

AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT DATA SHEET		1. TRANSACTION CODE <input type="checkbox"/> A = Add <input type="checkbox"/> C = Change <input type="checkbox"/> D = Delete	Amendment Number _____	DOCUMENT CODE 3
2. COUNTRY/ENTITY Inter-Regional		3. PROJECT NUMBER 936-5969		
4. BUREAU/OFFICE S&T/Health		5. PROJECT TITLE (maximum 40 characters) Technology for Primary Health Care II		
6. PROJECT ASSISTANCE COMPLETION DATE (FACD) MM DD YY 08 31 97		7. ESTIMATED DATE OF OBLIGATION (Under "B" below, enter 1, 2, 3, or 4) A. Initial FY 87 B. Quarter 4 C. Final FY 95		

8. COSTS (\$000 OR EQUIVALENT \$1 =)						
A. FUNDING SOURCE	FIRST FY 87			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	5,000		5,000	78,500		78,500
(Grant) S&T	(2,500)	()	(2,500)	(47,100)	()	(47,100)
(Loan) Buy-ins	(2,500)	()	(2,500)	(31,400)	()	(31,400)
Other U.S.						
Host Country						
Other Donor(s)						
TOTALS						

9. SCHEDULE OF AID FUNDING (\$000)									
A. APPRO-RELATION	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)	CS								
(2)	HE					31,400		31,400	
(3)						15,700		15,700	
(4)									
TOTALS						47,100		47,100	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)	11. SECONDARY PURPOSE CODE:
12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)	
A. Code	
B. Amount	

13. PROJECT PURPOSE (maximum 480 characters)

To support AID's worldwide efforts to achieve Child Survival targets by the end of the decade by strengthening Diarrheal Disease Control/Oral Rehydration Therapy (DEC/ORT) and Child Survival Programs in Lesser Developed Countries (LDCs).

14. SCHEDULED EVALUATIONS	15. SOURCE/ORIGIN OF GOODS AND SERVICES
Interim MM YY 1 2 9 0 MM YY 1 2 9 5 Final MM YY 0 9 9 7	<input type="checkbox"/> 000 <input type="checkbox"/> 941 <input type="checkbox"/> Local <input checked="" type="checkbox"/> Other (Specify) 935

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

17. APPROVED BY Signature: <i>Kenneth J. Bart</i> Title: Kenneth J. Bart, M.D. Agency Director for Science and Technology	Date Signed MM DD YY 10 20 97	18. DATE DOCUMENT RECEIVED IN AID/W, OR FC & AID/W DOCUMENTS, DATE OF DISTRIBUTION MM DD YY 10 20 97
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PROJECT AUTHORIZATION

Name of Country: Interregional

Project Title: Technology for Primary Health Care II

Project No.: 936-5969

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Technology for Primary Health Care II Project involving centrally funded planned obligations of \$47.1 million over a ten year period from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the project. Additional funding in the amount of \$31.4 million may be provided under the project by other A.I.D. bureaus and missions.

2. The project will support A.I.D.'s worldwide efforts to achieve child survival targets by strengthening diarrheal disease control/oral rehydration therapy and related Child Survival programs in less developed countries (LDCs).

3. The agreement(s) which may be negotiated and executed by the officer(s) to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority shall be subject to the following terms and conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

4. Source and Origin of Commodities, Nationality of Services

a. Commodities financed by A.I.D. under the project shall have their source and origin in the cooperating country(*) or the United States. Except for ocean shipping, the suppliers of commodities or services shall have the cooperating country or the United States as their place of nationality, except as A.I.D. may otherwise agree in writing.

* Each country where research, training, technical, or other assistance takes place under the project shall be deemed to be a cooperating country for the purpose of permitting local cost financing of goods or services for the activity being conducted in such country. Such activities may be undertaken in any country included in A.I.D. Geographic Code 935.

b. Ocean shipping financed by A.I.D. under the project shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States.

Approved: *W. A. Brady*

Disapproved: _____

Date: *5/12/87*

Clearances:

S&T/H, ATinker (draft)	Date <u>4/30/87</u>
S&T/H, GPettigrew (draft)	Date <u>4/30/87</u>
S&T/H, AVanDusen (draft)	Date <u>4/30/87</u>
S&T/PO, GGower <i>R. G. Gower</i>	Date <u>5/4/87</u>
GC/CP, STisa (draft)	Date <u>4/27/87</u>

Drafter: S&T/H, LFeinberg/5673r/4/23/87

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

MAY 1 1987

ACTION MEMORANDUM FOR THE SENIOR ASSISTANT ADMINISTRATOR FOR
SCIENCE AND TECHNOLOGY

FROM: S&T/H, Kenneth Bart, M.D. *Kenneth H. Bart*
SUBJECT: Authorization for the Technology for Primary Health
Care II project, 936-5969

Problem: Your approval is required to authorize the Technology for Primary Health Care II project, 936-5969, for a period of ten years at an estimated life of project amount of \$78,500,000, including \$47.1 million in S&T funding and \$31.4 million of buy-ins. Obligations totalling approximately \$5,000,000 are planned for FY 1987. The Project Assistance Completion Date will be December 31, 1997.

Discussion: This is a follow-on to the initial contract (PRITECH), under the Technology for Primary Health Care (PHC Tech) project, which will be completed on September 30, 1988. That project has served primarily as a catalyst to support the promotion and initiation of ORT programs throughout the Third World. The recent mid-term evaluation of that project concluded that it has been extremely successful in meeting the terms of its agreement with A.I.D.

That evaluation, as well as the PRITECH Technical Advisory Group, recommended that a follow-on project begin as soon as possible in order to provide continuity to activities and momentum already underway. Also, the TAG strongly urged AID to consider a long term commitment to diarrheal disease control and ORT in order to convince LDC leaders and decision makers of the importance that AID ascribes to the problem. Therefore, the project is proposed to extend over ten years and the initial five year contract should be signed before the end of the current fiscal year.

The initial contract will be openly competed and will overlap with the current PRITECH activity for approximately one year. This is due to the fact that the PRITECH contract is almost fully committed and therefore virtually closed for new activity starts. The new contract is necessary to respond to the significant demand for S & T assistance (as well as for buy-ins) from AID/W bureaus and USAID missions.

The proposed project moves from the catalytic and promotion stage into implementation and expansion. The project will

support the implementation and institutionalization of Diarrheal Disease Control/ Oral Rehydration Therapy (DDC/ORT) programs in countries which have already made commitments to such programs and in other countries where A.I.D. bilateral or other donor activities have generated interest and commitment. In addition, the project will support other, related child survival interventions, drawing and expanding upon lessons learned and mechanisms developed under the first project.

Approaches which have evolved over the past three and a half years include the recognition and focussing of project interventions on private physicians, pharmacists, traditional healers and mid-wives as important targets for training and support. In addition, the use of commercial advertising and marketing approaches for the development and dissemination of health messages has been utilized in a number of countries with promising results. A.I.D.'s generalized efforts to attract the attention of government policy makers to the potential of the private sector have also had considerable results in allowing private producers and suppliers to participate in ORS programs.

Based upon the interest of USAID missions and the Regional and FVA/PVO Bureaus in the PRITECH contract under the original PHC Tech project, it is anticipated that approximately 60% of the field activities will be funded through mission and AID/W bureau buy-ins.

Evaluation: Although you are being requested to authorize a 10-year project, implementation will proceed in two stages. There will be an evaluation between years four and five to examine progress made in the areas of program coverage and sustainability and to determine the degree to which the second stage of the project should begin to look at other health interventions that might evolve based on AID's ORT assistance experience.

Justification to the Congress: A congressional notification is in the clearance process.

Clearances: The project paper was discussed on a number of occasions with the Washington bureaus and over 20 USAID missions have submitted cables expressing satisfaction with the on-going project and support for the execution of the follow-on activity. The Health Sector Council recommended approval of the project at their April 3rd meeting after an earlier review by the Project Committee which was comprised of representatives from relevant AID/W bureaus.

11

Recommendation: That you approve the Technology for Primary Health Care II project for a period of ten years with a life of project of \$78,500,000 in health and child survival funds, including Mission and Bureau buy-ins, by signing the attached PAF.

Attachments:

1. Project Authorization
2. Sector Council Minutes, 4/3/87
3. Project Paper (936-5969)

Clearances:

S&T/H/HSD, ATinker Draft 4/30
S&T/H, GPettigrew RP 4/30/87
S&T/H, AVanDusen AWD 4/30/87
S&T/PO, GGower LMG 5/4/87
GC/CP, STisa Draft 4/27
BL

Drafted by: S&T/H, L^{ll}Feinberg:4/29/87:5598r

HEALTH SECTOR COUNCIL

Minutes of Meeting April 3, 1987

Attending: Kenneth Bart, S&T/H, Chairman
Charles N. Johnson, ANE/TR/HPN
Paula Feeney, LAC/DR/HN
Susan Kakesako, LEG
Nancy Pielemeier, PPC/PDPR/SP
Jack Thomas, AFR/TR/HPN
Hope Sukin, FVA/PPM
David Sprague, S&T/ED
Tony Meyer, S&T/ED
Robert Clay, S&T/H
Jeff Harris, S&T/H
Jean Pease, S&T/H (ISTI)
Sam Kahn, S&T/N
Edward Caplan, S&T/PO, Executive
Secretary

Legislation. Susan Kakesako reported on recent Congressional activities. Among them: The House Foreign Affairs Committee has proposed an earmark for guinea worm. Child survival hearings are scheduled for May. \$20 million from DA and the African Development Fund may be earmarked for AIDS research.

Vitamin A. Sam Kahn reported on a new technique for rapid diagnosis of vitamin A deficiency. Until now, only two procedures could detect the deficiency--clinical examination of the eye and blood analysis. Now it has been discovered that when the eye changes because of vitamin A deficiency, there is a decrease in one kind of cell. A blotting filter paper can pick this up; it is stained and laboratories can determine any diminution of that cell. The technique is useful especially in determining whether vitamin A interventions are effective. Dr. Bart, while saying that the potential for this technique is enormous, cautioned that it may depend on more skill than we had expected and is not yet a tool that can be used widely for prevalence studies.

