourth is to conduct various operational studies, including:

- (a) Testing of a new needs estimation model that is more sensitive to true demand for ORS;
- (b) acceptability of ORS production through a cottage industry, such as a social service group, rather than a pharmaceuticals manufacturer;
- (c) public preference of source of ORS;
- (d) determination of pharmaceutical costs according to the current approaches to treating diarrhea at various treatment centers;
- (e) feasibility of a pharmacists/dispensers workshop;
- and (f) feasibility of ORS or sugar-salt solutions being included in the traditional medicine industry.

The fifth is to conduct special training in ORS supply management and to conduct a special workshop for commercial manufacturers and distributors of ORS. The purpose of the workshop will be to stimulate interest in promoting ORS products more aggressively and to develop routine channels of communications between MOH policy makers and the principal actors in the commercial sector.

3.2.4 Project Inputs

The Project Amendment includes four major inputs: technical assistance, program monitoring and evaluation, training, and operations development. Table 1 at the end of this section provides a breakdown of the inputs by activity.

3.2.4.1 Technical Assistance

Approximately \$1.04 million in grant funds will be provided for technical assistance. These funds will finance 18 months for one long-term in-country consultant (the roving troubleshooter) to work with CDD and approximately 67 months of short-term technical assistance. Short-term technical assistance totalling approximately \$617,000 and approximately 41 person months will be provided through centrally-funded contracts (specifically, Pritech and Healthcom). The remainder, 26 person months, will be contracted in-country.

The majority of funds for short-term technical assistance will be required to support the communications and studies components of objective 1. In these components, short-term consultants will assist with the design and evaluation of communications/training materials and will support operational studies associated with the implementation of these efforts. Other short-term consultancies in support of this objective will be required as part of the efforts to upgrade ORT training within professional institutions. These efforts will include: developing and field testing kader training modules, launching and expanding kader training, supporting the development of rehydration centers, improving ORT curricula at medical schools, supporting a nursing faculty workshop, evaluating and distributing communications materials, and conducting a feasibility study for the information center for diarrheal diseases.

Achieving objectives 2 and 3 will also require short-term technical assistance. Funds under these objectives will be used to support program management improvements in CDD with a focus on supervision, improved reporting systems, and operational studies. Funds will also be provided for developing the Repelita IV and V work plans, developing program indicators for monitoring, providing support for workshops, providing assistance to INPRES to increase its field purchases of ORS, and developing an information sharing system for public suppliers of ORS.

3.2.4.2 Program Monitoring and Evaluation

Approximately \$667,000 of grant funds will be provided to finance program monitoring and evaluation activities. These funds will be used to strengthen reporting and recording systems associated with diarrheal diseases control and to assist the field supervision of CDD activities (objective 3). In addition, funds will support evaluations and special studies to assess the

effectiveness of specific field trials (objective 1), and to conduct a final evaluation of the overall initiative. Specific studies currently under consideration have been identified in Section 3.2.3.

Other funds will be used to monitor and evaluate the development of the Secretariat for Integration, the management information system, and operational studies to enhance CDD integration (objective 2); to develop program indicators for improved monitoring, recommend improvements to outbreak investigation procedures, and operational studies (objective 3); and to monitor and evaluate the kader training, clinical courses at hospitals with rehydration units, and support the development of rehydration units, improve ORT curricula, and design and evaluate communications materials for kader and mothers (objective 1).

3.2.4.3 Training

Approximately \$375,000 in grant funds will be provided to support training activities. The majority of these funds will be linked to efforts to improve the knowledge, attitudes and practices of health professionals, village health volunteers, and mothers (objective 1). The major initiatives to be supported include health center staff and kader training in the Intensification Areas; health personnel training in ORT at hospitals with rehydration centers, and the development of rehydration centers at kabupaten hospitals. Funds will also be provided to support ORT training associated with medical and nursing faculties to carry out a national ORT conference, and to support the CDD information system via operational studies.

In support of the efforts to strengthen program management within CDD (objective 3), training in information system development will be undertaken and an ORS suppliers' workshop will be held. Training support will also be given to CDD workshops, CDD supervision, and operational studies.

3.2.4.4 Operations Development

Approximately \$556,000 of grant funds will be provided to carry out the specific activities requiring operations development. A significant percentage of these funds will be required to support objective 1. These include financing the design and production associated with the mass media initiative, support costs associated with kader training materials, and support costs associated with training and other improvements at the rehydration centers. Operations development will also be provided for the start-up of the ORT newsletter as well as for the ORT conference, nursing faculty workshop, and development and feasibility studies.

Under objective 3, operations development support will be given to workshops and national meetings for CDD leaders.

3.2.5 End of Project Status

By the conclusion of the 24-month period designated for this Project Amendment, the following should be accomplished:

1. The knowledge, attitudes and practices of mothers, kader, and health professionals regarding the prevention and treatment of diarrheal diseases should be improved. This will be measured by the following indicators:
 - The results of morbidity, mortality and treatment surveys demonstrating an increased use of ORT for the treatment of dehydration cases and a decreased case fatality rate for severe cases of dehydration receiving ORT.
 - The design, evaluation and production of communications messages.

- The results of KAP surveys demonstrating both the acceptability of other channels of communication (e.g., graphics, television, radio, printed messages and unconventional media) and increases in the KAP of mothers, kader and health professionals concerning ORT.
2. Mothers' access to ORT-related health services should be improved.
The following indicators will be used to measure the accomplishment of this goal:
- The results of special studies on ORS and home fluid use, ORS mixing ability of mothers, village communication media, kader communication aids, kader supervision, the feasibility of providing incentive systems for kader, etc.
 - The results of indicators 1, 3 and 4.
3. A more adequate ORS supply management system should be evident.
This will be measured by the following indicators:
- The results of operational studies on ORS supply, production, and consumption.
 - The formulation of an information sharing system and a management information system for ORS suppliers.
 - The completion of training by public sector ORS suppliers.
4. More effective training programs for kader and health personnel should be in place. This will be measured using the following indicators:
- The development, testing and use of three training modules should result in the training of 30,000 kader.
 - The provision of support (candidate selection, curricula, methodologies, and courses) to 5 hospitals that are already functioning as rehydration centers.

- The development of courses for up to 10 rehydration centers at kabupaten hospitals.
- The development of ORT programs in the curricula of three medical schools.
- The provision of a national workshop for nursing faculty.
- The conduct of an ORT conference for health professionals.
- The results of a feasibility study for the development of the Information Center for Diarrheal Diseases for health professionals.
- The publication of a CDD newsletter for health professionals.