Pritech II Project. Robert Clay reported on a project committee meeting. A new draft gives the project the flexibility to address more than diarrheal disease control; later it will be

determined whether assistance for maternal health, acute respiratory infection and perinatal diseases is justified. The Sector Council endorsed the project.

This sparked a general discussion of buy-ins. It was the consensus that the system requires too much paperwork but prospects for change are scant at this time.

MSH Evaluations. Hope Sukin reported that a presentation by MSH on this subject should be ready soon. It was agreed that a special meeting will be held for it, and persons outside the Sector Council could be invited.

AIDS Public Health Communications Project. Jeff Harris, the S&T/H AIDS coordinator, reported that host countries and Agency offices have been responsive to efforts against AIDS. Thirty-seven African countries sent representatives to a conference; Zaire has officially reported no cases, but has an AIDS education program. Some Latin American countries have formed national AIDS committees. In the last month it has become clear that technical assistance over and above the amount supplied by WHO is needed.

Tony Meyer said the project is a cooperative effort among S&T/ED, S&T/H, and S&T/POP. It stresses the importance of behavior change through communications and education, applying what has been learned in these fields through other projects. The two big issues are: Sensitivity on the subject in some countries and limiting the project to technical assistance. A.I.D. does this sort of social marketing well, and many missions are asking for the kind of help this project will provide.

It was stated that the project will be on the street by the end of the FY 87 and that the regional bureaus should be ready with their paperwork to move on buy-ins immediately upon approval.

AFR Child Survival. Jack Thomas briefed the Sector Council on the Africa Bureau's Child Survival Action Plan. Each emphasis country is to have such an action plan of its own. The bureau plan follows the Agency strategy, but includes several items specific to Africa, such as AIDS, malaria, tropical diseases, and water and sanitation. Asked if Child Survival money could be used for AIDS, Dr. Bart replied that at this time it was not appropriate and that AIDS will probably have its own add-on or earmark in FY 88. Thomas said it is urgent to use Child Survival funds for AIDS in Africa.

111

Additional Items. Paula Feeney reported that a Child Survival fellow is working in LAC to help write strategies for the bureau's six emphasis countries. The bureau is developing a standard format and standard indicators. Sector Council members urged that the topic of indicators be included in this summer's HPN course.

The next regular Sector Council meeting will be held from 2 to 4 p.m. Thursday, April 30, in Room 3886 N.S.

1487b

1487b

I. BACKGROUND

A. Child Survival

Infant and early childhood mortality have been diminishing in most developing countries of the world. Yet, fifteen million children under age five die each year in the developing world, a figure that corresponds to more than 50% of total deaths from all age groups. They die, and millions of others suffer, from the ravages of disease and malnutrition, conditions that are, to a large extent, preventable. Among them, diarrheal disease, acute respiratory infections, malnutrition, and specific infections preventable by vaccination, particularly measles, show the highest incidence.

The magnitude of child mortality and the fact that we have proven, effective interventions -- ORT and immunization -- which can help save half of these children are the bases for making child survival the focus of A.I.D.'s health program.

A.I.D.'s focus is on developing a sustained capacity in each country to effectively provide ORT, immunizations and other important child survival interventions including nutrition and birth spacing to their vulnerable populations.

B. Diarrheal Disease

Diarrhea is the leading cause of mortality among children under five years of age in many developing countries, especially during the first two years of life. The death rate is estimated to be at present 20 per 1,000 children per year, with a total worldwide of 5-6 million children dying from diarrhea annually, 80% before the second year of life. It is, therefore, a major public health problem -- a priority one -- included in the AID Child Survival Policy, as well as in the policies of WHO, UNICEF, and other international agencies. It should be included in the national health policies of all countries where the condition is prevalent.

C. Oral Rehydration Therapy (ORT)

1. Discussion:

For the purposes of this paper, Oral Rehydration Solutions refers to mixtures of water with Oral Rehydration Salts from packets; mixtures of water with sugar and salt; or home available solutions (such as a rice, wheat, or corn gruel, chicken soup, etc.). The provision of Oral Rehydration Solutions in combination with appropriate feeding (including breastfeeding) and the referral of serious cases to a trained health care provider or health care facility, is referred to as Oral

Rehydration Therapy or ORT. The effective utilization of ORT can prevent or reverse dehydration in those 50-80% of diarrheal attacks in young children which are acute and watery, and if untreated, may lead to dehydration, electrolytic imbalance, and death.

ORT, however, cannot prevent nor control the diarrhea that causes dehydration. Once treated, children return to the same environment and are exposed to the same stresses be they biological, (i.e., infections), cultural or economic, coupled with the lack of effective health services. As a result, children in developing countries have an annual incidence (episodes/child/year) with a range of 0.8-10.7 and a median of 3.6 (WHO Diarrheal Disease Control (DDC) Program, Interim Program Report, 1986). Overall, according to Mata, children are ill with diarrhea from 10-20% of their first 3 years of life (Mata L. How Harmful is Diarrhea? World Health, April 1986).

The focus of the new project's activities will be case management of diarrhea episodes, i.e., control of dehydration and reduction of mortality. Where appropriate and feasible a comprehensive approach to diarrheal disease control, i.e., control of diarrheal disease and reduction of morbidity, will be undertaken. In the latter cases, prevention as well as case management intervention will comprise a complete country program of DDC.

With ORT as the cornerstone of a DDC program, progress in preventing and reversing dehydration may be measured in terms of availability of Oral Rehydration Salts (ORS), use, and effective use, a sequence of indicators that requires a carefully planned information system. Universal availability, high, effective use rates, and maximum reduction in diarrhea mortality will be best achieved where there is a well-functioning primary health care system, widespread and effective distribution of ORS packets through health units and/or commercial outlets, and sound messages to motivate the people. Well planned and managed ORT programs can help revitalize a poorly functioning primary health care system by improving training, supervision, supplies, logistics, and data collection. Full achievement of targets requires sustained political commitment and substantial mobilization of resources for expansion of this very cost-effective, life saving technology. ORT and immunizations together lead AID's efforts to overcome the syndrome of malnutrition, disease, unsanitary conditions, closely-spaced births, and lack of maternal education which today causes so many children to die.

Progress, up to now, through the concerted efforts of governments and the international community to provide technical and financial cooperation for the prevention and reversal of dehydration, has been impressive. Annual production of ORS has risen from 60 million one-litre equivalent packets in 1982 to

270 million in 1985. WHO has estimated that access of children in LDCs to ORS has increased from roughly 4% to 50% during the same period, and that ORT may have prevented up to 350,000 diarrhea deaths in 1984.

Even though these data are encouraging, they also point out the distance remaining to reach AID's goals in this field: (1) making ORT available to virtually every child who needs it; and (2) ensuring use of ORT in 45% of diarrhea episodes.

WHO has estimated that global ORT usage, excluding China, as of 1985, was 18% and that about 500,000 deaths from diarrhea may have been prevented. Even for this small percentage of the overall target, we are not sure if ORT was used effectively or not. In addition, we are uncertain whether the population, which has access to ORT, is in fact the one who actually needs the therapy the most. The remaining 50% may be in more need of assistance. This group may be much harder to reach and may require new strategies and approaches.

As the use of ORT expands worldwide, areas that require additional study have been identified. Packets of ORS are often not the appropriate size for the common mixing containers in many countries, and do not have clear instructions. In some countries, the quality control process is not adequate to ensure a safe and effective product.

Sugar/Salt/Solution (SSS) is currently the most widely promoted homemade fluid, particularly where there is not an adequate distribution system of ORS packets. However, problems have been associated with its preparation and use, which include the uncertain availability and variable quality of sugar and, at times, salt. There is often the lack of suitable utensils for measuring the ingredients and water and, most importantly, the difficulty in educating mothers to learn, retain, and use the skills required for its proper preparation and administration. The errors in preparation have been found to lead to a solution which is often ineffective and/or unsafe.

Alternative home-available solutions such as teas, juices, soups, and others, have not been adequately studied and may be equally problematic, especially in the area of communications.

The WHO suggests that more emphasis should be placed on promoting continued fluids and feeding during diarrhea in the home without necessarily introducing a new behavior such as mixing the SSS or ORS solutions. The new project will support research which looks at medical and traditional practices in program countries as they relate to diarrhea treatment. Research on home available fluids will also be directly linked to implementation activities which are carried out, especially in the areas of training (for medical and health personnel), the development of

formal and non-formal educational materials, and the preparation of mass media and marketing messages.

This will also be a topic which will be monitored and reviewed by the project's technical Task Force.

The use of new Oral Rehydration Solutions will take two courses. One, looks at formulas which are more adaptable to home use and, the other at a better commercial product. The cereal-based solutions will fall into this latter category. Some studies show that rice-based ORS can significantly lower stool volume and increase the overall duration between diarrheal episodes. Though at the present time the data are still insufficient to justify launching widespread implementation of such solutions, their introduction may be deemed feasible within the lifetime of this project. There will be many important implementation issues which the project will have to address when these new solutions are available.

The new commercial products might consist of glucose or polysaccharides, dipeptides, and amino acids. The interest in such products is their potential to reduce duration and volume of diarrheal stool and increase caloric content. Higher osmolarity may prove to be a limitation on just how many ingredients can be added to the solutions. Also, it may well be that the presently recommended ORS, plus appropriate feeding, may give results similar to dry cereal-based or super ORS solutions.

At the present time, there are no drugs that are recommended to be clinically efficient in immediately stopping diarrhea. Drugs are available but they do cause side effects that would limit their use or would cause such an expense as to become prohibitive for many families.

A significant proportion of overall serious diarrhea mortality and morbidity is caused by dysentery and prolonged (chronic) diarrhea. Antibiotics have a role in the treatment of these conditions. It has also been suggested that antibiotics may more rapidly improve the capacity of the gut nutrient absorption. On the other hand, more widespread use of antibiotics may have a detrimental effect on the population as a whole. More research is needed in this area. Also better epidemiological data are essential to understand the dynamic of both dysentery and prolonged diarrhea.

2. ORT and Nutrition:

If ORT is not integrated with nutrition, then progressive malnutrition may finally induce the death of the child. Diarrhea causes either a failure to gain weight or an actual weight loss. This growth faltering is related to decreased food intake due to anorexia or withholding of food by the mothers or the health workers (often including reduction of breastfeeding). There

may also be some decreased absorption of nutrients from the intestine caused by the diarrheal infection which inhibits weight gain. This can be prevented by proper feeding - especially breastfeeding - during diarrhea, and by extra feeding during a "catch-up" period after the episode.

Although diarrhea is not more frequent in malnourished children, it is more severe. Duration is prolonged and thus the volume of fluids lost is also increased. A vicious cycle, therefore, is created where diarrhea leads to malnutrition which in turn leads to increasingly severe diarrhea. "It is neither beneficial to mothers and children nor cost-effective to develop programs to counter diarrhea in isolation of nutrition programs, or vice versa." (International Nutrition Planners Forum. Nutrition and Diarrheal Disease Control. Report of an International Conference, United Kingdom, 1985).

There has been increasing recognition of the value of good nutrition management of the patient with diarrheal disease. A number of studies have appeared as of late, which demonstrate the significant degree to which nutrients are absorbed during diarrhea. By appropriately mixing carbohydrates, fats, and amino acids, even greater absorption may take place. Although available knowledge should be applied, particularly concerning breastfeeding, there remains a great need for further operational research related to diverse nutritional issues.

3. Referral of Severe Cases:

If ORT is practiced in the home by mothers or community health workers, there must be an appropriate referral mechanism for the more severe cases needing supervised administration of ORS, use of IVs or other intensive treatment. We should however, keep in mind that coverage of the population with health services is rather low in LDCs, particularly in rural areas, which makes referral rather problematic. Thus, the significance of preventing dehydration through effective education of mothers and local health personnel or volunteers to provide appropriate foods and fluids, including ORS, is considerable.

D. Prevention of Acute Watery Diarrhea

The infections which cause diarrhea often originate in unsanitary environments and are spread primarily through contaminated water and food, as well as soiled hands of mothers and children. Lack of hygienic practices exacerbate the problem. Some viral infections, most notably measles, are also often accompanied or followed by diarrhea. Prevention of this condition -- the reduction of morbidity -- is directly related to the control of these factors, through the improvement of the environment, changing the behaviors of mothers and children, and immunizations.

Sanitation improvements and the availability and use of increased quantities of water play a consistently critical role in improving children's health. For example; simple hand washing, an admittedly difficult behavioral practice to change quickly, can cut the incidence of diarrheal disease by as much as 40%.

Improvements in sanitation and water are community wide interventions which when they include the involvement and support of the entire community often have wide spin-offs in terms of communities participation in more preventive health interventions: ORT programs, and immunization. Findings from recent studies in water supply and sanitation have shown that completed immunization rates in these communities are 11-50% higher than in communities without water. There is evidence that suggests that knowledge of ORS recipes is also higher in communities with water supply projects which include community participation.

In addition, the evidence shows that a substantial proportion of diarrheal disease can be effectively prevented when breastfeeding begins early and is maintained for no less than 12 months, and is followed by appropriate weaning when clean water and basic sanitation services are provided; when mothers and children carry out routine personal hygiene and when children are adequately immunized, particularly against measles. New vaccines against rotavirus -- an important cause of serious diarrhea in infants -- and cholera, now in development, may provide additional protection, if clearly proven safe, effective, and manageable. For the time being, however, there is an arsenal of curative and preventive measures which, if properly used, can prevent dehydration, avert death, and control watery diarrheal disease to such an extent that it no longer need be a major public health problem in developing countries.

It would be a mistake, in the light of available experience, to believe that the prevention and cure of dehydration through ORT is a simple undertaking. Rather, the greatest constraint is, even in the presence of adequate facilities, the behavior of mothers and children that leads to the transmission of diarrhea. To change this behavior requires carefully planned health education programs, including face-to-face, printed and mass media communications. Early studies suggest positive potential impact of these methods.

Generally, problem areas encountered in the implementation of programs oriented to behavioral change such as DDC/ORT are related to poor planning, training, supplies and logistics, information system and data analysis, management, and inadequate participation of the private sector.

In synthesis, acute dehydrating diarrhea is a highly prevalent problem in most developing countries of the world, a leading cause of death of children below five years of age. A cost effec-

tive technology is available for preventing and reversing dehydration and controlling the disease as a public health problem. However ensuring that the technology is used affectively is a complex process and requires sustained efforts by the people -- particularly mothers -- governments, and the international donor community. AID has played and should continue to play a leading role in order to make the Child Survival Policy a reality.

II. PROJECT DESCRIPTION

A. Goal & Purpose

This project will contribute to the sector goal of reducing morbidity and mortality of infants and young children in less developed countries. In pursuing this goal, the project will support AID's worldwide effort to achieve child survival targets by the end of the decade by strengthening DDC/ORT and child survival programs in LDCs through appropriate case management, including feeding, fluids, and referral (ORT); promotion of preventive hygienic and sanitation practices; and other health related interventions. In addition, the project will develop and support a respository of up-to-date information, research results, and technical expertise to serve AID. This resource will not only serve the agency (including AID/W bureaus, USAID missions, AID-funded contractors, and PVOs), it will also assure the much needed role of technical leadership in support of collaboration with other multi- and bilateral donors, LDC government, non-governmental organizations, and private commercial entities which are actively or interested in becoming involved in DDC/ORT and other child survival activities.

Project assistance will also be directed toward related childhood diseases which interact with diarrheal disease and cause morbidity and mortality. Project supported activities within and beyond the initial contract will expand the lessons learned and mechanisms developed in ORT to be applied to other health areas which promote child survival, such as maternal health, acute respiratory and perinatal diseases, and others as may be deemed appropriate.

B. Initial Contract Outputs

The initial contract will have four categories of programatic interventions. The operational components consist of Country Programs and Health Systems Support Services. In addition, those activities, as well as other AID and non-AID child survival programs and the general state-of-the-art will benefit from outputs generated under the contract's Program Support Components, which will include Research and Evaluation

activities and Information Collection and Dissemination. These latter components will also support the project's growth in technical expertise in the DDC/ORT community.

Operational Components

Country Programs
Health Systems Support

Program Support Components

Research and Evaluation
Information Collection and Dissemination

These components of the initial contract and the outputs they will generate are illustrative of what may be included in other project-supported contracts and/or agreements which will be developed over the full ten years of the project.

The outputs which the first contract will produce will contribute to the actual implementation of DDC/ORT and other child survival programs. It should be noted that country and program-specific outputs and progress indicators will be identified at the beginning of each country program intervention. On a case-by-case basis, these may be articulated as process indicators or, in more advanced situations, impact indicators. For example, in some countries, the project objectives might be the successful training of 100% of its health workers; while in another program, the target may be a percentage of mothers effectively utilizing ORT. Or, the targets may refer to anticipated reductions in the incidence of dehydration or diarrhea-related mortality. The current PRITECH contract has become involved in the implementation of DDC/ORT programs and the mid-term evaluation of that project has provided a number of lessons learned and operational guidelines which will be incorporated in the new project.

One of the major conclusions of the mid-term evaluation indicated that many ORT/DDC programs suffer from systemic problems within the health care delivery system, governmental policies which are broader than ORT/DDC, or other infrastructural problem areas which are broader than just ORT/DDC. For example, situation where ORT/DDC training is a part of an over-all health/medical training program, or where ORS production/distribution/quality control issues are dependent upon a higher level food and drug policy-making authority, require interventions which are broader in scope than merely ORT/DDC.

In addition, lessons learned and mechanisms which have been developed through PRITECH-supported ORT/DDC activities have considerable applicability and relevance for other non-ORT/DDC

but closely related Child Survival programs. For example, the use of modern communications/media approaches and the incorporation of other commercial and traditional institutions in national ORT/DDC programs have considerable applicability for other emphasis Child Survival problem areas.

The new project is structured to respond to these and other recommendations emanating from USAID missions, AID/W bureaus, other donor representatives and LDC health officials. Therefore, it provides for short-term technical assistance which might be broader in scope than just ORT/DDC both through the Ad Hoc as well as the Health Systems Support components. These mechanisms will enable the contractor to address situations where ORT/DDC experience can be brought to bear on other Child Survival problem areas, as well as where ORT/DDC programs are obstructed by problems which lie outside the strict definitions of ORT/DDC.

The following sections address the initial contract's components and anticipated outputs in the light of AID's experience to date:

1. Country Programs

The major component of the initial contract will provide direct technical and limited financial support to planning and implementing DDC programs. Support will be categorized per country according to relative level of intensity and commitment, and will be planned, budgeted, managed, and evaluated accordingly.

There will be three country program categories in the project: 1) Sustained Programs; 2) Intermittent; and 3) Ad hoc. All three categories share the same objective of strengthening country DDC/ORT programs. Based on country-specific need, they will provide the same core assistance menu considered basic to developing and implementing a successful DDC/ORT program. In addition, they will be expected to provide assistance to strengthen other elements of public health systems which are considered necessary to achieve the respective DDC/ORT program objectives.