5. The MOH should significantly improve its coordination of ORT activities and the CDD infrastructure should be more capable of managing national ORT activities. The following indicators, including those in points 3 and 6, will be used to measure the achievement of this goal:

- The organization and functioning of the Secretariat for Integration and the CDD Working Group.
- The formulation of a modified and refined management information system.
- The results of operational studies and trials for the enhanced integration of CDD activities.
- The development of work plans for Repelitas IV and V.
- The development of program indicators for monitoring.
- The functioning of the roving troubleshooter.
- The completion of training for CDD leaders.

6. A more useful diarrheal diseases data collection system should be in operation. The following indicators will be used to measure this:

- The results of operational studies and trials on the disease information system.

- The formulation of new approaches to participation in the routine reporting system.
- The integration of reports from CDD and EPI sentinel sites.
- Recommendations made for improving the outbreak investigation system's procedures.

The activities described in this Project Amendment do not, of course, represent the entire scope of work that must be accomplished in ORT in Indonesia. Thus, the completion of the activities described here will represent the first phase of a two-phase project, with Phase 2 comprising a continuation of the initiatives begun in Phase 1. During Phase 2, it is anticipated that more Intensification Areas will be added to the CDD Program, that other activities will be replicated and expanded, and that the GOI's level of responsibility for project activities will be increased.

The extent to which expansion, replication, and the transfer of responsibility will occur will depend to a large extent on the experience gained during Phase 1. Phase 1 is thus considered to be primarily a learning phase for the development of knowledge, human and financial resources, systems, and management capabilities. The results of this learning phase will be documented in the findings of the special studies, monitoring and evaluation reports, and other analyses. If these "lessons" indicate that an activity was highly successful, it could be incorporated directly by the program and expanded. If activities prove feasible, they will be refined and improved and then applied on a wider basis.

The activities for Phase 2 are anticipated to be less costly and could be implemented more quickly and easily than those of Phase 1. For example, the lessons learned from the communications activities in the Intensification Area could be efficiently applied to other provinces because: a) The communications campaign will have matured to the extent

that province-wide activities will have been in place for at least 12 months before Phase 2 begins, b) much of the management and communications experience from the first Intensification Area can be transferred, and (c) the necessity for Phase 1 evaluations that attempt to quantify precisely the impact of activities on different segments of the population should be reduced.

Table 1
Project Inputs, by Objective

<u>Objective</u>	<u>Input</u>	<u>Person Months</u>	<u>US\$ (000)</u>
1. Improve the Knowledge, Attitudes and Practices (KAP) of Mothers, Kader and Health Personnel Regarding ORT	Technical Assistance	36.75	544.5
	Program Monitoring and Evaluation	-	247.5
	Training	-	540
	Operations Development	-	538
	<u>Sub-Total</u>	<u>36.75</u>	<u>1,870</u>
2. Strengthen the Capability of the MOH to Manage Complex Coordination Activities that Relate to ORT	Technical Assistance	1.6	25
	Program Monitoring and Evaluation	-	80
	<u>Sub-total</u>	<u>1.6</u>	<u>105</u>
3. Strengthen the Capability of the National CDD Program to Manage Support Systems Related to ORT Interventions	Technical Assistance	47.25	467.5
	Program Monitoring and Evaluation	-	349.75
	Training	-	195.25
	Operations Development	-	12.5
	<u>Sub-Total</u>	<u>47.25</u>	<u>1,025</u>
Project Amendment Totals	Technical Assistance	85.6	1,037
	Program Monitoring and Evaluation	-	677.25
	Training	-	735.25
	Operations Development	-	550.5
	<u>GRAND-TOTAL</u>	<u>85.6</u>	<u>3,000</u>

4. ADMINISTRATIVE ANALYSIS

Program outputs are dependent upon both the participation of various organizations and successful coordination among these organizations. Therefore, clearly-defined lines of administration need to be established.

The administrative arrangement proposed here (see the figure in this section) is designed to institutionalize an improved system of management for ORT. Specifically, it is anticipated that the following changes can be realized by the conclusion of the project: (a) The Secretariat for Integration will be organized and providing important services for CDD coordination; (b) the Working Group for CDD will be revitalized and functioning as a technical advisory body for CDD; (c) the Directorate, Communicable Diseases of Direct Transmission will assume a more active leadership role; (d) the national CDD office will be more capably managing implementation activities; and (e) the service providers and other support organizations will be using the national CDD office as a technical consultant.

The Chief of the Directorate, Communicable Diseases of Direct Transmission will become the Project Manager, or Pimpro. This Directorate will determine all policy issues and oversee all project activities. The national CDD office will be responsible for implementation activities and will ensure that field operations conform to established policy. This office will put into action the decisions made by the Pimpro through consultation with other offices.