Country-specific plans for sustained and intermittent programs will define the nature and levels of assistance required. At that time, concrete outputs will be established and be agreed upon by USAID and ST/H, specific to each country program, contractor, host country counterpart, and will provide a basis for measuring the contractor's performance.

a. Sustained Support:

The initial contract will identify a limited number of country DDC programs with which it will make 2-4 year commitments to provide specified assistance throughout that period. Follow up support may be provided during a phaseout period following of the project activity. The commitment will be represented by a written agreement in which the host country, cooperating entity, and perhaps other participants, also commit specific contributions. The current project has used this mechanism successfully for some of its "national" or "focus" programs. The initial contract will pursue approximately 12 "sustained support" programs and will provide assistance to a range of DDC activities in a "sustained" program. A complete package will include the following:

- DDC and ORT policy and strategy
- Program design (case management [ORT] and prevention)
- Community Education
- Training
- ORS production and distribution
- Financing of DDC/ORT Programs
- Health information system for monitoring and evaluation
- Operational research
- Resident project representative/technical advisor

Depending on the nature of each country's program requirements, the project may provide only a subset of the package. Commitments to "national" or "focus" services will be explicitly stated in each program agreement with corresponding estimated budget, and performance will be evaluated accordingly. If project assistance is requested for such a limited set of activities or at such a low level that it would have minimal influence on the country program outcomes, the project will decline to pursue it as a "sustained support" program, but may do so as "intermittent support".

An exception to this model will be made in non-emphasis child survival countries, for example in regions where AID and the contractor may identify countries in which the project will play a larger role in implementing a DDC/ORT program. In circumstances where host country and USAID capacity is unable to manage all of the inputs required, the contractor may take on

responsibility for doing so. In such cases the regional Bureau may provide funds, as a "buy-in" to this Project and/or as a direct grant to a national program, to cover the costs of additional contractor staff, materials, and local operating costs.

b. Intermittent (Limited) Support:

The contractor will identify a number of country DDC programs with which it will agree to provide some or all of the services included in the above package on an "as needed", intermittent basis. This type of relationship was included in the current project as "Limited Countries". The contractor will take responsibility for the performance of each task but not for the performance of the country program component for which the task is provided. This arrangement is illustrated by assistance PRITECH has provided to CCCD programs in Africa where CCCD manages the U.S. DDC assistance program and seeks technical contributions periodically from PRITECH.

The contractor will negotiate written agreements with cooperating entities governing these arrangements, committing itself to provide an estimated level of TA of a specified nature over a specified time period, not to exceed 3 years. Because the contractor will have less influence over the utilization of the assistance provided than in "Sustained Support" programs, capability of the recipient entity will be an important criterion for entering into an "Intermittent Support" agreement. A maximum of 12-15 countries will be permitted.

c. Ad hoc Short-Term Support:

The Project will be prepared to respond to requests from AID to provide short-term technical services to USAID's and country programs which support AID's DDC or broader health sector objectives. All AID-recipient countries, including other centrally-funded projects and programs, will be eligible for these services, most of which will be funded by USAID's or other AID/W bureaus through the project's "buy-in" mechanism.

Services provided through this category will be narrower in scope than those provided as "Systems Support" (SS) in the current project. The reason for this is that the broad scope of "Systems Support" corresponded to the broad scope of the original "Technologies for Primary Health Care Project" which no longer exists. Assistance for immunization programs and health services financing is available through the REACH Contract. The majority of SS assignments have been supportive of DDC programs generally and, assuming a continuing demand for similar services, future assignments should be managed as a part of the project's overall strategy and evaluated as such. A category of assistance which was not specifically designated in the Technologies for Primary Health Care Project

but which will have considerable importance in this Project concerns TA to FVA/PVC in assisting their management and support of PVOs operating CDD/ORT activities under their Child Survival Competitive Grants Program. Assistance will also be made available to the PVOs, through FVA/PVC, to address specific, operational needs.

Overall outputs for this component are as follows:

- c Sustained Programs - 12-15 programs over the 5-year contract life, minimum duration of 3 years and average cost of \$800,000;
- o Intermittent Programs - approximately 15 programs over the 5-year contract, minimum duration of 3 years and average cost of \$300,000;
- o Ad hoc Programs - 100 assignments over the 5-year contract life, maximum duration of 3 months and at an average cost of \$15,000 per month.

2. Health Systems Support

AID missions respond to health priorities of their respective countries, as well as to global priorities such as DDC. In fact, the relative prevalence, severity and priority of specific childhood life threatening health problems varies within and between countries and regions. Consequently, ST/H technical support projects should respond accordingly by providing timely assistance for countries' felt needs, but within the parameters of AID's and each mission's Child Survival strategies. Justification is to be based upon the inter-relationship of diseases resulting in morbidity and mortality and the inter-dependency of programs and health care systems components.

This Project component will enable the contractor to meet those needs. It will provide short-term technical assistance to USAIDs, ministries of health and others concerning child survival subjects which lie outside the scope of the Country Program DDC/ORT focus. These may include acute respiratory infection, growth monitoring, maternal health, immunization, health care financing, malaria, etc.. These outputs will help strengthen a country's overall health care system of which DDC/ORT is a part and/or which the success of DDC/ORT programs are dependent. They will also provide a mechanism to transfer lessons learned and mechanisms developed for DDC/ORT to other child survival problem areas.

By working on a variety of priority public health problems related to the DDC/ORT field, the contractors, and thus AID, will be able to stay abreast of developments in those fields and be in a position to incorporate them more explicitly into the

project as well as its overall health program in the future, as appropriate. This capability could serve to modify this project in its outer years, or to establish separate central or mission projects.

This component will resemble the ad hoc category of the Country Program component operationally, but is separated because it focuses on different subject matter. The latter assignments will contribute directly to the project's primary purpose of strengthening DDC programs and will be implemented and evaluated accordingly. By contrast, although each of the diffuse Health System Support assignments will be expected to produce concrete beneficial results, they will not contribute to one measurable outcome. Consequently, the contractor will be evaluated on the quality of performance of HSS assignments, but not on its collective contributions to any health goal.

The component will provide up to 200 person months of support at an average cost of \$15,000 per month.

Each HSS short-term assignment will produce an identifiable output, most often a report with recommendations to be pursued by the client. These may be in the form of concrete projects (i.e., AID health strategies, PIDs and Project papers), project evaluations or technical recommendations for use by USAIDs, ministries of health or private organizations.

3. Information Dissemination

The initial contract will include an Information Dissemination component which will collect and provide to DDC program planners, implementors, and evaluators technical and programmatic information about DDC and ORT. The information will be derived from published literature and intervention program reports (the project's and others) and disseminated via four mechanisms described below. It will essentially continue the services provided by the Information Services component of the current project, with some modifications:

Just as the target group of information users represents a wide range of disciplines and functions (physicians, communicators, anthropologists, planners, bureaucrats, economists, nurses, managers, LDC governments, donor agencies, PVOs, and consultants) the information content will be diverse as well, covering the multi-disciplinary scope of DDC/ORT programs. However, the information will be disseminated in a concise useable form to maximize its impact.

a. Information Center:

The Center will acquire relevant technical documents, catalogue them and distribute copies in response to requests from project staff and consultants, and outside professionals. It will advise addressees on a computerized mailing list of new acquisitions and periodically produce and discriminate a bibliography of its holdings. Documents will include both research and operational subjects related to diarrheal disease. Efforts will be made to expand the present mailing list and distribution to as many appropriate LDC users as possible. The Center will also be responsible for editing, binding, cataloging, and distributing project documents and reports and providing material for publication in journals/newsletters which have wide distribution in LDCs.

b. Technical Literature Update Series:

Project staff will select a number of current articles related to DDC/ORT at least bi-monthly, prepare a summary and technical comment on each one, and disseminate the summaries and comments to a subset of the Center's mailing list. This will constitute a monthly report of current literature on ORT and related health issues, and will be targeted at officials, technicians, and academics in both less developed and donor countries. These TLUs will emphasize social science and behavioral issues as well as biomedical ones.

c. Conferences/Workshops:

The Project will develop and implement a series of conferences to exchange current technical and programmatic information among persons responsible for designing and implementing DDC/ORT programs, associated with contractors, PVOs, donor agencies, host country institutions, and AID. Approximately one conference will be held each year, and T.A. and support will be provided, as appropriate.

4. Research & Development

Collective field experience gained from implementation of the current project, and other DDC/ORT programs worldwide, have generated many questions about ORT use and how to achieve program goals.

Questions about ORT technology and its application can only be answered from careful study of country programs themselves such as those which will be included in the new project.

The Science and Technology component of the current PRITECH contract is addressing some of these issues, including the following:

- Effectiveness of interpersonal health education activities in national ORT programs (constraints to ORT acceptance).
- Information systems and monitoring approaches for national ORT programs.
- Operational strategy for judging home-prepared solutions.
- Country policies on diarrhea case management.
- Use of ORT by physicians and pharmacists.

In addition, ST/H also supports DDC-related research through the PRICOR, CCCD, WASH, HEALTHCOM, DMD, and ADDR projects.

Program planners at AID, WHO, and PRITECH have already expanded their approaches beyond ORS. Current strategies now consist of a comprehensive case management approach including feeding and fluids from the onset of an episode, administration of ORS by a trained health worker at signs of potential dehydration and referral to a health facility for rehydration of severe cases, if necessary. ORT is a key part of this treatment strategy with additional benefits when fluids are combined with feeding.

This expansion has generated additional questions requiring analysis, in order to overcome country-specific program constraints and to provide a basis for developing broader guidelines. Consideration will be given to social science and behavioral studies of traditional feeding practices during diarrheal episodes, and constraints to use of recommended practices by mothers and health workers. Effectiveness of various home-prepared foods and liquids, identification of dehydration by mothers, and other subjects may also be studied.

Problem solving studies supported by this project will complement but not duplicate research carried out under the other AID projects cited above. In order to ensure this, the Project and the DDC/ORT Task Force will regularly monitor and review research being done by others in this field.

The Research and Development component will support studies carried out as part of, or in conjunction with, Project country programs. Funds provided by this component will be used to augment regular country program operating funds allocated to a particular program (usually a sustained program) and be used to hire expertise and pay other costs required to design and conduct appropriate studies.

AID and/or project country program representatives will request support for studies which they feel are required for proper design and successful implementation of their programs.

The contraction in collaboration with the S&T/H Project Manager will determine whether to support the request based on criteria to be established at the beginning of each project year in collaboration with AID and the ORT Task Force. Priority will be given to studies which will contribute to solving problems such as effective use of ORT by mothers and health workers, feeding practices during diarrhea, private sector participation, and integration of DDC/ORT programs with other health services.

Under supervision and approval by AID (S&T/H and field) the contractor will collaborate with the country program staff and counterparts in the design and implementation of studies financed by this component, including selection of persons to conduct them. Results of all studies supported by this component will be reviewed by AID and project staff and used, as appropriate, to augment the state-of-the-art. Significant findings of all studies will be disseminated regularly via the Information Dissemination component.

The component will provide approximately \$100,000 on average for each study and will support approximately 10 studies over the life of the Project. Therefore, a total of \$1 million exclusive of core staff and administration costs will be allocated to this for the entire Project period, of which \$.5 million will be assigned to the initial contract.

C. Project Beneficiaries

Ultimate beneficiaries of the assistance to be provided by this project include the millions of infant and children in LDCs who suffer from debilitating and/or fatal diarrhea episodes each year. The intermediate beneficiaries of the project's outputs would include child care providers; health and medical professionals and para-professionals; health educators; public health administrators, managers and technicians; and private pharmaceutical manufacturing, marketing, and retail personnel.

In their role as primary child care providers, and as public and private health care delivery agents, women will play a major role both as beneficiaries as well as implementors in this project.

D. Cost Estimates & Financial Plan

Project costs are estimated in terms of the four Project components plus management and evaluation for a five-year period. They are then extrapolated for the final five years, recognizing that project priorities, and thus costs, may change considerably by then. "Buy-ins" by missions, regional bureaus and FVA are projected at \$12.5 million, representing 66% of the Country Programs and Health Systems Support components combined. Cost experience

of the current PRITECH project has been used as a basis for the estimates, together with lessons learned from the recent evaluation of that project and current agency priorities. Cost estimates are shown in the tables below:

Initial Five-Year Cost Estimate

		Total (Millions)	ST/H	Buy-in
I	Country Programs -----			
	Sustained 12-15 X \$800,000	\$ 12.0	\$ 6.0	\$ 6.0
	Intermittent 15 X \$300,000	4.5	1.25	3.25
	Ad Hoc 100 X \$ 15,000	1.5	0.5	1.0
		18.0	7.75	10.25
II	Health Systems Support -----			
	200 X \$ 15,000	3.0	.5	2.5
III	Information Dissemination -----			
	Information Center 5 yrs X \$200,000	1.0	1.0	-
	Conferences Sponsored 10 X \$100,000	1.0	0.6	0.4
	Support 60 X \$ 20,000	1.2	0.8	0.4
		3.2	2.4	0.8
IV	Research & Development -----			
	Studies 10 X \$100,000	1.0	0.5	0.5
V	Management -----	6.25	6.25	-
	Contract Total	31.45	17.35	14.05
VI	Evaluation* 2 X \$ 50,000 -----	0.1	0.1	-
VII	Contingency and Inflation* -----	3.75	3.75	-
	GRAND TOTAL	\$ 35.3	\$ 21.25	\$ 14.05

 *Reserved for ST/H allocation to Project purposes but not through principal contractor.

Annual Cost Estimate
(Millions)

	I	II	III	IV	V	5 Yr. Subtotal	
Country Programs	\$ 2.0	\$ 4.0	\$ 4.0	\$ 4.0	\$ 4.0	\$ 18	
Health Systems Support	.5	.6	.6	.6	.7	3	
Information Dissemination	.5	.6	.7	.7	.7	3.2	
Research & Development	.2	.2	.2	.2	.2	1.0	
Management	1.25	1.25	1.25	1.25	1.25	6.25	
Evaluation	.0	.0	0.05	.0	0.0	.1	
Contingency/ Inflation	.25	0.50	0.75	1.00	1.25	3.75	
	<u>\$ 4.7</u>	<u>\$ 7.15</u>	<u>\$7.55</u>	<u>\$ 7.75</u>	<u>\$ 8.15</u>	<u>\$ 35.3</u>	
	VI	VII	VIII	IX	X	5 Yr. Subtotal	10 Yr Total
Country Programs	\$ 4.0	\$ 4.0	\$ 4.0	\$ 4.0	\$ 4.0	\$ 20.0	\$ 38.0
Health Systems Support	.8	.8	.8	.8	.8	4.0	7.0
Information Dissemination	.6	.6	.6	.6	.6	3.0	6.2
Research & Development	.2	.2	.2	.2	.2	1.0	2.0
Management	1.25	1.25	1.25	1.25	1.25	6.25	12.5
Evaluation	.0	.0	0.1	.0	0.1	.2	0.3
Contingency	<u>1.25</u>	<u>1.50</u>	<u>1.75</u>	<u>2.00</u>	<u>2.25</u>	<u>8.75</u>	<u>12.5</u>
	<u>\$ 8.1</u>	<u>\$ 8.35</u>	<u>\$ 8.7</u>	<u>\$ 8.85</u>	<u>\$ 9.2</u>	<u>\$ 43.2</u>	<u>\$ 78.5</u>

III. IMPLEMENTATION ARRANGEMENTS

A. Requirements for Initial Contract

Based on the nature of this Project and experience of the current PRITECH implementation, a number of important factors have been identified which must be accommodated in the new Project to maximize effectiveness and efficiency:

1. Contractor Selection:

Because of the highly technical nature and dynamic state-of-the-art of the DDC/ORT subject of this Project, we want to elicit proposals from the most qualified sources of expertise and encourage respondents to propose original and creative approaches to achieving the Project objectives. Therefore, the scope of work will state the Project objectives, desired outcomes, and country selection criteria, and ask respondents to demonstrate their understanding of the technical and non-technical aspects of Diarrheal Disease Control and other, related Child Survival problem areas.

2. Technical Qualification:

In recognition that this Project will focus on implementation and strengthening of 12-15 DDC/ORT programs in a sustained manner, the contractor must organize and staff itself accordingly.

The contractor must have in-house and/or ready access to technical expertise consultants capable of providing short- and long-term TA in DDC/ORT and child survival subjects in LDCs, including the following: health program planning, health policy formulation, community education and motivation, ORS production and distribution, public health, nutrition, training, program financing, program monitoring and evaluation, social science, behavioral and operations research, and management.

The task will require a resident representative/advisor in several countries, and a strong technical and management staff to supervise and support each of those resident representatives. Demands for strong technical capability will be even greater during the new Project than the current one because country programs will be fully engaged with numerous operational issues.

The initial contractor must stay abreast of research done in the DDC/ORT field in order to: (a) advise AID of new developments and their implications for the Project; (b) manage effectively the problem-solving R&D component; and (c) incorporate research findings and adapt the Project approaches to those findings, as appropriate.

The contractor must also be capable of deriving from project experiences the technical and implementation findings appropriate for dissemination to a wide audience of researchers, program sponsors, and implementors. This will be a part of the more general Information Dissemination component described in Section II.B (Project Outputs) above.

This project paper will not prescribe how the contractor should provide the requisite skills. Instead, the RFTP for contractor services will define the performance requirements and approximate volume of activity anticipated, and ask the respondents to propose appropriate numbers, mix and deployment of expert staff and consultants to do the job.

3. Gray Amendment Consideration:

The request for technical proposals will encourage offerers to subcontract with qualified small business, small disadvantaged, and/or small women-owned business concerns for services which it might not have an in-house capability.

B. AID Management

In order to ensure successful implementation of this project, ST/H will make available a full-time project officer for project management. He/she will serve as a coordination point for all inter-actions between the contractor and Missions, Regional Bureaus, FVA/PVC and other Agency offices requesting services and will facilitate communication between the contractor and Contracts Office.

The ST/H Project Officer will exercise approval authority over contractor decisions concerning initial country selection, and all "sustained" and "limited" country program plans and budgets. ST/H will delegate to the contractor responsibility and authority to make all program implementation arrangements pursuant to each country program plan and budget, including where appropriate, direct communications with USAID's and other host country counterpart organizations.

Requests from USAID's, AID regional bureaus, or others for short-term "ad-hoc" DDC/ORT services not governed by country program agreements (sustained or limited) will be reviewed by the ST/H Project Officer and referred to the contractor for action if he/she so decides. Requests which fall outside the DDC/ORT scope of the Country Programs component will be considered for action from the Health Systems Support component or referred to other appropriate AID assistance resources for response.

USAID's, representing their host countries, have several important roles in this project: (a) USAIDs can request TA or information; (b) will be consulted for approval on requests for TA in

their host countries that are not USAID-initiated; (c) will be responsible for informing the S&T/H project manager and grantee of any deficiencies in the execution of tasks by contractor staff; and (d) will be responsible for approval of draft consultants' reports before they are formally issued.

AID regional bureaus have the same roles outlined above for USAIDs when project activities are requested by a regional bureau. In addition, regional bureaus may wish to comment upon the Scopes of Work for services requested by their USAIDs and advise whether the activity would be more appropriately carried out under another project. Furthermore, evaluations from the regional bureaus, with respect to the content, presentation, and timeliness of the consultants' reports, will be requested, where appropriate. Regional bureaus will also be responsible for providing initial guidance on the topics for, and general organization of, any workshops and conferences to be held in their regions.

The Bureau for Food and Voluntary Agencies will be supporting approximately 60 projects with child survival funds during the course of the project. Many of these projects will include DDC/ORT activities. These PVOs will be encouraged to utilize technical expertise of the project through the FVA/PVC office.