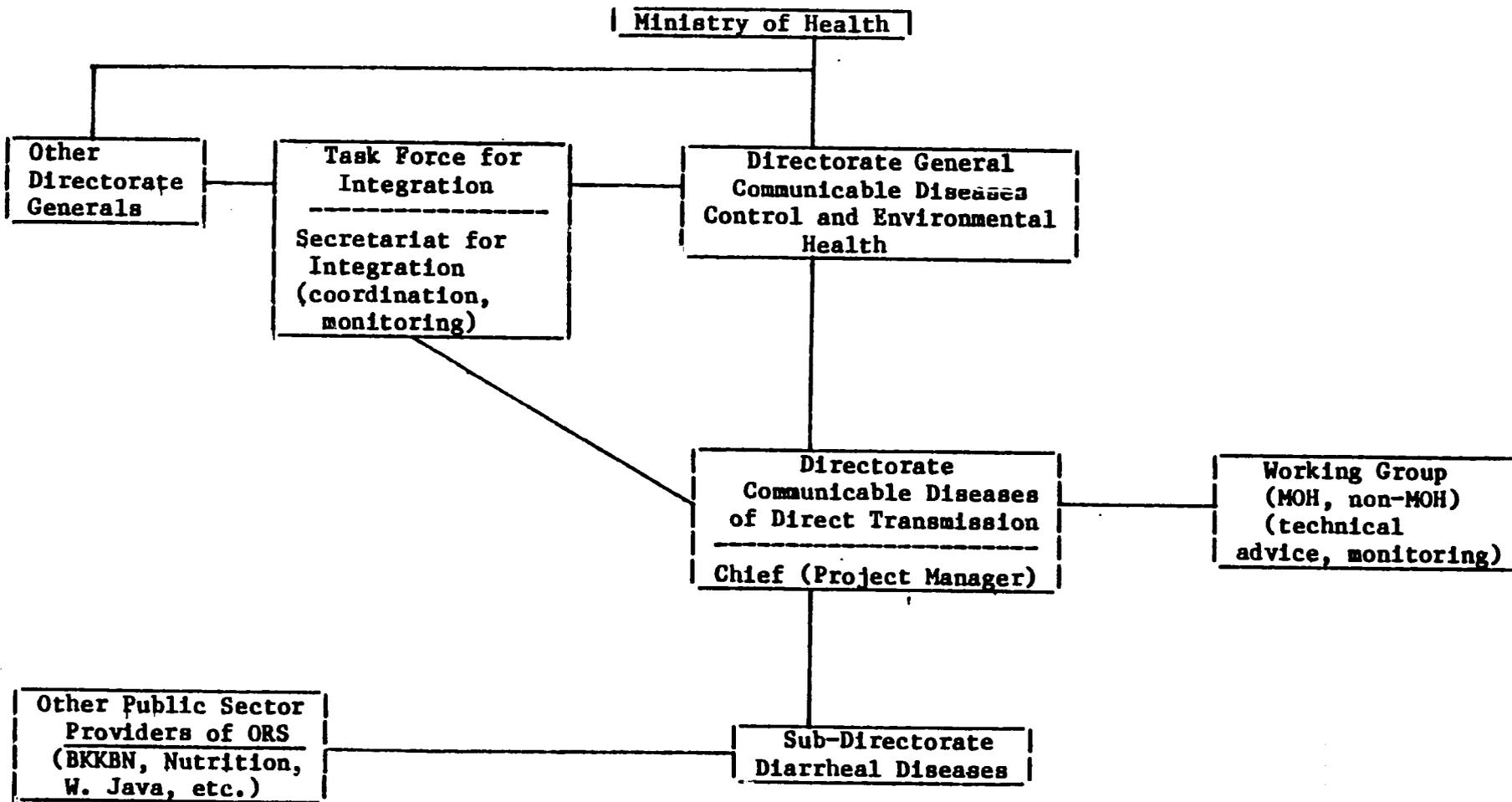
The central-level Task Force for Integration was established in 1984 to provide a mechanism for coordinating and monitoring the country's five basic health services. This intersectoral forum, represented by the Chiefs of the Sub-Directorates or Bureaus responsible for delivering these services, provides inputs to policy makers, including the Director General of CDC, Director General of Community Health, BKKBN, the Deputy

for Planning and the Deputy for Operations, on matters concerning the integration of health and family planning services. With this Project Amendment, the Task Force will focus its attention on ORT/ORS as one of the integrated services to be coordinated.

The Secretariat for Integration will monitor ORT integration activities and provide assistance to the Pimpro/Director Generals in overcoming difficulties. The Working Group for CDD will monitor policy decisions and implementation activities and provide suggestions for improvement to both the Director General, Communicable Diseases Control and Environmental Health and the Pimpro.

The Secretariat and the Working Group will provide strong resources for monitoring and technical assistance. The Director General, Communicable Diseases Control and Environmental Health and the Directorate, Communicable Diseases of Direct Transmission will provide high-level management leadership. All of the above, in addition to the activities designed to strengthen management capabilities, should significantly assist the national CDD office in performing its function in project implementation.

CDD ADMINISTRATION



5. COST ESTIMATE AND FINANCIAL PLAN

5.1 USAID Costs

The use of USAID funds for this amendment will be consistent with the present project which provides \$1.2 million for diarrheal disease activities. The table below indicates the amount of these funds to be allocated for specific inputs. The largest percentage of new grant funds will be used for technical assistance, both short and long-term. The estimated costs for non-Indonesian technical assistance on a short-term basis is \$15,000 per month. The estimated amount of technical assistance by work activity is as follows: \$394,500 for communications/social marketing, \$184,500 for logistics, \$150,000 for training, \$115,500 for monitoring/evaluation, \$112,500 for disease information, and \$80,000 for operations.

Training funds will be utilized for the development of CDD staff, health center workers, kader, and key personnel from support organizations. There will be no commodities purchased by USAID. Operational support refers principally to printing and production costs of training and communications/social marketing materials. Program monitoring/evaluation funds will allow new field studies to be conducted, e.g., in important areas of integration, kader training and incentives, ORS supply management, disease surveillance, outbreak investigations, and communications/social marketing; provide partial support of a new Secretariat for Integration; and assist in activities to measure the project's progress, especially field trials in Intensification Areas.

ESTIMATED BUDGET: (US dollars)

<u>ITEM</u>	<u>EXISTING BUDGET</u>	<u>PROPOSED ADDITIONAL</u>	<u>TOTAL</u>
Technical Assistance	232,000	1,037,000	1,269,000
Training	619,645	735,250	1,354,895
Operations Development	-	550,500	550,500
Program Monitoring/Evaluation	91,000	677,250	768,250
Contingency	300,000	-	300,000
TOTAL	1,242,645	3,000,000	4,242,645

5.2 GOI Costs

The GOI contribution to the project is \$1,194,600, as administered through the DIP Propinsi (provincial) and the DIP Pusat (central). All items listed below are part of the CDD development budget, with the exception of the operations item which includes monies from their routine budget. All funds for commodities are earmarked for the purchase of ORS, the essential ingredient in ORT. The operations fund includes salaries of full and part-time CDD personnel, especially at the health center level, support of vehicles, and miscellaneous administrative costs. The monitoring/evaluation fund provides for supervisory travel expenses for CDD personnel down to the kabupaten level and for outbreak containment activities. Finally, technical assistance funding refers to support of central CDD staff who provide CDD technical guidance to national ORT activities. The financial plan shown below breaks out USAID grant funding according to foreign exchange (FX) grant funds and local currency (LC) grant funds.

FINANCIAL PLAN

(\$ 000)

	<u>USAID GRANT</u>	<u>(FX) (Grant)</u>	<u>(LC) (Grant)</u>	<u>GOI</u>	<u>TOTAL</u>
Technical Assistance	1,037	750	287	43.40	1,080.40
Program Monitoring/ Evaluation	677.25	300*	377.25	502.20	1,179.45
Training	735.25	-	735.25	-	735.25
Commodities	-	-	-	462.30	462.30
Operations Development	550.50	-	550.50	186.70	737.20
	<u>3,000</u>	<u>1,050</u>	<u>1,950</u>	<u>1,194.60</u>	<u>4,194.60</u>

* Includes estimates for U.S. consultants and non-Indonesian 'companies' services.