C. Contractor Management

Although the management approach to be utilized by the contractor will be a major evaluation component in the review of responses to the RFTP, there are a number of lessons learned from the PRITECH contract which should be acknowledged in the project.

a. Headquarters Management:

The contractor will maintain a core technical administration and management staff based in close proximity to the ST/H office. The management staff must be fully aware of AID regulations and operating conditions and must also have considerable project management experience in LDCs. Their experience will be necessary in order for the headquarters staff to be able to understand AID programmatic and administration requirements as well as the needs and conditions behind all field requests.

The management and technical staff will:

i) Based upon the RFTP and winning proposal, develop annual work plans, to be reviewed and approved by ST/H in consultation with other AID/W bureaus;

ii) Based upon requests from USAID missions, regional bureaus, and FVA/PVC, through ST/H, for short-term services identify appropriate consultants, clarify scopes of work, follow all

proper selection and procurement procedures to field and support the consultants, and follow up on all consultancies to assess the satisfaction of the client, and prepare and distribute copies of consultancy reports.

iii) For "sustained support" programs, the contractor may identify, gain approval for and field a resident project representative/technical advisor. The project director will be responsible for all activities of these representatives, and will ensure that the ST/H Project Manager is fully informed of their activities.

Experience from the PRITECH contract clearly indicates that the full-time presence of a project representative is usually necessary to gain the minimal "momentum" to get programs such as CDD underway. For "sustained programs" where the project enters into agreements whereby AID and other institutions formally commit resources, AID should generally have a full-time agent.

iv) "Sustained Programs" will include intermittent short-term technical assistance as well as local costs, etc..

v) The Project Director and his professional staff will also be responsible for ensuring that the project and its discrete activities are flexible enough to respond to new opportunities and new requirements which may arise in the areas of TA, information, and research.

b. Field Management

i) Long and short-term advisors must have prior country clearance by the USAID and, as appropriate, by the host government and/or target institution. While in the field, they are responsible to report to and consult with the USAID health office. They are, however, supervised by the Project Director, unless the project has a Regional or Country representative.

ii) As stated above, a full- or part-time country representative or program assistant where there may be a Regional Representative, will be necessary for all "sustained programs". While every country intervention will be different, it has been the experience of PRITECH (and other projects in various disciplines) that an effective resident advisor/technician can benefit, if not salvage, critical program interventions which might otherwise falter or fail. Therefore, the qualifications and skills of these field representatives will depend upon the situation and conditions in each country. No matter what the expertise of the consultants, however, they must be flexible and able to recognize and respond to needs which arise.

D. Country Programs Arrangements

1. Carryover from the Technologies for Primary Health Care I Project

PRITECH will terminate activities funded by the current project in September 1988. Most of PRITECH's planned assistance to "national" programs will have been completed before then, having been initiated during 1984 and 1985. However, a number of "national" programs just got underway in late 1986 or early 1987. Even though promotional objectives may be achievable in less than 2 years, those programs, and some others, will require several more years of outside technical and management support to really institutionalize effective DDC/ORT programs.

As noted by the TAG and elsewhere in this Project Paper, the PRITECH program should now change from the promotion phase to implementation. Most national programs supported by PRITECH will require several more years of support from PRITECH and its successor provided through the new Project. The nature of support may change over time from program start-up activities to periodic technical consultations and assistance with monitoring and evaluation, for example.

AID will have to determine which country programs should be carried over to the new Project in order to preserve the gains made up to September 1988 and provide continuity of service. It will be important for the country program counterparts and collaborators (ministries of health, PVO's, UNICEF, WHO) to know that the AID support will continue where required. This determination by AID will represent a key part of the country selection process, together with additional criteria discussed in Section IV.A.

The new contractor will have to be capable of making a smooth transition from the current contractor in those carryover country programs, matching the type and quality of services currently provided. Prospective contractors will have to be advised clearly in the RFTP scope of work of the requirement to continue the work started by PRITECH in specific countries.

2. New Programs

The contractor should follow basically the same process that PRITECH used to initiate sustained and intermittent country programs (formerly national and limited programs). Following agreement with ST/H as to which countries to pursue, based on the selection criteria and internal AID analysis, the contractor will visit those countries, with USAID concurrence, to make preliminary assessments of the technical, institutional, and political climates

for initiating an assistance program. If positive, they will explore opportunities to: (a) strengthen new or ongoing AID-supported DDC programs, and (b) assist, establish, or strengthen national DDC programs regardless of what donor agency is supporting them, if any.

With concurrence of the local counterpart, USAID and ST/H, the contractor will then make an analysis of each DDC program, if any, and prepare a plan for providing technical support to it. When appropriate, the contractor will assist the responsible government public health organization to prepare a long-term strategy for DDC/ORT.

Following completion and acceptance by counterpart agencies, including USAIDs, of assistance plans, the contractor will negotiate written agreements to govern the commitments made by each party to execute the plans. The agreements will govern "sustained" and "intermittent" programs. The principal difference between the two types of programs will be that in the former, the contractor will take responsibility for producing certain specific program outputs and will plan its inputs over the agreed period accordingly. By contrast, for "intermittent" programs, the contractor will merely commit itself to provide estimated levels and types of TA over agreed periods to ongoing programs for which some other organization takes full responsibility.

Each country program agreement will be budgeted for and staffed appropriately to enable the contractor to meet its commitments. ST/H approval of each agreement will be required.

3. Counterpart Variability

Experience from the current project reveals that PRITECH has had to adopt a different modus operandi for each "national" program because of the unique institutional situation present in each country. The variability among countries has been enormous because many different organizations participate in DDC/ORT programs around the world. The problem this poses for PRITECH and the new Project is compounded because, not only does the Project have to adapt to new situations in each country, but since the Project provides only technical and limited financial support to country programs, it must depend on other organizations to provide essential inputs on time. Some programs have 5 or more participating organizations.

AID missions are present in almost all countries in which PRITECH has worked and where the new Project will work. That presence usually facilitates Project work and provides some institutional continuity between countries. However, the extent and nature of USAID's involvement in DDC programs varies widely and their impact on the Project will vary accordingly.

At one extreme, a well staffed USAID is implementing a DDC project in association with a relatively well organized ministry of health and PRITECH has been asked to provide some important, well-defined technical support to the program. Other resources required for the program are provided, for the most part, by the MOH and USAID. Although PRITECH does not control the program, provision of resources to it and performance of duties are reasonably assured and responsibility for key actions is concentrated in a few hands. Prospects for a productive relationship are good.

At the other extreme, the USAID is not engaged in the health sector and does not have time to facilitate PRITECH's activities. In these cases, the MOH may be receptive to a DDC/ORT initiative, but with little or no institutional, technical, and budgetary capacity for it. Other donors each contribute to various elements of a DDC program with little coordination. PVO's conduct several limited outreach programs containing some DDC interventions.

Most countries fall somewhere between these extremes. In all countries where the new project will operate, the contractor, in collaboration with the host country institution, AID and the S&T/H Project Manager will identify criteria and establish process indicators against which the contractor will plan, implement and monitor its interventions and by which it will be evaluated. The quality of contract performance will influence country DDC/ORT program performance and impacts, but only to the extent the assistance is matched by other essential inputs and effectively utilized by the program managers and implementors.

WHO provides technical support for DDC programs around the world. Resident representatives are present in all countries and they promote the official WHO policies and technical guidelines uniformly worldwide.

UNICEF has been the major supplier of manufactured ORS packets to LDC DDC/ORT programs and, is a major participant in most country DDC/ORT programs.

Bilateral donors are involved in a number of DDC/ORT programs, and can cause confusion or fragmentation of responsibility when relied on to provide specific inputs.

PVO's play a major role in DDC/ORT programs in a number of countries and despite their positive contributions, sometimes add to the confusion and fragmentation. Governments often have difficulty achieving standardization of ORT and related intervention practices and assuring quality control when numerous independent agencies design and implement their own programs. In

Bolivia, PRITECH is assisting a large-scale PVO DDC/ORT program (CRS/CARITAS) in lieu of a government-sponsored program. In other countries, PVO's play a part in larger government-sponsored programs which PRITECH assists.

In conclusion, the new Project will encounter a great variety of institutional situations among the countries in which it will work and the contractor, with AID support, will have to work out appropriate implementation arrangements in each case. This will require careful analysis at the outset of each country program, flexibility by both AID and the Project contractor and constant attention to maintenance of productive inter-institutional relationships in order to overcome problems inherent in these multi-institutional arrangements.

4. USAID & Regional Bureau "Buy-ins"

The current \$19 million PRITECH program has two sources of finance: \$12 million of S&T funds, and \$7 million of Regional Bureau "buy-ins" which pay for PRITECH TA for ORT programs or other health activities under Systems Support. Both accounts are fully subscribed.

An unintended consequence of the ceilings is that PRITECH is unable to provide all of the technical services which missions are prepared to pay for. Thus, while AID, through PRITECH, has mobilized a strong technical resource it cannot always bring this talent to bear on field programs. This can be remedied in the new Project by increasing the share of the total program reserved for "buy-ins".

Regional Bureau and USAID funds would be devoted to paying the majority of the costs of the Country Programs and Health Systems Support Services.

The FVA Bureau funds will be devoted to support for FVA/PVC and technical assistance for PVOs, most of which will be handled as "ad hoc" or "intermittent" country programs activity. The contractor will attempt to reach agreements with PVOs, facilitated by FVA, for defined levels and types of assistance over specific time periods, thereby constituting "intermittent" programs.

E. Technical Guidance Arrangements

S&T/H will establish a Technical Advisory Group (TAG) which will meet at least once each project year to review project progress and provide guidance concerning policy and program direction for upcoming year's activities. The TAG will be comprised of expert leaders outside of AID, representing CDC, WHO, and UNICEF, as well as specialists in DDC international public health, the social sciences, and other disciplines which

are integral to DDC/ORT programs. The group will consist of 15-20 members and the meetings will be facilitated by the contractor but will be chaired and hosted by S&T/H.