DISBURSEMENT SCHEDULE (\$ 000)

(Indonesian FY)

	<u>86/87</u>	<u>87/88</u>	<u>88/89</u>
Technical Assistance	200.40	472.20	364.40
Program Monitoring/Evaluation	146.82	328.72	201.71
Training	89.40	386.55	259.30
Operations Development	110.10	275.25	165.15
	<u> </u>	<u> </u>	<u> </u>
TOTAL	546.72	1,462.72	990.56

6. IMPLEMENTATION PLAN

6.1 Annual Plans and Budgets

The project will continue to be administered by the Ministry of Health, and the Director General, Communicable Diseases and Environmental Health will continue to be the official signatory for all funding documents. The Directorate, Communicable Diseases of Direct Transmission (Pimpro) will assume overall responsibility for the project, while the national CDD office will oversee implementation. CDD activities in every province will be reviewed for the preparation of annual plans. Expenditure of project funds will follow Project Implementation Letter (PIL) procedures.

When the Indonesian government budget request (DUP) is prepared, as part of the annual DUP-DIP (budget approval) cycle, an annual implementation plan and budget proposal for grant funding will also be prepared to support activities where greater flexibility of budget planning is required. The narrative for grant support will stress the problem analysis approach. Additional funding for activities, such as procuring commodities and monitoring and evaluation, is expected from an anticipated increase in GOI development monies for the 87/88 fiscal year.

6.2 Contracting

Two long-term foreign consultants for this project will continue to be contracted through AID's Health Communications project. A logistics expert will be provided on a part-time basis as foreign consultant contracted through AID/Washington's Pritech IQC. Finally, a public health advisor will be provided, also on a part-time basis, as a foreign consultant through a PASA with CDC, Atlanta, Georgia. Short-term foreign consultants will be arranged through the AID/Washington IQC with Pritech.

Both the Pritech and Health Communications projects were competitively procured by AID/W with maximum consideration given to the

use of Gray Amendment entities. They were established to facilitate Mission access to highly qualified technical assistance in the two areas - ORT and Health Communications - of primary concern for additional diarrheal control activities included in this amendment. Contracts for short-term technical assistance not available for these projects will be competed locally in Indonesia by the Ministry of Health using host country contracting procedures. In addition, a new position, the roving trouble shooter will be contracted for eighteen months under a host country PSC to be issued with the Ministry of Health.

Additionally, long-term contractual relations with ICDDR/B for training, clinical diagnosis, treatment and case management will continue. And, training institutions in the region, such as Mahidol University in Thailand, will also be considered when reviewing project contractual needs.

The USAID/Indonesia Mission Director in approving the Project Paper Amendment certifies that maximum consideration has been given for the use of Gray Amendment entities in the implementation of the amended Project.

6.3 Implementation Schedule

The following schedule reflects the key dates for project implementation. Because the schedule is linked directly to actual dates in the GOI fiscal year, dates by month are used in this schedule rather than elapsed time in months.

- June, 1986 Amendment signed.
- July, 1986 Secretariat for Integration established and staffed. Logistics review conducted nationally and in West Java. Training materials for West Java completed. Launch training in West Java conducted.
- August-December, 1986 Work plan finalized.
Expansion training in West Java conducted.
Communication materials completed and utilized in Intensification Area.
KAP survey in West Java completed.
CDD-EPI sentinel areas integrated.
Clinical training initiated.
New rehydration centers started.
Consultancies provided to professional institutions.
Logistics and management MIS developed.
Integration studies begun.
CDD program review completed.
Roving troubleshooter contracted.
- January - June, 1987 Logistics activities field tested.
Operational studies initiated in communications, surveillance, logistics, management, and training.
Workshop of central section chiefs conducted.

Central Working Group functioning.
Logistics training initiated.
Logistics needs estimation model developed.
ORS supplier information developed.
Expansion and clinical training continued.
Training in epidemiology initiated.

--July - December, 1987

Information center proposal reviewed.
Expansion training concluded.
National ORT conference conducted.
West Java resurvey completed.
Training/communication materials revised.
Nursing school workshop conducted.
Workshop for manufacturers and distributors
of ORS conducted.
National meeting conducted for CDD managers.

--January - June, 1988

All training and consultancies concluded.
Operational studies concluded and results
summarized.
Final project evaluation completed.
Phase 2 strategy developed.

--September, 1988

The above activities will be completed.

7. CONDITIONS AND COVENANTS

The Government of Indonesia agrees to establish a Secretariat as part of the Task Force for Integration, consisting of a Secretary and three administrative assistants. Members of the Secretariat will work full time for the Task Force. The purpose of the Secretariat is to provide analysis of integration issues. It will (a) monitor planned integration activities, identify discrepancies in any technical or operational guidelines, and provide recommendations for resolution of these problems; (b) monitor utilization of funds earmarked by the MOH for use in integrated activities; and (c) evaluate performance of integrated field activities and recommend improvements.

8. MONITORING AND EVALUATION PLAN

Monitoring and evaluation are integral aspects of all the activities included in this Project Amendment, as well as those activities funded under the existing project. Monitoring and evaluation activities will be centered at the Directorate, Communicable Diseases of Direct Transmission, and will be a joint effort of the national CDD office, the new Secretariat for Integration, and the revitalized CDD Working Group.

Monitoring and evaluation activities will be carried out in a way that strengthens the capability of the Directorate to monitor the performance of its programs and to test innovative approaches to program implementation. Technical assistance will be provided to support the above initiatives.

Improvements in communications, social marketing and training (objective 1) will be monitored and evaluated principally through survey results, such as qualitative and quantitative assessments of knowledge, attitudes and practices (KAP). Improvements in KAP will be the indicators used to make necessary revisions in training and communications materials and in the type or frequency of the information channels utilized.

Improvements in program coordination and management (objectives 2 and 3) will be closely monitored during the two-year period of the amendment. The basis for this monitoring will be the work plan developed by CDD for the implementation of activities necessary to meet these objectives. General categories of indicators to be used for this monitoring activity include: the establishment and functioning of the Secretariat for Integration within the Task Force for Integration, the revitalization of the CDD Working Group, and the development and utilization of an improved routine reporting system. Specific indicators for this monitoring process will be identified as part of the work plan process.

Monitoring of the improved routine reporting system mentioned above will concentrate on three general areas: improvements in the overall health information system related to diarrheal diseases control, integration of the CDD and EPI sentinel reporting systems, and the information system linked to ORS distribution. Therefore, improved monitoring will allow for improved logistics, morbidity, mortality, and treatment evaluations.

An evaluation of the amendment initiatives is planned for the end of year two. Studies of morbidity/mortality and studies of the KAP of village health volunteers and mothers/caretakers (funded under the existing project) will provide the baseline for this evaluation. In addition, special studies/evaluations of such topics as kader training, village communication networks, mass media materials, and private sector marketing of ORS are planned during the two-year amendment period. The primary purpose of these special studies will be to assess specific aspects of the ORT communication system. The results of these special studies should assist in providing more effective communications to communities about ORT.

ANNEX A

PP AMENDMENT APPROVAL MESSAGE

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UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523



APR 17 1985

O/PA

WORKING COPY

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THROUGH: A/AA/PPC, Allison B. Herrick
FROM: AA/ASIA, Charles W. Greenleaf, Jr. CG 2/0 4/85
SUBJECT: INDONESIA -- (1) Health Training Research and Development (497-0273) and (2) Applied Agricultural Research (497-0302)

Problem: We request that you delegate to the Mission Director, USAID/Jakarta, ad hoc authority to:

- (1) extend the PACD of the Health Training and Research Project from 9 to 12 years; and
- (2) extend the PACD of the Applied Agricultural Research Project from 5 to 12 years and authorize total life-of-project funding from \$25,900,000 up to \$33,000,000.

Authority: Under Delegation of Authority Number 133, you have delegated to the Assistant Administrator, Bureau for Asia, authority to amend project authorizations if the amendment does not result in total life-of-project funding of more than \$30,000,000 or present significant policy issues or require issuance of waivers. You have also delegated to the AA/ASIA authority to approve life-of-project extensions which do not result in a total life-of-project of more than 10 years. You have retained for yourself authorities beyond these limits.

(1) HEALTH TRAINING RESEARCH AND DEVELOPMENT (497-0273)

Background: The Health Training Research and Development (HTRD) Project was approved in May 1978 and has an amended nine-year life-of-project funding level of \$10,900,000. The project has four components: (1) manpower planning, (2) research and development, (3) management information systems, and (4) diarrheal disease morbidity/mortality control.

In 1983 USAID and the Ministry of Health (MOH) reached agreement that AID would provide \$1,800,000 to support the Government of Indonesia's (GOI) comprehensive program to control diarrheal diseases (CDD). U.S. assistance has been focussed on planning, management, training and evaluation of CDD and ORT programs. However, MOH lacked adequate mid-level managerial capability to make effective use of USAID resources in a timely manner and progress was slow. Today the MOH has improved its staff resources and planning capability. The recently created Diarrheal Disease Control Unit within the MOH is the focal point for USAID assistance. Though only

CGR	CSO	UNIT	PER	INFO	ENR	VIP	ENR/T	ENR	ARD	ENR/FA	ENR/S	FIN	CA	ACT	PRO	LA	REG/REV	DPA	DD	DIR	TO	USAID ROUTING
																						ACT. INF.

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a year old, the Unit has already developed strategies to expand and improve acceptance of ORT, established "sentinel" clinics in areas presumed to have a high incidence of diarrheal disease, developed case management and surveillance systems, and initiated an ORT promotion program through mass media. In fact, the World Health Organization estimates that Indonesia, with an ORT use rate of 17% and an access rate of 33%, has one of the most successful CDD programs in the world.

Discussion: Given the delay in establishing the Diarrheal Disease Control Unit, it is not possible to complete the originally proposed activities within the existing HTRD project time frame. Furthermore, until the Diarrheal Disease Unit was in operation, USAID/Jakarta could only estimate the level and type of technical assistance which would be required. It is now apparent additional funding will be necessary for mass media activities, support for surveillance system management and etiology identification

A discontinuation of assistance in 1986 would leave the Unit at a vulnerable stage in its institutional development process. Diarrheal disease control is one of the Mission's priorities. If this project is not extended, the Mission will have to design a follow-on project with the same objectives and the same essential relationship with the Diarrheal Disease Control Unit. The proposed amendment would increase the life-of-project from nine to twelve years and would increase funding for the diarrheal disease control component from \$1,800,000 to \$4,800,000, bringing the total HTRD life-of-project funding level to \$13,900,000. It raises no policy or programmatic issues and sufficient expertise exists at the Mission to preclude returning the proposed amendment to Washington for substantive technical review.

Recommendation: - That you delegate to the Mission Director ad hoc authority to extend the PACD under the Health Training Research and Development Project (497-0273) from nine to twelve years.

Approved James A. Mori

Disapproved _____

Date 5/23/85

(2) APPLIED AGRICULTURAL RESEARCH (497-0302)

Background: The Applied Agricultural Research Project (AARP) was authorized in September 1980 with a life-of-project of 5 years and a total funding level of \$25,900,000. This project is designed to assist in the development of 17 agricultural research stations located primarily in Indonesia's outer islands. Research conducted at these stations involves food crops, forestry, fisheries, and livestock and is targetted mainly to small holder production.

Implementation has been slow due to shortfalls in GOI counterpart funds, changes in management of the GOI's implementing agency (the Agency for Agriculture Research and Development), and difficulties with new GOI regulations requiring increased local procurement.

ANNEX B
B/G REQUEST FOR ASSISTANCE

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REPUBLIC OF INDONESIA
NATIONAL DEVELOPMENT PLANNING AGENCY
JAKARTA, INDONESIA

No. : 7D.I/5/1986

Jakarta, May 23 , 1986

Mr. William P. Fuller
Director
USAID/Indonesia
c/o American Embassy
Jakarta

Dear Mr. Fuller:

On behalf of the Government of Indonesia we hereby request an additional grant of \$3.0 million under the ongoing Health Training, Research and Development Project No. 497-0273, and an extension for three years of the Project Assistance Completion Date, to allow for additional funding for the expansion of the Diarrheal Disease Control Component of the project.

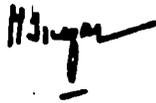
These additional funds would increase the project amount to \$12.45 million grant and \$1.45 million loan over the 12-year life of project. The Government of Indonesia will provide an additional rupiah equivalent of \$1.2 million in cash and in kind contributions or total contributions of rupiah equivalent of \$5.4 million in cash and in kind in support of this project.

This project will be implemented by the Ministry of Health.

We look forward to your favourable consideration.