DDC/ORT Task Force

The contractor, within 3 months of initiation of the contract, will establish a Technical Task Force on DDC/ORT which will provide ad hoc assistance to the contractor and to S&T/H over the life of the project.

The Task Force will also meet formally at least once each year and will address an agenda of technical issues which will be established by the contractor, after prior consultation with S&T/H and the Task Force members.

The members of the Task Force will be experts in each of the major technical disciplines addressed by the project. These include ORS production and distribution, training, communications, marketing, operations and social science research, and public administration/organizational development. Membership will consist of technical experts who may or may not participate in actual implementation as members of the contract team.

F. Implementation Plan

Quarter/Fiscal Year

3	/	1987	Project Paper Approval
3	/	1987	Project Authorization
3	/	1987	RFTP Issued for Initial Contract
4	/	1987	Proposals Submitted
4	/	1987	Initial Contract Executed
1	/	1990	Mid-term Evaluation #1
1	/	1991	RFTP Issued for Second Contract
2	/	1992	Second Contract Signed
4	/	1992	Conclusion of Initial Contract
2	/	1993	Mid-term Evaluation #2
1	/	1995	Mid-term Evaluation #3
2	/	1997	Conclusion of Second Contract
4	/	1997	Final Evaluation

IV. DETERMINANTS OF DEMAND FOR PROJECT SERVICES

The objective of this section is to analyze the anticipated nature of demand for Project services and constraints which may limit effective demand. Determinants of demand discussed are as follows:

- o Carryover from PRITECH contract.
- o Emphasis on implementation vs. promotion.
- o AID-supported ORT projects.
- o Country technical selection criteria.
- o Scope of services provided.
- o Institutional capacity.
- o Financial Viability.

1. Carryover from PRITECH Contract

As discussed in Section II.B (Project Outputs), the majority of countries in which PRITECH is now supporting "national" programs will probably require continued assistance with program implementation and strengthening. These requests should be assessed in terms of several factors: the adequacy of the government's (or in some cases, a non-governmental organization's) allocation of resources to the DDC/ORT program; the level of efforts to institutionalize the program through provision of staff, support, training, organizational structure, etc.; achievement of program targets, if anticipated, or the articulation of such process indicators or targets for the period of continued assistance; and a political or institutional commitment to a long-term DDC/ORT program.

It is anticipated that approximately ten ongoing PRITECH country programs will request and qualify for either sustained or intermittent support under the new project.

2. Emphasis on Implementation vs. Promotion

The initial project reflected AID's view that an effective ORT program could be introduced over a relatively short period of time using short-term external technical assistance to promote national commitments to diarrheal disease and ORT policy and strategy, to design programs, to prepare and promote educational material, to train health workers, to assess ORS production and distribution assistance needs, to develop information systems to monitor and evaluate the ORT intervention, and to do operational research related to the intervention. Long-term advisors were to be placed in the field, principally to orchestrate the short-term technical inputs, and in the case of Africa, to provide support for monitoring project activity where missions did not have staff capacity to do so.

PRITECH's task as catalyst to promote the adoption of ORT programs is largely accomplished. ORT has been promoted successfully worldwide by WHO, UNICEF, and AID (assisted by PRITECH). AID is financing health and child survival projects in 48 countries with ORT components. PRITECH itself has assisted ORT interventions in one way or another in 27 countries.

However, it is evident that effective and sustainable DDC/ORT programs cannot be established in a short time frame. Program implementation and sustainability will require much more attention. The question of effective use of ORT is also a key issue. Help in creating effective information and evaluation systems and in sponsoring relevant operational research will take on increased significance. Redesign of educational materials, communications strategies and related training programs, will also be called for as experience suggests new approaches to achieve program objectives.

Strategies for controlling diarrheal disease continue to evolve. Early feeding and fluids at the onset of diarrhea now promoted by WHO, UNICEF, and AID will require modifications of existing country strategies. Ongoing activities will need to be assessed to assure the presence of this component in education and training materials. Plans to incorporate prevention elements, such as breastfeeding, handwashing or community sanitation in ORT programs, will have to be flexible and incorporated on a case-by-case basis. Extreme caution is required in pressing national programs to proceed faster than administrative, financial, or technical abilities can support, or than target populations (health care agents and child providers) can effectively absorb.

The role of NGOs and the private commercial sector are also extremely important as government policies provide for, or delegate more opportunities to the non-governmental sector. The new project will be available to respond to requests from this sector in the areas of production, distribution and marketing of ORS, the development of communications materials, training, etc..

In recognition of the difficulties in achieving effective use of ORT, the Project will emphasize assistance geared to that problem. That will generate a large demand for services from countries where programs are already underway or beginning, in contrast to a demand for assistance in initiating new programs as was the case of the current project.

3. AID-Supported DDC/ORT Projects

This Project will place a high priority on providing overall guidance and coordination to many of the numerous DDC/ORT projects and activities which AID is sponsoring directly through its missions and indirectly through PVOs. Promotional efforts by AID, WHO, UNICEF, and others have generated a great response from the field.

As of February 1987, there were 144 AID-financed health projects in 48 countries which include ORT components. Many of those projects would benefit from overall guidance and coordination from this Project.

With the exception of sustained and intermittent country programs and overall coordination, most of this help for AID-supported DDC/ORT projects will probably be provided as ad hoc country program support. The potentially large demand for these services will have to be handled so as not to detract from the contractor's ability to achieve the Project's objectives with respect to sustained and intermittent DDC/ORT country programs.

4. Country Technical Selection Criteria

In addition to the existence of AID supported ORT activities, there are several technical criteria which must be assessed in order to weigh the relative merits of selecting one country over another for sustained or intermittent assistance.

a. Documentation of the etiology of DD is considered to be critical. Severity of the problem in terms of infant and early childhood mortality and high incidence and deaths due to dehydrating diarrhea, or diarrhea-associated conditions. Information about shigellosis, cholera, and persistent diarrhea, if available, would also be useful.

b. The Government's concern about the problem and the decision to formulate, with assistance when needed, a feasible and comprehensive program of control with a limited or national coverage, and to commit human, material, and financial resources coupled with AID and/or other international agencies investments.

c. Host country program implementation capacity and existing health system infrastructure. Efforts will not be limited to countries with a well established primary and secondary health care system, or a well managed Ministry of Health that can facilitate program success, but will include countries such as those in the Sahel, where existing facilities are meager, but where investment in DDC/ORT, as in immunizations, can serve to strengthen the health delivery infrastructure and outreach. In the latter group of LDCs, the DDC/ORT program should probably start with a demonstration area to convince the people and the government of the significance of the problem and the feasibility to deal effectively with it.

d. Population size and density. Investment for project startup, administration, and TA would have maximum quantitative impact on child survival in a larger population with high infant and diarrheal mortality rates. However, this should not be interpreted that only the largest countries in the world should be selected.

e. The existence of immunization programs, particularly measles vaccination, nutrition, and water and sanitation services that could be synergistic to DDC/ORT activities. The latter should be developed where the former are ongoing, i.e., in the same areas of the country, because they will make a greater impact on morbidity and mortality, together rather than separately.

f. The advances made by the PRITECH contract in the countries where it has been operating, in order to build upon them with the investments of the new Project, either enlarging the areas covered, or focusing on specific key activities.

g. Activities of other international and bilateral agencies, as well as PVOs, and the gaps, both geographical and functional, that exist and could be filled by AID through the new Project. Such collaborative support will enhance the results obtained for each AID dollar spent.

5. Scope of Services Provided

The volume of services provided by the contract will depend on the scope or range of subjects considered eligible. In order to strengthen DDC/ORT programs, or program components, it is often necessary to strengthen related elements of the health services system of which it is a part. This has been the experience of the current contract and should be continued in the new contract. For instance, consultants may be asked to help develop a health information system covering an entire primary health care system of which DDC/ORT is only a part. The help should be provided to ensure that the DDC/ORT needs are covered and to strengthen the system upon which viability of the DDC/ORT program depends.

Requests for short-term services unrelated to DDC/ORT will be reviewed by S&T/H and either handled through the Health Systems Support component or referred to other more appropriate sources.

6. Institutional Capacity

A successful ORT program depends heavily on changing the behavior of mothers, and health workers, as well as the medical and educational establishments.

Significant organizational and institutional changes in the public sector, and substantial effort to involve the private sector, will also be required. None of these changes can be realized quickly, and AID must be prepared to extend long-term support to achieve results.

Ministries of Health are among the weakest development/service organizations in the less developed world. They are beleaguered by an array of political, financial, and

organizational problems which limit the ultimate effectiveness of PHC beyond the scope of donor assistance. While external technical assistance and training can assist in programmatic development in the short run, it must be recognized that ORT programs are only as strong and as sustainable as the ability of the bureaucracy to carry out its functions over the long term. One of the challenges of this project is to identify those institutional constraints which can be overcome or modified in order to increase the probability that the MOH will sustain the program over time.

The contractor will be expected, in some cases, to provide limited operational support in the start-up phase to the LDC implementing agency. Contractor financing of one-time local costs (for example, training, preparation and distribution of educational material, travel, and packet supply or production) can break local bottlenecks and accelerate program implementation.

However, primary responsibility for programs must remain with the local government or private implementing organization. The contractor will assist, but not substitute for the responsibility which must ultimately rest with the local implementing organization if the program is to be sustained.

7. Financial Viability

One advantage of promoting an ORT "categorical" program is that it can lead to the long range objective of strengthening the basic preventative/curative health systems by demonstrating that it can deliver important health benefits, thereby drawing financial and management resources to it. Diarrheal disease programs reinforce the main elements of primary health care systems, training of health workers, supervision, management information, drug distribution, family education, and case referral. In time, the "categorical" program would be absorbed in the general system as part of an effective health delivery system. On the other hand, AID's study of the sustainability issue suggests that many vertical programs, to the extent they establish separate or parallel health delivery systems, are very difficult to integrate and jeopardize sustainability. Therefore it is necessary that AID and the contractor incorporate whatever measures are necessary and possible to coordinate DDC/ORT activities with other development initiatives whether sponsored/supported by AID, other donors, or by the government or its own.