Sincerely yours,




Muntarudin Siregar
Deputy Chairman

ANNEX C
FINANCIAL ANNEX

CDD Project (U.S.\$ - US \$1.00 = Rp. 1,123)

July, 1986 (IFY)

<u>Expenditure by Input</u>	<u>Total Units</u>	<u>Unit Cost</u>	<u>FY 85/86</u>		<u>FY 86/87</u>		<u>FY 87/88</u>	
			<u>Units</u>	<u>Costs</u>	<u>Units</u>	<u>Costs</u>	<u>Units</u>	<u>Costs</u>
1. Training								
Kader - IA								
AID FX (none)	0	0	0	0	0	0	0	0
AID LC (local travel, per diem)	32,000	5	0	0	20,000	100,000	12,000	60,000
Health Staff (disease information, logistics, supervision)								
AID FX (none)	0	0	0	0	0	0	0	0
AID LC (local travel, per diem, rental space)	820	2.25	100	22,500	400	90,000	320	72,000
National Meetings, Workshops								
AID FX (none)	0	0	0	0	0	0	0	0
AID LC (airfare, per diem, rental space)	3	21,000	0	0	3	63,000	0	0
Clinicians (old and new rehydration centers)								
AID FX (none)	0	0	0	0	0	0	0	0
AID LC (course preparation, per diem, airfare)	500	574	100	57,400	200	114,800	200	114,800

<u>Expenditure by Input</u>	<u>Total Units</u>	<u>Unit Cost</u>	<u>FY 85/86</u>		<u>FY 86/87</u>		<u>FY 87/88</u>	
			<u>Units</u>	<u>Costs</u>	<u>Units</u>	<u>Costs</u>	<u>Units</u>	<u>Costs</u>
1. <u>Training (cont.)</u>								
Special Projects (information center, models, medical schools)								
AID FX (none)	0	0	0	0	0	0	0	0
AID LC (material preparation, per diem, local travel)	163	250	<u>38</u>	<u>9,500</u>	<u>75</u>	<u>18,750</u>	<u>50</u>	<u>12,500</u>
TOTALS			89,400		386,550		259,300	
GRAND-TOTAL	<u>735,250</u>							
2. <u>Commodities</u>								
ORS - 200 cc								
GOI FX (none)	0	0	0	0	0	0	0	0
GOI LC	3,000,000	.10	0	0	2,000,000	200,000	1,000,000	100,000
ORS - 1 Liter								
GOI FX (none)	0	0	0	0	0	0	0	0
GOI LC	1,082,000	.15	0	0	<u>800,000</u>	<u>120,000</u>	<u>282,000</u>	<u>42,300</u>
TOTALS					320,000		142,300	
GRAND-TOTAL	<u>462,300</u>							

<u>Expenditure by Input</u>	<u>Total Units</u>	<u>Unit Cost</u>	<u>FY 85/86</u>		<u>FY 86/87</u>		<u>FY 87/88</u>	
			<u>Units</u>	<u>Costs</u>	<u>Units</u>	<u>Costs</u>	<u>Units</u>	<u>Costs</u>
3. <u>Program Monitoring/</u>								
<u>Evaluation (cont.)</u>								
<u>Field Reporting</u> (supervision, MIS, indicators)								
AID FX (none)	0	0	0	0	0	0	0	0
AID LC (airfare, local travel, per diem, supplies)	275	400	50	20,000	125	50,000	100	40,000
GOI FX (none)	0	0	0	0	0	0	0	0
GOI LC (airfare, local travel, per diem, supplies)	455.5	400	55.5	22,200	250	100,000	150	60,000
<u>Field Test Training</u>								
AID FX (contracts, airfare, per diem)	10	5,000	2	10,000	5	25,000	3	15,000
AID LC (airfare, per diem, supplies)	30	750	5	3,750	15	11,250	10	7,500
GOI FX (none)	0	0	0	0	0	0	0	0
GOI LC	0	0	0	0	0	0	0	0
<u>Field Test Communications</u>								
AID FX (contracts, per diem, airfare)	11	5,000	1	5,000	6	30,000	4	20,000
AID LC (per diem, airfare)	40	500	5	2,500	20	10,000	15	7,500
GOI FX (none)	0	0	0	0	0	0	0	0
GOI LC (none)	0	0	0	0	0	0	0	0
TOTALS			219,020		598,720		361,710	
GRAND-TOTAL			219,020		598,720		361,710	

<u>Expenditure by Input</u>	<u>Total Units</u>	<u>Unit Cost</u>	<u>FY 85/86</u>		<u>FY 86/87</u>		<u>FY 87/88</u>	
			<u>Units</u>	<u>Costs</u>	<u>Units</u>	<u>Costs</u>	<u>Units</u>	<u>Costs</u>
4. <u>Operations Development</u>								
Preparation of Training Materials								
AID FX (none)	0	0	0	0	0	0	0	0
AID LC (module printing)	50	2,150	10	21,500	25	53,750	15	32,250
GOI FX (none)	0	0	0	0	0	0	0	0
GOI LC (none)	0	0	0	0	0	0	0	0
Health Center Staff								
AID FX (none)	0	0	0	0	0	0	0	0
AID LC (none)	0	0	0	0	0	0	0	0
GOI FX (none)	0	0	0	0	0	0	0	0
AID LC (partial salary)	1,000	140	200	28,000	500	70,000	300	42,000
Preparation of Communication Materials								
AID FX (none)	0	0	0	0	0	0	0	0
AID LC (newsletter, social marketing, indicators)	1,000	443	200	88,600	500	221,500	300	132,900
GOI FX (none)	0	0	0	0	0	0	0	0
GOI LC (none)	0	0	0	0	0	0	0	0
Vehicle/Office Maintenance								
AID FX (none)	0	0	0	0	0	0	0	0
AID LC (none)	0	0	0	0	0	0	0	0
GOI FX (none)	0	0	0	0	0	0	0	0
GOI LC (electricity, repairs, gas)	100	467	20	9,340	50	23,350	30	14,010
TOTALS				147,440		368,600		221,160
GRAND-TOTAL	737,200							

<u>Expenditure by Input</u>	<u>Total Units</u>	<u>Unit Cost</u>	<u>FY 85/86</u>		<u>FY 86/87</u>		<u>FY 87/88</u>	
			<u>Units</u>	<u>Costs</u>	<u>Units</u>	<u>Costs</u>	<u>Units</u>	<u>Costs</u>
5. <u>Technical Assistance</u>								
Long Term (months)								
AID FX (none)	0	0	0	0	0	0	0	0
AID LC (trouble shooter, DepKes contract-salary, housing, travel, etc.)	20	3,500	2	7,000	12	42,000	6	21,000
GOI FX (none)	0	0	0	0	0	0	0	0
GOI LC (central CDD staff routine salary)	25	1,736	6	10,416	12	10,832	7	12,152
Short Term (months)								
AID FX (travel, per diem, supplies, salary)	50	15,000	10	150,000	20	300,000	20	300,000
AID LC (travel, per diem, supplies, salary)	25	8,680	5	43,400	15	130,200	20	43,400
GOI FX (none)	0	0	0	0	0	0	0	0
GOI LC (none)	0	0	0	0	0	0	0	0
TOTALS								
GRAND-TOTAL	1,080,400			210,816		493,032		376,552

ANNEX D

LONG-TERM TECHNICAL ASSISTANCE: SCOPES OF WORK

COMMUNICATIONS/SOCIAL MARKETING SPECIALIST

1. Participate in designing and conducting pre-program research, including practical studies on audience beliefs and practices about ORT use, health personnel and infrastructure capacity to support a communications component, and an inventory of other systems, programs and personnel who can be integrated into an ORT communications component strategy;
2. Develop a variety of research and evaluation efforts in order to assess changes in health behavior regarding diarrheal diseases as a result of the communications component and other activities of the pilot test. These efforts should include:
 - service provided/commodities distribution monitoring
 - quantitative KAP studies
 - mortality and morbidity studies;
3. Develop an annual strategy plan which, based on the pre-program research described above, defines the communications strategy, target audiences, behaviors to be modified, messages to be promoted, and materials to be developed, the first of which is to be submitted 60 days after initiation of the contract;
4. Develop and test messages and other educational materials and communications techniques and/or review materials already available to ensure suitability for use;
5. Assist with implementation of West Java pilot program and ensure appropriate use of the various materials, mass media and support personnel components. This will involve preparation of health personnel, including orientation of health workers, training and related extension supports, distribution of materials and scheduling;

6. Assist with development of systematic monitoring for practical periodic feedback in order to assess the output and impact of the communications component;
7. In the third quarter of the first year, provide USAID and MOH with a report identifying lessons learned and impact of mass media and health practices in effecting ORS promotion in the pilot project area of West Java. This report will serve as an evaluation of the component and be used by AID in determining inclusion of a mass media and health practices component in a proposed Morbidity and Mortality Reduction Project being developed by USAID for FY 86 start; and
8. Coordinate activities with other donors such as UNICEF, WHO and World Bank.

EPIDEMIOLOGIST

1. Analyze surveillance needs for CDD program at various administrative and decision levels, analyze strengths and weaknesses of existing surveillance systems (routine, sentinel and intermittent), recommend alternatives for modification of surveillance systems, and assist in implementation of systems selected by MOH;
2. Accumulate, systematize and analyze available epidemiologic information on diarrheal diseases in Indonesia, recommend systems for easy availability and dissemination of epidemiologic information, identify gaps in data, recommend survey/study instruments to acquire missing data, assist implementation and analyses of surveys/studies;
3. Assist in analyzing control programs as to their targeting, cost-benefit and cost-effectiveness as measured against existing epidemiologic data on diarrheal diseases around the country;

4. Suggest ways to strengthen training in CDD based on epidemiologic capabilities needed at various program levels, training CDD staff at central CDD office in appropriate epidemiologic analytic methods;
5. Participate in a limited number of outbreak investigations for the purpose of enhancing staff capabilities to efficiently gather and analyze information necessary for program management decisions; and
6. Perform other administrative and technical tasks as agreed upon by GOI and USAID.

MANAGEMENT SPECIALIST

1. Analyze strengths and weaknesses of existing planning, internal control, monitoring and evaluation procedures for routine management of CDD program; suggest alternatives to GOI for such procedures; assist in implementing any agreed upon changes;
2. Assist in design, implementation and analysis of special assessments/studies necessary for program planning and management, such as impact studies; assessments of strengths and weaknesses of existing ORT training programs; feasibility studies for various means of producing and distributing ORS; training materials' effectiveness, etc;
3. Analyze implications and management modifications necessary to implement GOI program of integration of diarrheal diseases control with other MOH and family planning services;
4. Suggest and provide staff training for CDD management; and
5. Perform other administrative and technical tasks as agreed upon by GOI and USAID.

ROVING TROUBLESHOOTER

1. Monitor all policies and plans concerning CDD implementation that have been mutually agreed upon by members of the Task Force for Integration;
2. Identify progress and constraints to daily program implementation;
3. Report findings to the Secretariat and present possible solutions through recommendations;
4. Provide liaison with each level of the delivery system to assure that adequate reporting procedures are being followed and that adequate supplies are on hand or ordered;
5. Provide feedback to the Secretariat and CDD Office regarding appropriate teaching of ORT to mothers by kader;
6. Identify sources of ORS, including the private sector, and determine ORS accessibility to mothers; and
7. Particularly during the launch phase, identify potential or actual issues that require higher-echelon intervention to ensure program implementation.

ANNEX E

STATUTORY CHECKLIST

5C(2) PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A. includes criteria applicable to all projects. Part B. applies to projects funded from specific sources only:
B.1. applies to all projects funded with Development Assistance loans, and
B.3. applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

YES. SEE ANNEX F GPT II PP AMENDMENT NO. 2

YES

A. GENERAL CRITERIA FOR PROJECT

1. FY 1986 Continuing Resolution Sec. 524; FAA Sec. 634A.

Describe how authorizing and appropriations committees of Senate and House have been or will be notified concerning the project.

A CN has been prepared. Obligation will occur upon expiration of the Notification period, without Congressional objection.

2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

(a) Yes.

(b) Yes.

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

No further legislative action is required.

4. FAA Sec. 611(b); FY 1986 Continuing Resolution Sec. 501. If for water or water-related land resource construction, has project met the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See AID Handbook 3 for new guidelines.) N/A.

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project? N/A.

6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. No.

7. FAA Sec. 601(a). Information and conclusions whether projects will encourage efforts of the country to: N/A.
 - (a) increase the flow of international trade;
 - (b) foster private initiative and competition;
 - (c) encourage development and use of cooperatives, and credit unions, and savings and loan associations;
 - (d) discourage monopolistic practices;
 - (e) improve technical efficiency of industry, agriculture and commerce;
 - (f) strengthen free labor unions.

8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise). N/A.

9. FAA Sec. 612(b), 636(h); FY 1986 Continuing Resolution Sec. 507. Describe steps taken to assure that, to the maximum extent possible, the country is contributing local-currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars. GOI will gradually assume local costs obligations of Project, as amended.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? No.

11. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes.

12. FY 1986 Continuing Resolution Sec. 522. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N/A.

13. FAA 118(c) and (d). Does the project comply with the environmental procedures set forth in AID Regulation 16. Does the project or program take into consideration the problem of the destruction of tropical forests?

This Project will have no adverse environmental impact. It is for health manpower development and reduction of disease through simple non-toxic therapies.

14. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom)?

N/A.

15. FY 1986 Continuing Resolution Sec. 533. Is disbursement of the assistance conditioned solely on the basis of the policies of any multilateral institution?

No.

16. ISDCA of 1985 Sec. 310. For development assistance projects, how much of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

The in-place TA contractors were competitively selected by AID/W with maximum consideration given to use of Gray Amendment entities. No specific amount of Project funds are available only for this purpose.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance
Project Criteria

a. FAA Sec. 102(a), 111, 113, 281(a). Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status, (e) utilize and encourage regional cooperation by developing countries?

The PP amendment will strengthen the capability of the Ministry of Health to manage complex coordination activities that relate to ORT; strengthen the capability of the national CDD office to manage support systems related to ORT interventions; and improve the knowledge, attitudes, and practices (KAP) of mothers, kader and health personnel regarding ORT. In so doing the above, (b), (c) and (d) objectives should be achieved.

- b. FAA Sec. 103, 103A, 104, 105, 106. Does the project fit the criteria for the type of funds (functional account) being used?
- c. FAA Sec. 107. Is emphasis on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?
- d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed country)?
- e. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

This Project meets fully the requirements of Section 104 of the FAA

Yes. The GOI will contribute approximately 28% of the total Project's costs in cash or "in-kind".

Y

f. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?

The project will be so monitored.

g. FAA Sec. 281(b): Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.

The project will strengthen Ministry of Health institutional capability to plan, implement, train and manage public health personnel; to conduct applied research; and educate communities in health practices.

2. Development Assistance Project
Criteria (Loans Only)

- a. FAA Sec. 122(b). Information an conclusion on capacity of the country to repay the loan, at a reasonable rate of interest. PP Amendment increases grant funding only.
- b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan? N/A.

3. Economic Support Fund Project
Criteria

- a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of part I of the FAA? N/A.
- b. FAA Sec. 531(c). Will assistance under this chapter be used for military, or paramilitary activities? N/A.
- c. ISDCA of 1985 Sec. 207. Will ESF funds be used to finance the construction of, or the operation or maintenance of, or the supplying of fuel for, a nuclear facility? If so, has the President certified N/A.

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that such country is a party to the Treaty on the Non-Proliferation of Nuclear Weapons or the Treaty for the Prohibition of Nuclear Weapons in Latin America (the "Treaty of Tlatelolco"), cooperates fully with the IAEA, and pursues nonproliferation policies consistent with those of the United States?

- d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

N/A.

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5C(3) - STANDARD ITEM CHECKLIST

Listed below are the statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. Procurement

1. FAA Sec. 602. Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? Yes.

2. FAA Sec. 604(a). Will all procurement be from the U.S. except as otherwise determined by the President or under delegation from him?? Yes.

3. FAA Sec. 604(d). If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company? Indonesia does not so discriminate.

4. FAA Sec. 604(e); ISDCA of 1980 Sec. 705(a). If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.) N/A.

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5. FAA Sec. 604(g). Will construction or engineering services be procured from firms of countries which receive direct economic assistance under the FAA and which are otherwise eligible under Code 941, but which have attained a competitive capability in international markets in one of these areas? Do these countries permit United States firms to compete for construction or engineering services financed from assistance programs of these countries?

N/A.

6. FAA Sec. 603. Is the shipping excluded from compliance with requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates?

No.

7. FAA Sec. 621. If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? If the facilities of other Federal agencies will be utilized, are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

Yes.

The proposed PASA with CDC/Atlanta is particularly suitable and not truly competitive with private enterprise. It will not interfere with CDC's domestic programs.

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8. International Air Transportation Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?

Yes.

9. FY 1986 Continuing Resolution Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States?

All direct contracts under the amended project will so provide.

B. Construction

1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used?

N/A.

2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

N/A.

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the CP)?

N/A.

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C. Other Restrictions

- 1. FAA Sec. 122(b). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter? The amendment is grant funded only.

- 2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? N/A.

- 3. FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? Yes.

- 4. Will arrangements preclude use of financing:
 - a. FAA Sec. 104(f); FY 1986 Continuing Resolution Sec. 526. (1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo (1) Yes.
(2) Yes.

- sterilization; (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; (4) to lobby for abortion? (3) Yes.
- b. FAA Sec. 488. To reimburse persons, in the form of cash payments, whose illicit drug crops are eradicated? Yes.
- c. FAA Sec. 620(g). To compensate owners for expropriated nationalized property? Yes.
- d. FAA Sec. 660. To provide training or advice or provide any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? Yes.
- e. FAA Sec. 662. For CIA activities? Yes.
- f. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? Yes.

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- g. FY 1986 Continuing Resolution, Sec. 503. Yes.
To pay pensions, annuities, retirement pay, or adjusted service compensation for military personnel?
- h. FY 1986 Continuing Resolution, Sec. 505. Yes.
To pay U.N. assessments, arrearages or dues?
- i. FY 1986 Continuing Resolution, Sec. 506. Yes.
To carry out provisions of FAA section 209(d) (Transfer of FAA funds - to multilateral organizations for lending)?
- j. FY 1986 Continuing Resolution, Sec. 510. Yes.
To finance the export of nuclear equipment, fuel, or technology?
- k. FY 1986 Continuing Resolution, Sec. 511. Yes.
For the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?
- l. FY 1986 Continuing Resolution, Sec. 516. Yes.
To be used for publicity or propaganda purposes within U.S. not authorized by Congress?

ANNEX F

Health Training Research and Development Project
Revised Financial Plan
(U.S. \$)

CATEGORY	Prior Obligations		1986* (Grant Only) Obligations	TOTAL USAID		TOTAL GOI	TOTAL
	Grant	Loan		Grant	Loan		
1. Technical Assistance	5,601,151	1,450,000	1,037,000	6,638,151	1,450,000	1,193,400	9,281,551
2. Training	1,145,354	- 0 -	735,250	1,880,604	- 0 -	1,530,000	3,410,604
3. Commodities	169,481	- 0 -	- 0 -	169,481	- 0 -	562,300	731,781
4. Research & Develop.	1,147,002	- 0 -	- 0 -	1,147,002	- 0 -	1,120,000	2,267,002
5. Diarrheal Disease Morbidity/Mortality Reduction	1,242,645	- 0 -	- 0 -	1,242,645	- 0 -	- 0 -	1,242,645
6. Operations Develop.	- 0 -	- 0 -	550,500	550,500	- 0 -	186,700	737,200
7. Program Monitoring/ Evaluation	100,000	- 0 -	677,250	777,250	- 0 -	502,200	1,279,450
8. Contingency	44,367	- 0 -	- 0 -	44,367	- 0 -	305,400	344,367
TOTAL:	9,450,000	1,450,000	3,000,000	12,450,000	1,450,000	**5,400,000	19,294,600

*Total is for Amendment for Diarrheal Disease Control, by category.

**of which 1,200,000 is earmarked for Diarrheal Disease Control

under the amendment

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