It is clear that sustainability, a critical issue for the success of the DDC/ORT program, has to be addressed at the very beginning of the program intervention. An understanding of the complete recurrent and maintenance costs is required at the onset of a project. A realistic plan for a phased transfer of financial responsibility for all donor-funded activities to the host insti-

tution should be agreed early on. The institutionalization can only be achieved by carrying out a deliberate and sustained plan of action to achieve the objective. The assurance of adequate financial support for the life of the program by the host institution is critical. While donor assistance is essential for initial project costs, the burden of providing continued support for operating expenses falls with the host institutions. PHC programs, such as DDC/ORT, which rely heavily on recurrent expenses such as salary, transport, training, supervision, drugs, medical supplies, and mass media communications, are regularly underbudgeted and/or face unexpected budget cuts as new capital development projects come on line. Therefore, DDC/ORT programs should reflect the ability of the host institution to commit those financial resources necessary for project operation and expansion over the long-term. Both public and private sources and amounts of local program financing should be identified and realistically assessed, based on past financial performance, existing resource constraints and project/program objectives. While the contractor may assume limited operational support in the start-up phase of the project, funding sources and potential constraints for obtaining and releasing those funds should be identified at the outset.

As part of the project's research program, the initial contractor should study in depth the issue of sustainability, both institutional and economic, of at least one nationwide DDC/ORT program, and the effect such a program has on public health system priorities and capacity to deliver other public health services.

V. TRAINING STRATEGY

DDC/ORT programs are based upon the critical assumption that diarrhea related behavior can be changed. This refers to the behavior of medical, health and pharmaceutical personnel, community workers, volunteers, providers of child care and especially mothers. The project will approach this task through the provision of technical expertise, equipment, supplies, and local costs, as appropriate. One essential core ingredient underlying all efforts to change behavior is training, in association with communications and supply.

The project's initial contractor will address the whole issue of training, beginning with its own staff and consultants by ensuring that up-to-date, state-of-the-art information is provided to them through the internal sharing and distribution of articles and documents held by the Information Center. Consultants hired to work on program design and support activities will especially need to be briefed and provided with state-of-the-art information. Given the rapid changes in technology and the evolution of new practices and approaches, field personnel must be aware of developments and also must receive guidance from the contractor as to what the Project's policy and position is on the various issues.

The project will also sponsor or participate in sub-regional or regional seminars and workshops designed to update and upgrade the knowledge and skills of DDC/ORT project and program managers.

The project includes a substantial formal training component in all of its country interventions, including the provision of assistance in the development of curriculum materials, the development of training strategies and programs and the actual implementation of competency-based pre-service and in-service training programs which also include management, supervision and evaluation components. This training will be provided in public, private, and NGO sectors. As a guiding principle, the contractors will also ensure that there is adequate follow-on to formal training activities so that skills developed will be reinforced and strengthened. Assessments will be made by the contractor to evaluate this process during the course of the initial contract, the results of which will be utilized in future training activities.

WHO has identified training as the single, most important area of need in their CDD programs today. Where-ever possible, the new project will complement the training activities of WHO and UNICEF. This will require close collaboration between the contractor, USAIDs, the DDC implementing agencies and the donors to identify and assume responsibilities for various training components.

VI. EVALUATION STRATEGY

The project will include three mid-term evaluations scheduled for Project Years 2, 6, and 8, and a final evaluation will be carried out in Year 10. The evaluation in Year 6 will serve as a final evaluation for the first contract.

These evaluations will primarily be guided by the recommendations of the annual meetings of the Technical Advisory Group (TAG) and will address issues highlighted by the DDC/ORT Task Force.

In addition, the project will be closely monitored by the A.I.D. Project Manager and the staff of S&T/H. There will be annual management reviews as well.

A. Internal Monitoring

The new project and its initial contract will be addressing DDC/ORT and child survival problems with varying levels of effort, different mixes of support and assistance and with varying levels of responsibility and accountability.

Therefore, in the beginning of each "Sustained" or "Intermittent" country association into which the project contractors enter, reasonable and measurable objectives will be established in order for AID, the host country client and the contractor to be able to assess progress and success. These objectives will be in the form of quantifiable measurable indicators of process and/or impact and will be established by the contractor with the concurrence of the S&T/H Project Officer and the appropriate USAID mission.

Each year, the ORT Task Force and Project TAG will review and make recommendations on these indicators and the methodologies which will be used to monitor and analyze the results of the interventions.

VII. SOURCE AND ORIGIN OF GOODS & SERVICES

Each country where project activities take place shall be deemed a cooperating country for the purpose where necessary of permitting local cost financing. The aggregate cost of all goods and services under each sub-agreement in a cooperating country may be procured in the special free world category (Code 935) up to \$750,000 for the purpose of permitting local cost financing.

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

ANNEX: PHC Tech II Logframe
Life of Project:
From FY 87 to FY 97
Total U.S. Funding \$78,500,000
Date Prepared: March, 1987

Project Title & Number: Technology for Primary Health Care II (PHC Tech II)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS																
<p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p>To improve the health status of infants and children in LDCs.</p>	<p>Measures of Goal Achievement:</p> <p>Reductions in infant and child morbidity and mortality.</p>	<ul style="list-style-type: none"> - Vital statistics, data from MOH records, data and special health surveys. - Epidemiological data from MOH records - AID program data and special health surveys. 	<p>Assumptions for achieving goal targets:</p> <ul style="list-style-type: none"> - Disease control technologies & selected strategies selected are effective reducing infant & child morbidity & mortality. - Improved management & training of health workers will result in improved health status of children. 																
<p>Project Purpose:</p> <p>1. To strengthen DDC/ORT and child survival programs in IDCs through appropriate case management, including feeding, fluids, and referral (ORT); promotion of preventive hygienic and sanitation practices; and other health related interventions.</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <p>Conditions that will indicate purpose has been achieved: end of project status.</p> <p>a) Improved hygienic & sanitation practices.</p> <p>b) Improved dietary management of diarrhea.</p> <p>c) Improved rates of effective use of ORT.</p>	<ul style="list-style-type: none"> - Sentinel & random sample surveys. - National CDD program monitoring reports. - WHO monitoring reports. 	<p>Assumptions for achieving purpose:</p> <p>Cooperating institutions will commit resources & adjust policies to support ORT/CDD programs.</p> <p>Diarrhea related behavior can be changed through sound communication strategies combined with the provision of ORS packets, trained health, medical & pharmaceutical personnel, and referral facilities.</p>																
<p>Outputs:</p> <p>Improved Country Program Operations</p> <p>Improved Health Delivery Systems</p> <p>Information Center and Services</p> <p>Research & Development Studies</p>	<p>Magnitude of Outputs:</p> <p>12-15 "sustained" country programs completed.</p> <p>15 "limited" country programs completed.</p> <p>100 "ad hoc" DDC/ORT short-term tasks completed.</p> <p>200 short-term tasks completed.</p>	<ul style="list-style-type: none"> - National ORT/CDD program reports. - Contractors reports. - USAID mission reports. - FVA/PVD reports. - Training assessments, including follow up monitoring. 	<p>Assumptions for achieving outputs:</p> <p>Relevant skills & expertise required by AIDs will be available through contractor's services.</p>																
<p>Inputs:</p> <p>Technical assistance.</p> <p>Commodities and supplies.</p> <p>Funding for some local costs of: training, educational materials production, research, evaluation.</p>	<p>Implementation Target (Type and Quantity)</p> <table border="0"> <tr> <td>Country Programs</td> <td>\$ 38,000,000</td> </tr> <tr> <td>Health Sys. Support</td> <td>7,000,000</td> </tr> <tr> <td>Info. Services</td> <td>6,200,000</td> </tr> <tr> <td>Research & Develop.</td> <td>2,000,000</td> </tr> <tr> <td>Management</td> <td>12,500,000</td> </tr> <tr> <td>Evaluation</td> <td>300,000</td> </tr> <tr> <td>Contingency</td> <td><u>12,500,000</u></td> </tr> <tr> <td></td> <td>78,500,000</td> </tr> </table>	Country Programs	\$ 38,000,000	Health Sys. Support	7,000,000	Info. Services	6,200,000	Research & Develop.	2,000,000	Management	12,500,000	Evaluation	300,000	Contingency	<u>12,500,000</u>		78,500,000	<p>Contractors accounting records.</p> <p>Annual project manager reviews.</p> <p>Mid-term & final evaluations.</p>	<p>Assumptions for providing inputs:</p> <p>AID inputs available in a timely fashion.</p> <p>Contractor/implementation mechanism able to meet broad interdisciplinary needs.</p>
Country Programs	\$ 38,000,000																		
Health Sys. Support	7,000,000																		
Info. Services	6,200,000																		
Research & Develop.	2,000,000																		
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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

ANNEX: PHC Tech II Logframe
 Life of Project: From FY 87 to FY 97
 Total U.S. Funding \$78,500,000
 Date Prepared: March, 1987

23

Project Title & Number: Technology for Primary Health Care II (PHC Tech II)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes:	Measure of Goal Achievement:		Assumptions for achieving goal targets: -- Improved knowledge, attitudes & practices of mothers and child care providers will result in reductions in morbidity and mortality rates.
Project Purpose: 2. To develop a repository of state-of-the-art information, research results, and technical expertise to serve A.I.D..	Conditions that will indicate purpose has been achieved: End of project status. d) Decreased rates of dehydration. e) Improved referral services.		Assumptions for achieving purpose:
Outputs:	Magnitude of Outputs: Acquisition & maintenance of 3,000 documents. 60 bi-monthly technical literature updates. 70 conferences, workshops, seminars sponsored or supported. 20 research & development studies completed.		Assumptions for achieving outputs:
Inputs:	Implementation Target (Type and Quantity)		Assumptions for providing inputs: