

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE

A A = Add
C = Change
D = Delete

Amendment Number

DOCUMENT CODE

3

COUNTRY/ENTITY

Dominican Republic

3. PROJECT NUMBER

517-0239

4. BUREAU/OFFICE

Latin America and the Caribbean

5. PROJECT TITLE (maximum 40 characters)

Child Survival

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY
09 30 91

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

A. Initial FY 87 B. Quarter 4 C. Final FY 89

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

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	436	356	792	1,847	2,305	4,652
(Grant)	(436)	(356)	(792)	(1,847)	(2,305)	(4,652)
(Loan)	()	()	()	()	()	()
Other						
U.S.						
Host Country		336	336		3,350	3,350
Other Donors)						
TOTALS	436	692	1,128	1,847	6,655	8,002

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) HE	530-B	510			--	2,700	--	4,652	--
(2)									
(3)									
(4)									
TOTALS				0	--	2,700	--	4,652	--

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

11. SECONDARY PURPOSE CODE

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

A. Code	BR	BU	NUTR	PVOU	PVON
B. Amount	2,300	2,300	400	3,800	400

13. PROJECT PURPOSE (maximum 480 characters)

To improve the quality and expand the coverage of child survival services offered by SESPAS and PVOs in selected regions.

14. SCHEDULED EVALUATIONS

Interim MM YY MM YY Final MM YY
0 6 8 9 0 6 9 1

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000 941 Local Other (Specify)

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

Approval of Methods of Implementation and Financing

T. Bebout, CONT

17. APPROVED BY

Signature: Thomas W. Stukel
Title: Director, USAID/Dominican Republic

Date Signed: MM DD YY
09 24 87

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

MM DD YY

PROJECT AUTHORIZATION

NAME OF COUNTRY: Dominican Republic
 NAME OF PROJECT: Child Survival
 NUMBER OF PROJECT: 517-0239

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Child Survival Project for the Dominican Republic involving planned obligations of not to exceed Four Million Six Hundred Fifty Two Thousand United States Dollars (\$4,652,000) in grant funds over three years 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. The planned life of Project is four years from the date of initial obligation.

2. The Project will provide support for a limited number of health and nutrition interventions intended to reduce the rates of infant and child mortality in rural and urban areas of the Dominican Republic. To this end the Project will provide financing for training, educational materials, budget support and commodity assistance, through a coordinating U.S. Private Voluntary Organization, to the Secretariat of State for Public Health and Social Assistance and Dominican and U.S. Private Voluntary Agencies.

3. The Project Agreement which may be negotiated and executed by the Officers to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority shall be subject to the following essential terms, covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

a. Source and Origin of Commodities, Nationality of Services

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

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.

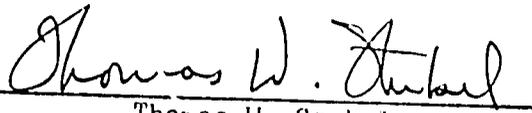
b. Conditions Precedent to First Disbursement

Prior to first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee will, except as A.I.D. may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.: (a) an opinion of the Legal Advisor to the Grantee that this Agreement has been duly authorized and executed on behalf of the Grantee, and that it constitutes a valid and legally binding obligation of the Grantee in accordance with all of its terms; and (b) a statement of the name of the person who will represent the Grantee, and of any additional representatives, together with a specimen signature of each person specified in such statement.

c. Special Covenants

(1) Project Evaluation A.I.D. and the Grantee will establish an evaluation program as part of the Project. Except as they may otherwise agree in writing, the program will include at least one evaluation at the mid-point in the implementation of the Project and one more at the Project conclusion. The evaluations will include, but not be limited to: (a) evaluation of progress toward attainment of the purpose of the Project; (b) identification and evaluation of problem areas or constraints which may inhibit such attainment; (c) assessment of how such problems may be overcome; and (d) evaluation, to the degree feasible, of the overall development impact of the Project.

(2) Support for Child Development. The Government of the Dominican Republic will assure an efficient flow of resources to the project by (a) taking steps to assure prompt approval, provide adequate budgets and allocation of counterpart funds to all participating Dominican public and private organizations; (b) establishing within SESPAS, no later than 120 days after signing this agreement, a decentralized revolving fund for operating expenses in the selected SESPAS Health Regional offices; and (c) allocating by year three of the Project, sufficient operating funds from the SESPAS budget to sustain recurring costs of materials and maintenance of equipment in the target regions.



Thomas W. Stukel
Director

USAID/Dominican Republic

9/24/87
Date

PROJECT PAPER

Child Survival

Project No. 517-0239

USAID/Dominican Republic

Sept 9, 1987

CHILD SURVIVAL PROJECT PAPER

(517-0239)

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List of Acronyms and Abbreviations

A.I.D.	Agency for International Development
ANEP	Applied Nutrition Education Project
ARI	Acute Respiratory Infections
BCG	Vaccine for Tuberculosis
CENACES	Centro Nacional de Educación de Salud
CENISMI	Centro Nacional de Investigación en Salud Materno Infantil
CMR	Child Mortality Rate
CONANI	Consejo Nacional de la Niñez
CONAPOFA	National Council on Population and the Family
C/PVO	Coordinating Private Voluntary Organization
CRS	Catholic Relief Services
CS	Child Survival
DDC	Diarrheal Disease Control
DHS	Demographic and Health Survey conducted by Westinghouse
DR	Dominican Republic
EPI	Expanded Program of Immunizations
FVA	Bureau of Food and Voluntary Assistance
GODR	Government of the Dominican Republic
IMR	Infant Mortality Rate
LAC	Latin American and Caribbean Regional Bureau of A.I.D.
LBW	Low Birth Weight
LDCs	Less Developed Countries
MCH	Maternal and Child Health
MIS	Management Information System
MMR	Maternal Mortality Rate
NCHS	Maternal Child Health Standards
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PAHO	Pan American Health Organization
PHC	Primary Health Care
PL-480	Public Law 480
PSC	Personal Services Contractor
PCV	Peace Corps Volunteer
PVO	Private Voluntary Organization
SBS	Servicios Básicos de Salud
SESPAS	Secretaría de Estado de Salud Pública y Asistencia Social
SSID	Servicios Sociales de la Iglesia Dominicana
TSP	Technical Secretariat of the Presidency
UNDP	United Nations Development Program
USAID	The A.I.D. Mission in the D.R.
VLBW	Very Low Birth Weight

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CHILD SURVIVAL (517-0239)

PROJECT PAPER

I. SUMMARY PROJECT DESCRIPTION

A. Summary of the Problem

Dominican children are dying or being severely weakened by the cycle of malnutrition and infectious diseases at an unacceptable high rate, especially in the southwestern border areas and the poorest barrios of the capital. The infant mortality rate (IMR) for the Dominican Republic is currently estimated between 80 and 84 per 1,000 live births. Further, the southwestern and border areas have much higher mortality - Health Region IV headquartered in Barahona has an IMR between 88 and 101, and Region VI headquartered in San Juan de la Maguana, between 90 and 103. These are much higher than the goal of 75/1000 stated in the AID Child Survival Strategy. Similar problems are found in the lowest-income neighborhoods of Santo Domingo.

Infant deaths are substantially underreported in the D.R., and are often not listed by cause. For cases where the cause of death is known (usually reports from hospitals), the most common causes are intestinal infections (36%), respiratory ailments (14%) and other bacterial infections (13%). Malnutrition is listed as a cause of infant death in the Demographic Health Survey (DHS) (6%), although other studies attribute many more deaths to malnutrition (13%). Historically in the Dominican Republic, high rates of infant mortality have been attributed to malnutrition. In the mid 1970s, it was reported that some 76% of infant deaths here occur among malnourished children, demonstrating the interaction between poor nutrition and intestinal or respiratory infection.

The child mortality rate (CMR - 12 to 59 months old) is estimated at 18 per 1,000 children nationally, with 24/1000 in Region VI and 22/1000 in Region IV. This is also much higher than AID's goal of 10/1000. The reported leading causes of child death are intestinal infections (28%), respiratory infections (15%), and malnutrition (11%), all of which can be substantially reduced by simple, home-based interventions and education.

The problems summarized above are not being adequately treated by the existing public health care system, the private medical system, or the few PVOs that have health programs in rural and slum areas. The physical and organizational framework is in place, but improvements are needed in skills and knowledge of the personnel, and supporting supply systems, information systems, and logistics.

B. Summary of the Project

Contributing to USAID's goal of improving the health of children in the Dominican Republic, the Child Survival Project will deliver selected services in three targeted geographic regions through the Ministry of Health (Secretariat of State for Public Health and Social Welfare - SESPAS) and private voluntary organizations (PVOs). The purpose of the four year Project is to reduce average infant mortality rates from as high as 103 per 1000 live births to 80 per 1000 and reduce the average child mortality rate from 18 per 1000 to 10 per 1000 by 1991 in the most severely affected health regions selected by the Project. The target population of approximately 750,000 low-income children under the age of 5 and their families will be given access to education and services in maternal-child nutrition, diarrheal disease treatment, and acute respiratory infections, shown to be the principal threats to young children.

USAID and Dominican counterpart institutions will carry out a service delivery strategy that provides a rapid response to the nation's malnutrition and childhood infectious disease problem by implementing a limited number of proven interventions in targeted communities. The Project will rapidly increase the service delivery capacity of public and private sector health service providers who can address child survival problems in the areas where they operate. SESPAS and Dominican PVOs will offer the services to families, following intensive staff training and improvement or establishment of supporting systems of educational materials, logistics, and information flow to monitor activities and outcomes.

The Project's total budget is US\$8.0 million, of which US\$4.65 million will be provided as an A.I.D. grant, and the equivalent of US\$3.35 million will be contributed by the GODR in funding and in-kind counterpart. The AID funds will be granted to the Technical Secretariat of the Presidency, due to the intersectoral nature of the effort and the amount of GODR support required. A U.S. PVO (to be called the coordinating PVO, or C/PVO) will be assigned major responsibility for assuring that the program content is consistent, that needed systems are strengthened or established, and that AID funds are properly applied. The C/PVO will be competitively selected to receive a Cooperative Agreement grant. The Project will also provide funds for limited operational budget support, vehicles, and simple field equipment for the promoters, their supervisors, and their parent organizations. Funding will be available for an improved information system, and for audits and evaluations.

II. PROJECT BACKGROUND AND RATIONALE

A. Scope of the Problem

1. Infant and Child Mortality

According to the A.I.D. Blueprint for Development, the Agency aims to reduce infant mortality rates (IMR) to 75/1,000 or below. The estimated IMR in the Dominican Republic is between 80 and 84 per 1,000 live births and is even higher in the southwestern and border regions. For instance, in Health Region IV, whose headquarters are in Barahona, the IMR is between 88 and 101; in Region VI, whose headquarters are in San Juan de la Maguana, it is between 90 and 103.

The incidence and causes of infant deaths in the D.R. are underreported. The most commonly reported causes are intestinal infections (36%), respiratory ailments (14%) and other bacterial infections (13.3%). According to the Demographic Health Survey, malnutrition is the cause of 6% of infant deaths. However, since there is no consensus in the D.R. on how to report cases in which badly malnourished children die from other diseases, other studies attribute even more deaths to malnutrition (13.1%). Malnutrition has historically been blamed for high rates of infant mortality in the Dominican Republic. In the mid 1970s, the Secretariat of State for Public Health and Social Assistance (SESPAS) noted that some 76% of infant deaths occurred among malnourished children, demonstrating the interaction between poor nutrition, intestinal or respiratory infection and eventually, death.

The nation's child mortality rate (CMR - 12 to 59 months old) is estimated to be 18 per 1,000 children. In Health Regions VI and IV, the CMR is estimated to be 24/1,000 and 22/1,000, respectively. According to the A.I.D. Blueprint for Development, the Agency's child mortality goal is 10/1000 or below. The leading reported causes of child death are intestinal infections (27.6%), respiratory infections (14.8%), and malnutrition (10.9%), all of which can be prevented by simple, home-based interventions and education.

In the capital city of Santo Domingo, where most of the nation's wealth is concentrated, the IMR is 72/1,000. The IMR in the city's marginal barrios far exceeds 75/1,000. The National Council for Children (CONANI) reports that over 67% of infant and children deaths in the marginal areas of the city are caused by gastroenteritis, malnutrition, acute respiratory infections or diseases that could be prevented by vaccines.

The national maternal mortality rate (MMR) in mid-1980 was 13 per 10,000 live births. Both Health Regions IV and VI have MMRs of 18, much higher than the national average. The principal reported causes of maternal deaths include toxemia, hemorrhage, sepsis and abortion.

2. Malnutrition

In 1986-1987, Tufts University conducted a nationwide nutrition survey financed by the Mission. Preliminary data indicate that 33-38% of Dominican youngsters are malnourished (Grade I - 27-33%; Grade II - 5%; Grade III - 0.5-1%). (Weight for Age, Gomez classifications.) Infants and children in Region IV suffer from the highest incidence of malnutrition, 51-58%.

Estimates of low birth weight (LBW - under 2,500 grams) range from 10 to 25% and very low birth weight (VLBW - under 1,500 grams) from none to 2.5%. According to the Tufts Nutrition study, under which LBW data for the past 5 years was gathered from the files of eight public hospitals and two private clinics in selected areas of the country, 10.2% of all births nationwide are LBW and the nation's average birth weight is 3,200 grams (7.04 lbs.). Although this data indicates that LBW does not appear to be a significant problem on a national level, figures vary dramatically from region to region. Health Regions IV and VI report LBWs of 12% and 20%, respectively, and VLBWs of 0.8%. With regard to the marginal neighborhoods of Santo Domingo, the incidence of LBW is estimated at 20 to 25% and VLBW at 1.8%. The study found a significant rise in LBW infants between 1983, when the rate was 6.8%, and 1985, when it was 13.6%.

The Tufts Nutrition Survey data shows that the growth curves of Dominican infants begin to decline quite rapidly during the first year of life. A major contributing factor is the custom of feeding infants and children only one or two meals a day. Inadequate duration of breastfeeding, poor quality of weaning foods, lack of supervision of children while eating (allowing them to spill food and permitting older children to take food from younger ones) and the use of bottle feeding were also found to foster poor nutrition.

The highest prevalence of malnutrition occurs in the 5-8 month old age group. This is attributed to: (a) abrupt cessation of breastfeeding by mothers returning to work when infants are 4-5 months old; (b) inadequate bottle feeding, especially due to dilution of formulas; (c) the practice of joint breastfeeding and bottlefeeding; and (d) inappropriate hygiene.

SESPAS maintains a nutrition surveillance system for children under 5 years of age in the rural areas. In 1986, a total of 135,581 children (29% of all children in this age group) were weighed. 40% of the children were found to be malnourished. Of these, 29% had Grade I malnutrition, 10% had Grade II malnutrition, and 2% had Grade III malnutrition. In Health Regions IV and VI, respectively, 57% and 48% of children were malnourished and 2% in each Region had Grade III malnutrition. SESPAS reports an increase in malnutrition between 1984 and 1986 in Health Regions IV and VI.

3. Diarrheal Disease

Diarrhea is the principal killer of Dominican children under 4 years of age, who experience an average of 5.2 diarrheal episodes per year. Children under the age of one experience even more bouts of diarrhea - an average of 6.7 episodes per year. Diarrhea is more prevalent among lower income people, although some estimates claim that 90% of all Dominicans regardless of socioeconomic status are affected by parasites. According to a 1986 study conducted by the Centro Nacional de Investigación en Salud Materno-Infantil (CENISMI), children under 5 years old living in low income neighborhoods of Santo Domingo have a 1.2 to 2.8 times greater chance of suffering severe dehydrating diarrhea than children of the same age group living in higher income neighborhoods. A factor that contributes to the frequent occurrence of diarrheal disease is the lack of potable water and adequate sanitary and waste disposal facilities. In urban areas, only 60% of households have running water in the home and an additional 15% have "reasonably" close access to a public water system. Only 22% of urban households are connected to the public sewage system, with an additional 50% claiming to have household sanitary facilities. Only 30% of the rural population has access to potable water and 60% has access to sanitary facilities.

4. Acute Respiratory Infections

Dominican children under 5 years of age suffer 5 to 6 million episodes of acute respiratory infection (ARI) each year. ARI occurs more frequently among malnourished children of low socio-economic status living in crowded conditions.

A 1986 study conducted by the Robert Reid Cabral National Children's Hospital found that 60% of deaths in the hospital were caused by pneumonia. Nationwide, respiratory infection is the fifth leading cause of infant mortality and the third most frequent cause of illness in preschool children. Pneumonia due to measles and pulmonary tuberculosis are other frequent causes of infant and child mortality.

As part of the Tufts Nutrition Survey, mothers were asked if their children had been sick during the previous two weeks. Of those who said yes, 48% cited respiratory problems, 20% fever, 14% diarrhea, 11% skin and eye problems, and 4% other undefined causes.

5. Other Targeted Infectious Diseases

The Dominican Republic has participated in the Expanded Program of Immunization (EPI) since 1978, under which all children under 5 years of age are immunized against diphtheria, tetanus, pertussis, polio and measles, and all women of childbearing age are immunized against tetanus toxoid. Reported mortality and morbidity rates for all five diseases have decreased since the EPI began, especially since mass campaigns began in 1983. The polio mortality

rate decreased from 0.17 deaths per 100,000 population in 1978 to 0.04 deaths per 100,000 in 1983. Polio morbidity declined from .59 per 100,000 in 1976 to .03 in 1985. Measles mortality declined from 5.30 per 100,000 population in 1976 to 1.39 in 1982. Measles morbidity was cut in half (from 149.42 to 70.3). Diphtheria mortality was reduced from 1.58 deaths per 100,000 in 1974 to 0.27 in 1982. Mortality due to pertusis decreased from 0.08 in 1978 to 0.05 in 1982. Morbidity rates for diphtheria and pertusis decreased from 8.95 and 49.01 per 100,000, respectively in 1976, to 1.60 and 2.78 in 1985.

Mortality due to tetanus at all ages also dropped, from 3.80 per 100,000 in 1976 to 0.93 in 1982. Morbidity declined from 5.35 per 100,000 in 1976 to 0.94 in 1985. Mortality and morbidity due to neonatal tetanus dropped slightly, from 0.6 and .35, respectively, in 1976 to 0.5 and .30, respectively, in 1982.

All of these diseases are now reported at 9-21% of their pre-EPI frequency. Nevertheless, since serological data on the reportedly immunized populations are not available, it is not possible to ascertain the percentage of women, infants and children protected against these diseases. Therefore, the effectiveness of the mass campaigns has not been fully demonstrated.

6. Birth Spacing

Closely spaced births are associated with increased maternal and infant mortality and morbidity. A 1975 study in the Dominican Republic determined that the IMR was 105 for children born within less than two years of another sibling, whereas when birth spacing was 2 to 3 years, the IMR dropped to 75 and when the interval was 4 years or more, the IMR dropped to 60.

In 1975 and 1980, studies were conducted to determine trends in the median interval between births among women in different age groups. During that period, the average national birth interval increased from 16.7 months to 18.8 months. The use of family planning methods by Dominican women is thought to be the main factor contributing to the increase in birth interval.

B. Beneficiary Population

This Project intends to address the health/nutrition problems of women of reproductive age (15-49 years) and 0- to 5-year-old children from the lower socio-economic class, who primarily depend on public or subsidized health programs to meet their health care needs. The Project will initially focus on Health Regions IV and VI (the Southwest) and 0 (the National District, especially the marginal barrios of Santo Domingo). The size of the target population is presented in the following table:

Project Target Population
(in 000)

	Region			Total
	IV	VI	0	
Infants and Children (0-59 mon.).	46	54	299	399
Women (15-49 yrs.).	67	109	580	756
Total	113	163	879	1,155
=====				
Covered by Project:				
80% rural.	90	130	-	220
60% urban.	-	-	527	527
				<u>747</u>

Source of data: Instituto de Estudios de Población y Desarrollo
based on census projections for December 31, 1986.

As indicated above, the Project will attempt to cover 80% of the total eligible population of women, infants and children in Regions IV and VI. The remaining 20% live in remote areas that the Project is unlikely to reach, or live in towns and have sufficient income to afford private services. In region 0, the Project aims to cover 60% of women of reproductive age and children under the age of five. The remaining 40% are from upper and middle class families living in residential and working class neighborhoods of Santo Domingo, who are serviced by the city's large network of private physicians, pharmacies, private health insurance companies, the Dominican Institute of Social Security, and other state health programs (eg. the Armed Forces).

C. Present Health Care Services

When illness strikes, low income Dominican families use several types of health services simultaneously. For instance, they might begin at a free public health clinic or go to a traditional healer. If still not cured, they might pay a private physician to treat them.

1. Public Sector Services

The GODR offers health services through the Secretariat of State for Public Health and Social Assistance (SESPAS), the Dominican Institute for Social Security (IDSS), and the Armed Forces and National Police. Public health services are also offered through several smaller CODR institutions, such as the National Council for Children (CONANI).

SESPAS is the largest provider of health care in the D.R. and one of the few health care providers in the rural areas. Although the actual size of the population attended by SESPAS is unknown, the percentage of the population it covers is estimated to be 40% to 65% of the nation's population. Based on the distribution of its facilities, SESPAS provides health services to approximately 70% of the urban and 57% of the rural population. Since SESPAS does not charge more than nominal fees for its services, its main beneficiaries are the poorest members of society.

IDSS covers about 4% of the population, consisting of employees of the private sector and some autonomous parastatal organizations. Coverage is limited to workers. The male worker's spouse is only covered during pregnancy, and children are only covered up to one year old. The Armed Forces and National Police cover 4% of the population, with programs that are not open to the general public. Thus, SESPAS is by far the largest public sector health care provider in the country.

SESPAS has an infrastructure of over 650 health facilities containing approximately 6,500 beds. Of the 650 facilities, about 400 are rural clinics staffed by auxiliary nurses and one or two physicians. In all, SESPAS employs about 2,600 doctors, 110 dentists, 420 graduate-level nurses, 4,000 auxiliary nurses and 6,000 community health promoters and supervisors.

The nation is divided into eight health regions and SESPAS maintains a Regional Office in each one. Each Regional Office manages a network of rural hospitals, sub-centers and rural clinics. Each rural clinic is the home base for teams of supervisors and community health promoters. Each supervisor oversees the work of 8-10 promoters and each promoter works with approximately 60-80 families. Promoters are rural families' main resource for health education, preventive services and referral to more sophisticated levels of health care.

Much of SESPAS' rural health system was established with assistance from A.I.D. under Health Sector Loans I and II (517-U-028 and 517-U-030). Prior to the signing of Health Sector Loan I in 1975, SESPAS had few trained personnel delivering health care in rural parts of the country. Under the two loan programs, 5,400 promoters and supervisors were trained to deliver immunizations, family planning advice and contraceptives, and refer persons with more complicated health problems to a network of newly built rural clinics and hospitals. The promoters also taught rural residents proper nutrition, encouraged better sanitation practices and collected vital statistics from the communities in which they worked. By August 1981, this program was fully integrated into the SESPAS physical and human infrastructure, and became known as the "Servicios Básicos de Salud" (SBS).

The SBS only operated in rural areas of the country. Attempts to initiate an urban SBS in Santo Domingo failed as a result of high promoter attrition and perceived duplication of health services already available in the city.

In May 1983, Management Sciences for Health (MSH) evaluated the effectiveness of the SBS. The evaluation pointed out many of the strengths and weaknesses of the SBS that still exist today. MSH credited the SBS for having: (1) increased health care coverage of the rural population and created a health infrastructure in the rural areas, mostly devoted to preventive medicine; (2) possibly leading to a decrease in the infant mortality rate, the mortality rate for children aged 1 to 4 years, and the fertility and birth rates during the period 1976-83; (3) receiving strong community support; (4) leading to a high rate of immunization coverage in the rural areas; and (5) receiving strong government support and showing the GODR's commitment to rural health and preventive medicine as opposed to urban hospital-based medicine.

The MSH evaluation also pointed out many constraints in the rural health system of 1983, which still exist today. In 1983, promoters' and supervisors' productivity was low and there was little tangible output in areas other than immunizations and possibly family planning. The supervisory system was nearly non-functional. There was almost no continuing education and re-training. Data collection and the information system were weak and unreliable, hindering the systematic, constructive evaluation of the SBS. Logistics problems abounded. There was a lack of flexibility, due to little decentralization of authority to the regional level. (See Annex 4)

Unfortunately, the SBS has deteriorated even further since MSH's 1983 evaluation. During the 1983-86 period, most of SESPAS' resources were utilized to mount massive, nationwide campaigns against EPI diseases (except BCG for the prevention of tuberculosis), intestinal parasites and rats. SESPAS even carried out a campaign to distribute ORS packets. Prior to the mass campaigns, immunizations had been available at health facilities and the estimated coverage of target populations ranged from 12% to 34%. The mass campaigns, which relied largely on trained outreach volunteers, resulted in much higher coverage rates. In 1986, coverage ranged from 93% to 98%. However, the mass campaigns did not comply with World Health Organization and certain EPI standards and therefore, these estimates may not be accurate.

Although the campaigns appear to have been successful in substantially increasing immunization coverage, the rural health system had become a staging ground for campaigns and little else. Since the change of GODR Administration in 1986, campaigns have continued. SESPAS' current goal is to immunize all children under 5 years of age against diphtheria, tetanus, pertussis, polio and measles, and to immunize all women of childbearing age against tetanus toxoid. As is described in more detail in this Section, I.I.D., several donor agencies, including A.I.D., are providing financial support to the SESPAS immunization program.

Despite its interest in continuing the campaigns, SESPAS' main priority is to revitalize the rural health system. As part of this effort, the entire corps of health promoters was replaced during the summer of 1987. However, SESPAS faces major constraints in making the revitalized system

succeed: it does not have the physical, financial and technical resources it needs to train and equip the new promoters, establish effective supervisory and information systems and a continuing education program, develop appropriate educational and mass media promotional materials, institute adequate planning and evaluation systems, and solve its logistics problems. Therefore, SESPAS is seeking support in these areas from donor agencies, including A.I.D.

On August 12, 1987, the Secretary of Health announced the creation of the National Child Survival Plan (Plan Nacional de Supervivencia Infantil - PLANSI) with the aim of revamping the rural health system to be able to deliver child survival interventions throughout the country, and formed a committee to develop an integrated child survival plan for SESPAS. PLANSI calls upon international donors to assist SESPAS in implementing the following seven interventions:

- The Expanded Program of Immunizations;
- Oral rehydration therapy (ORT) and diarrheal diseases control;
- Growth monitoring and nutrition education;
- Promotion of breastfeeding;
- Prevention of low weight births;
- Prevention and treatment of acute respiratory infections; and
- Birth spacing.

SESPAS wishes to implement PLANSI at a national level as soon as possible, beginning by defining each intervention and the functions of each level of worker in the system (promoter, supervisor, rural clinic staff, etc.). This will be followed by staff training, beginning at the central and regional levels and concluding with field personnel.

As this project paper is being written, SESPAS is completing the design of PLANSI, while maintaining considerable communication with A.I.D. and other donors.

An important constraint to PLANSI's success that SESPAS is attempting to remove is that SESPAS has traditionally been divided into a series of isolated, "vertical" delivery programs that extend from the central level to the point of delivery, bypassing regional authorities. The vertical programs, such as mother child health, nutrition and immunizations, are often poorly planned and coordinated, resulting in confusion and competition for staff and resources at the delivery level.

Under PLANSI, SESPAS intends to completely revamp its organizational structure by creating the position of the Director General of Health, thereby providing leadership, direction and a forum for coordinating the activities of the "vertical" programs. Also, SESPAS will strengthen its regional offices and is prepared to delegate sufficient authority to allow them to better manage the services they deliver. These new organizational directions will benefit the Child Survival Project, for which coordination between programs and fast decision-making at the regional level are essential.

However, SESPAS faces other constraints that bring into question PLANSI's sustainability. A major constraint is the lack (or poor allocation) of funds. The portion of the GODR budget allocated to public health has declined in real terms during the past 8 years. Despite a noticeable increase in funding in 1987, (due to special presidential subsidies to cover extraordinary costs associated with the purchase and distribution of medicines and vaccines), SESPAS has never allocated enough money to pay the recurrent costs of the rural health system. Although personnel costs are covered (personnel is by far the most costly line item in the SESPAS budget, accounting for 53% of SESPAS funds), approximately 90% of the budget pays for operating expenses (including personnel), leaving little for medicine and equipment purchases, training and supervision, and other support functions that make health programs effective. A.I.D. is working with SESPAS to address this constraint under the Health Systems Management project and is also conducting several health care financing studies that will provide SESPAS with basic information to assist in setting rational health care financing policies.

Another important constraint to PLANSI's sustainability is the lack of a civil service system, which has traditionally resulted in the wholesale firing of thousands of employees without regard to the quality of their performance, and the wholesale hiring of thousands of employees without regard to their qualifications. This is typified in the wholesale firing by SESPAS of all of its promoters and supervisors in the summer of 1987, claiming that they were "too political" and were not serving the needs of the program. New promoters were selected by the political party, without considering their qualifications. Some persons claim that the new promoters are better than the old ones, but others say that many lack such minimum qualifications as the ability to read and write. The Child Survival project will address this issue by assisting in training, supervising and evaluating staff, defining the promoter's functions and carrying out policy dialogue to promote stability of promoters who perform well and encourage the replacement of those who do not. Nevertheless, just as the SBS collapsed upon the wholesale firing of promoters and supervisors, the long term success of PLANSI is in jeopardy as long as the possibility of wholesale firings exists. Despite this constraint, the Mission feels that it should support the SESPAS program, because in spite of the losses that have resulted from politically-motivated changes, the SBS as an institution has always survived. For instance, although the SBS deteriorated during the 1983-86 period and eventually collapsed with the firing of personnel in 1987, it still forms the basis without which the present immunization program would never have been possible. The SBS is the only

proven national network for bringing health activities to rural communities. This network has been utilized time and again (albeit in an uncoordinated fashion) by SESPAS officials, regardless of political affiliation, and is generally accepted as a permanent system, despite its constantly changing personnel. Moreover, the skills and knowledge provided to former SBS personnel have provided rural communities throughout the country with thousands of people trained in health promotion. These people may no longer work for SESPAS, but they are a resource for PVOs searching for skilled employees and communities seeking basic health advice.

2. Private Sector Services

Several studies show that Dominicans of all socio-economic classes increasingly began using (and paying for) private sector health services during the 1976-84 period, largely because of perceived deficiencies in the public sector delivery system, and that a large portion of Dominican family income is allocated to health care. Increased demand for private services has resulted in increased supply. For instance, in 1967, there were two Igualas Médicas (health maintenance organization-type prepaid private health insurance programs) in the D.R.; in 1985, there were seventeen. Nevertheless, most clients of private health care programs are from the working class or above. There are few fee-for-service physicians that serve the lower class population. In Health Regions IV and VI, where 12% of the total Dominican population resides, there are only 2% of the nation's organized private sector services. These regions contain only 4% of the nation's private physicians, 7% of the nurses and less than one per cent of the nation's dentists.

Pharmacies also play a role in the health care of low income Dominican families; many Dominicans bypass the health system and go directly to pharmacists, requesting a diagnosis and recommendation of which medicine to buy. Nevertheless, 70% of prescriptions issued are never filled, mostly because of lack of family funds.

Private Voluntary Organizations (PVOs) also play an important role in preventive health care. For instance, CARE-Dominicana distributes PL-480 Title II foods to 140,000 beneficiaries (pregnant and breastfeeding mothers and children under 6 years of age) through the Ministry of Education Preschool program, Ministry of Health rural clinics and various other distribution sites throughout the country, including orphanages. Also, Catholic Relief Services, in collaboration with Caritas Dominicana, implements the Applied Nutrition Education Program. Briefly, this program carries out growth monitoring, nutrition and diarrheal disease control education in 100 rural communities throughout the country. In addition, Church World Services, in collaboration with Servicio Social de Iglesias Dominicanas (SSID), implements an integrated community development program, including health and nutrition activities, in the border region of the country. Each Catholic Diocese has a preventive health care program, implemented in coordination with local mothers groups. FUDECO (Fundación para el Desarrollo Comunitario), the representative of the Save the Children Foundation in the Dominican Republic, implements an

integrated community development program along the Haitian border, which includes some preventive health care education and a child sponsorship program. Also, there are many other smaller PVOs working in the target area of this project, providing a variety of preventive and curative health care and education services to the rural population.

Many PVOs are interested in expanding their services to incorporate more health and nutrition activities. However, they face major constraints in achieving this objective: they do not have the physical, financial and technical resources needed to train and equip their personnel, establish effective supervisory and information systems, develop educational materials, and institute adequate planning and evaluation systems. Therefore, they are seeking support in these areas from donor agencies, including A.I.D.

D. Other Donor Activities

Aside from USAID, UNICEF and the Pan American Health Organization (PAHO) are the only other major donors that fund child survival activities in the Dominican Republic.

UNICEF's assistance has been extensive in the area of child survival. For instance, in 1986, UNICEF updated its 1983 diagnostic study of the Situation of Children in the Dominican Republic. This document provides important data and analyses of the status of child health in the D.R. UNICEF also provided funding to the Dominican Pediatric Society to train hundreds of Dominican doctors in ORT and diarrheal disease control. It also assisted SESPAS in establishing oral rehydration centers in most of its major public health facilities, as well as autonomous oral rehydration centers in marginal neighborhoods of Santo Domingo. Between 1987 and 1991, UNICEF expects to provide approximately \$2.5 million in funding for a range of multisectoral public and private sector child survival activities. UNICEF will assist PLANSI, but has not yet decided which specific activities to support. No doubt, SESPAS will request UNICEF to assist in regions and activities not covered under the USAID Child Survival Project.

PAHO plays an advisory role in its relationship with SESPAS. Although its financial resources are limited, PAHO relies on a cadre of resident advisors to provide continuous technical assistance in such areas as ORT, health administration, water and sanitation, and immunization. PAHO expects to provide about \$50,000 per year to fund technical assistance in child survival and water and sanitation activities.

PAHO is the lead organization in the D.R. in the LAC Accelerated Immunization program and PAHO, USAID, UNICEF, BID, Rotary International and SESPAS meet periodically to monitor the program's implementation. This model of donor coordination has worked so effectively that it will be replicated in the planning and implementation of PLANSI. USAID will maintain constant communication with donors involved in child survival so that assistance programs do not duplicate one another. Moreover, USAID will encourage SESPAS

to seek the assistance of other donors in such areas as water and sanitation, which will not be addressed under the Child Survival Project.

E. Relationship to A.I.D. Strategy, USAID/DR Strategy and Other Projects

1. A.I.D. Strategy

Fifteen million children under the age of five die each year in developing countries, accounting for more than half of all deaths in these countries. Malnutrition, disease, unsanitary conditions, closely spaced births and lack of maternal education all interact in a vicious circle to bring about high infant and child death rates. Two simple technologies, oral rehydration therapy (ORT) and immunization, can break this circle significantly reducing the rates of infant and child deaths and disability. It is estimated that up to half of infant and child deaths, or one quarter of all deaths in the developing world, could be prevented by these simple technologies. They are the "twin engines" of A.I.D.'s child survival strategy. Two other interventions are also considered to be core components of A.I.D.'s child survival strategy: nutrition and birth spacing.

A.I.D. has joined other donors in a worldwide effort to achieve targeted reductions in infant and child mortality by the end of the decade. The aim is to prevent two million deaths through the use of ORT, provide 80% immunization coverage by the end of the decade and use child survival interventions as the basis for building a more sustainable health care system over time. The Agency's Blueprint for Development includes among its goals the reduction of infant mortality to less than 75 per 1,000 and the reduction of child mortality (ages 1 to 5 years) to less than 10 per 1,000. (Please refer to Annex 4 for a summary of A.I.D. child survival policies.) The Project described herein applies the Agency's Child Survival Strategy to health conditions in the Dominican Republic.

2. Mission Strategy.

As stated in the FY 88-89 Action Plan, the Mission's goal is to assist in developing sustained and equitably distributed economic growth in the Dominican Republic, targeted at the urban and rural poor. To achieve this development goal, USAID/DR supports economic recovery and growth in the Dominican Republic through a private sector-led expansion and diversification of the country's economic base. The objectives are as follows:

- continued progress in implementing the GODR's economic stabilization program;
- expanded private investment in industrial and agricultural sectors and the development of a broader base of non-traditional exports;

- rapid diversification of the agricultural sector into non-traditional crops with foreign exchange earning potential; and
- promotion of equitable distribution of economic growth as a means of improving the standard of living of the target population, by means of greater employment opportunities, training and improved access to health care, nutrition and family planning services, by reinforcing the private sector's capacity to meet these needs.

In addition, the Action Plan states that:

"The USAID program is focused on those elements of poverty with which the Agency's Strategic Plan is most concerned. First, we are supporting efforts that will create or increase productive and sustained employment within the private sector. The greater individual income that results will enable poor Dominicans to secure social and other services that the public sector cannot afford to provide. This should have a significant impact on the hunger problem because malnutrition in the Dominican Republic is more a function of income level than the availability of food. However, in the short term, immediate measures must be taken to deal with the current high rate of malnutrition found in the country. Child survival and related efforts are needed to carry the malnourished through a critical period until the results of longer term measures that deal with the basic causes of the problem are felt. The Mission will address other health problems by attempting to make the large and poorly financed public health system more efficient and better able to provide services to those who cannot afford to secure them on their own. To address the currently rising rate of infant mortality, we are using PVOs to implement child survival interventions and to expand the availability of potable water which is of critical importance in improving family health. For those who can afford to pay for minimum preventive and curative care, we will help broaden the coverage and lower the cost of private health service systems. We will also help the country reduce population growth by increasing the availability of voluntary family planning services."

In the Action Plan, the Mission lays out fourteen specific objectives. Objective 10 is to reduce infant and child mortality. The major instrument to achieve this objective is the Child Survival Project.

3. Relationship to Other Mission Projects

Many aspects of the Child Survival project were developed based on the Mission's experience with other SESPAS projects. For instance, as described in Annex 4, lessons learned from Health Sector Loans I and II (517-U-028 and 517-U-030) have been incorporated into the design of the Child Survival project. Also, the Applied Nutrition Education Project (ANEP, 517-0174), which is currently being implemented by CRS and Caritas Dominicana, aims to improve infant and child nutrition by carrying out regular growth monitoring and providing nutrition education to parents. A recent evaluation of ANEP has shown that these interventions have had a significant positive

impact on the nutrition of children enrolled in the program compared to children in control communities. Therefore, the growth monitoring and educational activities of the ANEP Project have been incorporated into the Child Survival Project.

In addition, the Child Survival Project will be complemented by the Mission's Family Planning Services Expansion Project (517-0229), the LAC Accelerated Immunization Project (517-0242), the PL-480 Title II program, and the Health Systems Management Project (517-0153).

The five-year, \$5 million Family Planning Services Expansion Project became operational in September 1986. The Project's goal is to increase the access of Dominicans throughout the country to voluntary family planning services, by training the service delivery staff of PROFAMILIA and ONAPOFA in family planning methods and providing improved logistics support and more effective records systems.

The five-year LAC Accelerated immunization program, which is jointly funded by A.I.D., PAHO, UNICEF, the Inter-American Development Bank and Rotary Club International and implemented by SESPAS personnel with assistance from PAHO, became operational in the summer of 1987. Under this program, immunizations will be provided by promoters according to guidelines established under the Expanded Program on Immunizations (EPI).

Thus, in addition to the activities to be implemented under the Child Survival Project, the Mission is supporting immunizations and birth spacing under other Projects, thereby supporting the full range of child survival interventions.

Under the Mission's Health Systems Management Project (517-0153), SESPAS is revamping its financial management, management information and human resources systems. With regard to financial management, the project should significantly improve the chances of sustaining SESPAS' child survival activities after the Child Survival project ends because, starting in 1988, SESPAS' budget will be based on programmatic targets set by each SESPAS operating unit or program (e.g. growth monitoring). This will ensure that each activity is allocated the amount of funding it needs to meet the objectives it sets. In addition, under the Health Systems Management project, indicators of efficiency, productivity and quality will be established for SESPAS programs and activities.

The Health Systems Management project also aims to establish a uniform information system throughout SESPAS and to install computer capability at the regional level. Therefore, all information systems activities to be carried out under the Child Survival Project will be done in coordination with activities being carried out under the Health Systems Management Project.

In addition to its health programs, USAID supports other development efforts that seek to alleviate the poverty underlying poor health conditions.

As part of their activities, these projects seek to increase rural incomes and economic activity in the areas covered by Health Regions IV and VI. In the area near Azua, increased agricultural production of non-traditional crops is being improved under the On-Farm Water Management Project. This Project seeks to increase yields of irrigated agriculture in the Ysura River Basin, benefitting 5,000 farm families who are being organized into water users' associations and trained to make more efficient use of water on their farms.

The Agribusiness Promotion Project has provided credit to support the growth of agribusinesses in the two regions. These businesses provide employment to about 3,000 to 4,000 farmers and farm workers.

F. Project Rationale and Strategy

1. Alternatives Considered

a. National vs. Regional Approach

Ideally, a child survival Project should be implemented nationally, thus reaching as many children as possible. The institutional analysis has shown that, with the exception of immunizations and family planning, SESPAS and the potential participating PVOs are generally too weak administratively to mount a major national child survival Project at this time.

The SESPAS immunization program has been operating on a national basis for over 10 years. Family planning services are also offered via the SESPAS network of staff and facilities. What has given these two services stability and continuity is the degree of outside support they receive in the form of budgetary and technical assistance. The immunization program has received special financial assistance and vaccines from PAHO and UNICEF over the years and technical assistance has been forthcoming from PAHO's Expanded Program for Immunizations (EPI). UNDP, UNFPA and A.I.D. have been the primary supporters of family planning services. Funding and technical assistance has been provided to the National Council on Population and the Family (CONAPOFA) which, in turn, implements voluntary family planning services through the SESPAS infrastructure. Unfortunately, the other interventions proposed by the present Project have not been fully developed within SESPAS nor have the majority of their staff been trained in the delivery of these services. While SESPAS has considerable experience in immunizations and family planning, the PVOs, particularly CARE and CRS/Caritas, have the major experience in nutrition education and growth monitoring within selected regions of the country.

Another major factor that has influenced the initial geographic focus of the Project is the high turnover of SESPAS field personnel which would make the implementation of a nation wide program very questionable at this time. As documented in several evaluations, the rural health services offered by SESPAS have deteriorated substantially in the last four years and

climaxed with the broadscale firing of all the community health promoters and their supervisors (over 5,500 persons in all) during the spring and summer of 1987, following the change of government in August of 1986. This massive change of personnel is both a target of opportunity and a liability for the present Project. On the positive side, the Project will be able to assist SESPAS in the redesign and streamlining of its rural health services and focus them on effective child survival interventions. On the negative side, the Project design team recognizes that without experienced community health workers, program implementation is bound to move more slowly than if these services were being introduced to a well functioning delivery system.

For these reasons, all parties to this Project have agreed that the present child survival Project should be carried out according to a phased implementation plan, whereby new and improved child survival interventions are initially introduced in selected regions of the country, rather than throughout all health regions simultaneously. By concentrating Project resources in a limited geographical area, more management attention and technical assistance can be concentrated on fewer target communities. Then, after conducting a detailed mid-term evaluation that focuses on the attainment of service delivery objectives and the quality of service administration, additional resources may be provided by A.I.D. and the CODR so that Project activities can be replicated in additional needy regions, or in such special situations as Sugar Council workers' communities.

As far as PVOs are concerned, during the initial implementation phase, assistance will be provided to those that only operate in the selected regions. When the Project reaches the phase of nationwide replication, assistance may be provided to PVOs operating in other regions of the country.

b. Criteria for Selecting Initial Participating Regions

Two Health Regions have been selected to participate in the initial phase of the Project, thereby serving as test sites for applying and evaluating Project activities before they are replicated nationally.

Health Regions IV and VI, which make up one third of the country's geographic area, with a population of approximately 800,000 (12% of the national population), were chosen for the following reasons:

- They are located in the Southwest, which is the poorest region of the country, with 38.6% of the families earning an income below the poverty line. The illiteracy rate is 41% for persons 15 and older.
- 58% of the population under 5 years of age in the Southwest suffer from malnutrition, Infant mortality in 1982 was estimated as 86.1 per 1,000 births. The Westinghouse Demographic and Health Survey of 1987 indicates that the region has an infant mortality rate of between 90 and 103 per 1,000 births.

- These regions have the highest fertility rate in the country (VI is highest with 5.3%, followed by IV with 4.9%, compared to the national average of 3.8%) and most women have their first child while they are in their early teens, thus limiting their future for further education or employment opportunities.
- There are two SESPAS offices in the Southwest, one in San Juan de la Maguana (Region VI) and another in Barahona (Region IV). Both regions have a network of public health staff, hospitals, subcenters, rural health clinics, supervisors and promoters.
- There is strong political support from the Secretary of Health to initiate the program in these two regions as a means to reactivate the rural health system. SESPAS staff in these regions have also indicated their willingness to participate.
- The Southwest region contains a wide variety of PVO headquarters and branch offices and many have expressed interest in participating in the Project. They include: CARE, CRS, FUDECO/Save the Children, Caritas, SSID, church and civic groups, and service clubs such as Rotary and Lions. Also, due to the relative isolation of the region, there appears to be less potential for conflict and duplication of effort among these organizations than there would be among organizations located in more accessible regions.

While these regions have both acute needs, and a basic system of service delivery, they also have the most geographically dispersed populations in the country (55 inhabitants per Km²), which will make it difficult to meet the Project objective to provide services to 80% of the population. Also, according to the Social Soundness Analysis and evaluations of other Projects implemented in the Southwest, the people of this region tend to be less accepting of new ideas and very individualistic, rarely banding together to carry out mutual benefit programs. Nevertheless, CARE's Title II Enhancement Program, which includes growth monitoring (an activity to be implemented under the Child Survival Project), is meeting with success in the Southwest. The Project plans to build upon this experience.

In addition to Health Regions IV and VI, the Project will support child survival activities in urban barrios of Santo Domingo. The selection of participating barrios will be left to the coordinating PVO, in consultation with participating local PVOs, USAID and SESPAS.

c. Private vs. Public Sector Approach

In order to reduce infant and child mortality and malnutrition in 80% of the families in the target regions, many well-trained, well-equipped

community-based health workers are needed. Since no single organization in the Dominican Republic has such an extensive and effective health delivery network, several alternatives that were considered for achieving this level of coverage are summarized below.

Alternative One: Relying Only On SESPAS. If this alternative were selected, all Project funds would be made available to SESPAS to augment the number and improve the effectiveness of its promoters and supervisors in order to better reach the target population. However, past experience has shown that SESPAS cannot adequately meet the recurrent costs nor successfully administer and evaluate a large, community-based rural health program. Moreover, in addition to the information provided in the preceding section, it should be recognized that since SESPAS does not have a civil service system, its personnel change sporadically. No sooner are new personnel trained (usually at the expense of international donors), than are they removed by new GODR administrations or Ministers. Therefore, it would not be advantageous for SESPAS to become the nation's sole provider of child survival services.

Alternative Two: Relying Only On PVOs. Although several PVOs have demonstrated their ability to deliver child survival interventions on a limited scale in the Dominican Republic, they are, unfortunately, a minority. In fact, relatively few PVOs in the Dominican Republic provide health care. Moreover, those that work in health have a limited ability to train, supervise and support large networks of community-based health workers. Also, if A.I.D. were to greatly expand PVO capacity to deliver child survival interventions, the existing SESPAS rural health system would be duplicated. For these reasons, USAID decided against supporting a child survival effort implemented solely by PVOs.

Alternative Three: A Mixed Public/Private Sector Delivery Strategy. Despite the weakness within the private and public sector health providers as noted above, the Mission believes, based on the findings from the institutional analysis, that there is sufficient administrative capacity to deliver a limited number of child survival interventions through SESPAS and selected PVOs who are presently engaged in health care. The Project, therefore, will assist those interested public and private health institutions that work in the target areas so that they may be upgraded to deliver child survival interventions more effectively and efficiently. In essence, the Project wants to build upon and strengthen the present institutions in the field who qualify for support.

Given the mixed sectoral approach, and the change from past practice that this Project represents for the delivery of health services, the USAID determined that the funds should be provided in a way that requires top-level support of the government, while retaining for USAID the essential conceptual direction (and financial control of AID funds) during this initial effort. By making a handbook 3 grant, followed by the careful selection of a coordinating entity under competitive procedures, we can assure the technical

and management expertise that is required (discussed below).

In discussions with the Technical Secretariat of the Presidency and the Secretary for Public Health, it was agreed (and later ratified by letter) that a government-to-government grant to the TSP would meet these requirements, with the understanding that AID would make the implementation arrangements that involve A.I.D. funds. The TSP coordinates all foreign assistance flowing to public and private agencies, contains within it in the National Planning and Budget Offices, jointly programs and oversees with USAID the Local Currency Program, and thus is in a unique position to assure the kind of top-level, intersectoral support and resources that this Project requires. In total, the CODR will provide nearly 44% of Project resources, as a combination of the work of and support for nearly 1,000 SESPAS personnel, and RD\$3,000,000 or more in local currency. By this arrangement, we do not place the TSP in an inappropriate role as Project implementer, while gaining its commitment to support this important program.

d. Rationale for a PVO Under Cooperative Agreement

To provide detailed plans for key activities, coordinate and provide technical cohesion in the implementation of this private/public sector approach, a U.S. based PVO with known expertise in child survival health care will be selected competitively and assisted with a Cooperative Agreement. This organization, to be known as the Coordinating PVO (C/PVO) will manage and financially control nearly all of the AID's resources in order to meet Projects objectives, provide long and short term technical assistance to all participating parties, and arrange for the integrated application of such Project resources as training and educational materials, transportation and related Project supplies. This will achieve a number of objectives:

- The C/PVO will provide technical expertise to design the detailed approaches, plans for training and educational materials development and the like, through submission of a proposal tailored to achieve the outcomes described in this Project Paper. The C/PVO will be expected to update and refine for operational planning the baseline analyses on which the Project is based, and develop plans of action to meet the identified needs.
- Provides relief for USAID's limited technical and backstop staff of the workload involved in detailed planning and daily supervision, major procurement actions, disbursement of subgrants and other payments, and other administrative burdens associated with direct methods;
- At the same time, allows USAID, through the involvement provisions of the Cooperative Agreement mode, to continue to influence the design and implementation of the Project, and to change, if necessary, the conditions of the Cooperative Agreement;

- Assures that a proven team is providing its institutional capacity to the Project, by selecting a PVO from a roster developed by AID/W of entities with child survival expertise;
- Through the competitive selection criteria and process, the PVO will be chosen not just on technical grounds, but also based on its track record in managing A.I.D. grant resources for training, commodities, technical services -- in effect acting in AID's place -- under previous Field Support Grants or Cooperative Agreements.
- Fulfills AID's repeated injunctions to the field, founded in the Congressional mandate in Section 123 of the FAA, to make maximum appropriate use of PVOs in carrying out our assistance; and
- Builds into the Project, through the C/PVO, the flexibility to shift Project resources to or away from participating organizations according to their performance. This will provide that participating organizations who do not live up to their commitments in the Project can be dropped if, after a reasonable amount of Project assistance, there is no visible improvement in their performance.

There is ample precedent in the DR of private sector institutions receiving A.I.D. assistance to work with public sector institutions. For example, CARE manages the PL-480 Title II program with SESPAS and the Secretariat of Education as its counterparts. The University of South Carolina works with the National Malaria Eradication Service and a private university on Vector Control Research. The Mission believes that this administrative arrangement will not jeopardize the autonomy of the participating entities who will have a subgrantee relationship with the C/PVO.

2. Final Project Strategy to be adopted: Rapid Response, Limited Interventions, and Beneficiary Targeting

USAID and Dominican counterpart institutions have agreed upon a service delivery strategy that provides a rapid response to the nation's malnutrition and childhood infectious disease problem by implementing a limited number of proven interventions in targeted communities.

A rapid response to the rising incidence of infant and child mortality and morbidity is needed to reverse these negative trends and bring credibility to provider organizations, particularly SESPAS. Thus, the Project will rapidly increase the service delivery capacity of public and private sector health service providers who can address child survival problems in the areas where they operate. In order to deliver services as effectively as possible, the Project will concentrate on a limited number of interventions that have proven to be most effective in diminishing infant and child

mortality in the Dominican Republic. Moreover, the services will be targeted to the most vulnerable segments of the population.

Acting through the C/PVO to promote the timely delivery of child survival services, the Project will train community-based health personnel, their supervisors and administrators. Supervisory staff of the implementing organizations will be trained first and then they will teach community-level workers. The training program will prepare workers to apply their new knowledge and skills as soon as they return to their communities. Workers will receive all the necessary manuals, equipment, educational materials and instructions at the training site and will be tested and certified before leaving the site.

To support community-based workers, administrative personnel will be trained to manage and evaluate the services offered under the Project. The Project will supply resources to improve programming, information and record keeping, transportation, logistics, and mass media education. Also, participating institutions will be assisted to develop a simple management information system that will enable them to track resources and their impact on improving the health of the target population. Special conditions will be incorporated in the Grant to the GODR to provide for the sustainability of the program after A.I.D. resources terminate.

The C/PVO will work in collaboration with an Executive Committee for the Project, composed of representatives of SESPAS, the PVOs, and A.I.D.

III. PROJECT DESCRIPTION

A. Project Goal and Purpose

The goal of the Child Survival Project is to improve the health status of Dominican children. This is to be measured by a reduction in average infant mortality rates from as high as 103 per 1000 live births to 80 per 1000 and reduction in the average child mortality rate from 18 per 1000 to 10 per 1000 by 1991 in the most severely affected health regions selected by the Project. The purpose is to improve the quality and expand the coverage of child survival services offered by SESPAS and PVOs in selected regions.

B. End of Project Status.

By the time the Project ends in September 1991, the the agencies involved are expected to achieve the results listed below in selected regions.

1. Reduce infant mortality and diseases by the following amounts and means:

-Reduce malnutrition from 40% to 30% of child population

-Reduce low birth weights by 50%

- Reduce diarrhea by 20%
- Reduce infant and child mortality due to diarrhea by 30%
- Increase use by mothers of proper diarrhea treatments;
- Decrease infant deaths due to acute respiratory infections;
- Mothers improve recognition and treatment of respiratory infections; and
- Improve access to immunizations and family planning services under separate but coordinated projects.

2. Operate a mixed private and public system of child survival services that shows:

- Improved delivery of child survival services by SESPAS and PVOs involved in public health;
- 1,500 promoters and supervisors trained in technology and supervision, data collection and reporting;
- Established, reliable data collection system based in communities, and showing 80% validity of information;
- 1,400 medical personnel providing improved child illness diagnosis and treatment, prenatal care, and related services;
- Reduced referral of ill children to clinics due to early identification and treatment in the home;
- Increased public awareness of child survival problems, causes, prevention & treatment; and
- 50% of communities organized and actively supporting promoters' efforts.

More detailed objectives for each service and for the delivery system are provided in Annex 3.

C. Project Methods and Techniques

1. Introduction

The Project, conducted principally through the plans and activities of the C/PVO, will support SESPAS and PVOs to provide effectively through delivery teams and service centers the following services: (1) growth

monitoring and related nutrition services for mothers and children under 5 (promotion of breast feeding, preparation of weaning foods, improved feeding of children and pregnant/lactating mothers); (2) diarrheal disease control, including oral rehydration therapy for diarrhea (ORT); and (3) proper prevention and treatment of acute respiratory infections (ARI). In addition, the Project will coordinate with the Family Planning Services Expansion Project and the Expanded Program of Immunizations to improve the same delivery systems' ability to help prevent diseases and increase families' knowledge of and access to child spacing.

This Section describes how the delivery system is expected to work as the Project evolves, the content of the services to be delivered, and the dual support techniques of rapid response and service improvement.

2. Delivery Modes

The existing system of health service delivery, discussed in the Background and further in the Institutional Analysis Sections, consists of two basic modes used by both SESPAS and PVOs: (a) delivery to families and communities through outreach teams of promoters and their supervisors, and (b) delivery at service centers to which clients or patients bring their children. These two modes are not mutually exclusive; often service centers act as a base for paid or volunteer outreach teams. As the philosophy of the Project is to support and improve the existing system, it will work with both, with a strong preference for outreach networks.

a. Outreach to Families

PVO providers and SESPAS both have community level health promoters, some form of supervision and quality control, administrative support mechanisms and information/reporting systems. Promoters are front-line health workers in frequent contact with families. In SESPAS, they receive a stipend, while in PVOs they may be volunteers, school teachers providing their time outside working hours, or persons on modest stipends. Supervisors are anyone who directly supervises or supports the promoter, and area managers may have different titles within SESPAS and PVOs (they may be the chief health person for a PVO, for example). Area managers are those who oversee groups of supervisors and are the next link in the management and information chain. Regional or headquarters staff are those responsible for their organization's program for the country or in the region, and are the staff who report and work most closely with the C/PVO.

The community level health promoter is the key person in the delivery system as he or she is the point of contact between the health program and the beneficiary population. All other program staff, in one way or another, play supportive roles to the promoter. If the promoter cannot relate effectively with the beneficiary population, the program will not be able to reach its objectives and the supporting staff will have played a

superfluous role. Therefore the Project, working through the participating provider, must assure that promoters are able to deliver child survival services, including the health education necessary to cause a positive change in the mother's behavior so that she is able to protect the life and health of her children. The major responsibilities of the promoter are to:

- o Provide leadership and direction in the implementation of a simplified community health assessment resulting in a census, community health profile and map of the promoter's area of influence;
- o Provide child survival services and education directly to the mothers in her community;
- o Act as liaison between the larger health delivery system and the family and facilitate the referral of individuals for services offered at higher levels of the delivery systems;
- o Assist the providers' medical team in the design and implementation of programs necessary to achieve the Project's objectives;
- o Maintain accurate and complete documentation of health statistics and refer requested information to higher levels of the delivery system; and
- o Serve as liaison between the community and other health and community development institutions;

In summary, each promoter will teach families about the need and use of child survival interventions through monthly home visits to approximately 60-80 families. While mothers are the prime object of the program, in many Dominican homes the children are tended by older siblings, aunts or grandmothers. Promoters will also hold community meetings and organized activities on such topics as the growth monitoring profile of all children in the community. The health promoter will be trained in technical skills for teaching and assisting families to carry out child survival actions and will be responsible for maintaining up to date records. Each community will have a designated location where records and minimal equipment and supplies will be kept. Provider organizations, with technical assistance from the C/PVO, will be encouraged to explore different work incentives for promoters to encourage better performance, in recognition that some promoters are volunteers, while others receive a small stipend and few are paid a minimum wage.

The Project will not encourage the involvement of promoters in community development or income generation activities per se. The participating organizations who have their own programs in these areas will be free to pursue them with their own resources.

Primary responsibilities of supervisors of promoters will be to:

- o Serve as on-site technical trainers of health promoters in the various services offered by the child survival Project;

Supervise the promoters' work so as to assure that the information/education given by promoters is accurate;
- o Verify promoters' reports, perform spot checks, and summarize data for the information system;
- o Promote communities to organize health committees to work on solutions to major health problems; and
- o Serve as a resource for the community in supplying information, making contacts with other institutions, and encouraging the community to organize to combat the causes of the principal illnesses in children under five and pregnant and lactating women (i.e., water and sanitation, income generation, food availability, etc.)

b. Service Centers

These centers include a wide variety of organizations, from SESPAS hospitals, clinics and subcenters, to neighborhood community services, church-supported dispensaries and pharmacies, and nutrition rehabilitation or supplementary feeding posts.

The Project will seek to improve the quality of information (educational materials) provided by these centers, the technical and interpersonal practices employed by the paid and volunteer staffs of the centers in working with mothers and children, and the record-keeping and general administration of the centers. Where the centers are not supporting an outreach program to work with and educate families in their homes, they will be encouraged and assisted to establish such practices, in line with the Project analysis finding that in-home services are more likely to have lasting effects than treatments or lectures delivered in centers.

3. Content of Services

The key services to be provided by the Project are described here as they are expected to be delivered through the two methods by the end of the Project. Some of these activities are occurring now in some locations, but the full agenda described here is a vision of the future. A detailed presentation of the full range of tasks is provided in Annex 3.

In Growth Monitoring and Education the promoters or service center workers will weigh (and potentially measure) all infants and children under 5

years old and plot these measures on a growth chart which will be located in two places: the household of the participating family, and in the family health records that will stay with the promoter or center. This activity also encourages up to three or four meals per day for young children rather than the usual one or two (depending on the family's economic situation); educates mothers about the value of exclusive breast feeding (meaning only mother's milk) for the first four months of life and prolonged breastfeeding during weaning; and demonstrates preparation and conservation of proper weaning foods. The promoter will record (by family) indications of improved feeding practices (extended breast feeding, additional meals, foods added to diet). The supervisor will conduct spot checks on homes to see if feeding practices are changing, and check validity of promoter reports; recommend incentives or awards for promoters whose target families are showing notable progress; and once validated, summarize indicator data for area or regional management information system.

The Maternal and Child Health/Nutrition service includes maternal health/nutrition, infant and child nutrition, and food supplementation. In Maternal Health/Nutrition promoters identify pregnant women and monitor them for signs and symptoms of pregnancy complications such as edema or vaginal hemorrhage and refer complications to the nearest medical facility; refer pregnant women for regular prenatal check-ups at the nearest medical facility; educate pregnant women regarding personal hygiene and care of breasts during lactation, so as to reduce infant diarrhea; and suggest that pregnant women and mothers consume vegetables and fruit which are locally available and are often not eaten. They also teach mothers about the importance of increased fluid and food intake during lactation; and record information about the onset of pregnancy, medical or health problems reported by women, and referrals made. Supervisors coordinate the transfer of complicated pregnancy cases to rural clinics or hospitals, monitor households to determine whether required promoter tasks are being performed, arrange for retraining if necessary, and verify promoters' reports with clinics and spot checks with pregnant women, and summarize data for area managers.

With respect to Food Supplementation, promoters identify infants and children with moderate to severe malnutrition (Gómez II/III) and refer them to rural clinics or nutrition rehabilitation centers for food supplementation. They then monitor supplemental feeding of these malnourished children, and track and record growth/weight data on progress of children in rehabilitation, and on return home. The supervisors are to visit families systematically in the area of a promoter to determine through empirical methods whether the above tasks are being performed, and provide information on availability and proper distribution of PL-480 or other supplemental feeding to the families under their aegis through rural clinics or other facilities, should that become necessary.

When working on Diarrheal Disease Control (DDC), promoters treat diarrhea and other minor infections within their competency, distribute oral

rehydration salts (ORS) envelopes to families and child caretakers, identify signs and symptoms of acute diarrheal disease, and refer infants and young children with severe diarrhea and dehydration to clinics. They are also to educate mothers how to identify diarrhea per WHO standards (3 or more loose watery stools within 24 hours) and when to take their children to health professionals for care, and about basic causes of diarrhea and their relation to hygiene practice (i.e., handwashing, proper feces disposal, proper food handling and storage). A key task is to educate families in the preparation and use of oral rehydration therapy (ORT) solution, and to identify whether ORT was applied correctly during the last episode. Promoters are to note in the family records (preferably on the growth chart) the number of diarrhea episodes of each child under 5 years of age experience since the last home visit. Supervisors provide backstopping to ensure that harmful local traditional remedies are not being perpetuated by promoters as an alternative to ORT and perform outreach to mothers' clubs and local schools for teaching teachers and school children ORT use and diarrhea control principles. They summarize promoters' reports on diarrhea episodes and treatments (with salts or home-prepared remedies) after validation of reports.

Diagnosis, treatment and prevention of Acute Respiratory Infections (ARI) is a relatively new area for this country, and will require training of medical personnel, promoters and supervisors to recognize the signs and symptoms that distinguish between mild, moderate and severe cases of ARI. Delivery teams will record cases in the family record, and in severely ill ARI cases, refer them to rural clinics for treatment. The delivery teams and service centers will learn to teach families to recognize respiratory symptoms that require taking the child to medical facilities, i.e., fast breathing, noisy breathing, nasal flaring and cyanosis. They can administer simple treatment measures such as ORT solutions and aspirin for mild ARI cases, and help educate families regarding home treatment for mild and moderate cases of ARI such as continued breast feeding and/or feeding, hydration, humidifying the child's environment, home remedies and proper intake of antibiotics when prescribed. The effort also involves educating families regarding transmission and prevention of ARI, including their relationship with environmental factors such as crowding, especially at night and damp house sites and construction; and helping families to understand that some of the causes of severe, (and often fatal) respiratory infections can be prevented by immunizations, i.e., pertussis, tuberculosis, measles and diphtheria. The promoters will record reported or observed cases of ARI among families served. Supervisors will verify that the above measures are being properly carried out, and follow up on supply lines to assure that promoters have the minimum equipment and medicines necessary to treat mild ARI cases (i.e., aspirin, functioning thermometer, ORT packages, etc.)

Not all promoters and supervisors will provide all of these services or tasks at the outset of the Project. A phased program of skills development will be designed by the C/PVO to build up to the full array of services and education described above.

The following services will be provided in conjunction with the Expanded Program of Immunizations and the Family Planning Services Expansion Project. Those Projects will provide the necessary staff training in these skills. The Immunization activity will be aimed at achieving timely vaccination coverage in children under 5 years of age. The basic program of vaccinations includes BCG, DPT 1-3, Polio 1-3 and measles. Promoters will distribute vaccination cards in all households assigned to them. Alternatively, vaccinations will be accurately recorded in the appropriate space of the growth charts that will be left in the home as part of the work on Nutrition. Families will be taught to post them on their doors in plastic program envelopes. Each time any member of the family is vaccinated (either by a physician or by a campaign) they are instructed to present their card in order for the vaccination date to be recorded. If the family member does not have his/her vaccination card at the time of vaccination, the health professional will give a vaccination certificate that the family members will take with them to the home and place in the plastic envelope with their permanent vaccination card. At the time of the promoter's regular visit, he/she will enter the vaccination date in the appropriate cell of the permanent card, and in their own records for supervisors to summarize and pass on.

In disseminating messages on Birth Spacing, promoters will help mothers understand that short birth intervals are associated with low birth weight children, increased risks of the child deaths, and a less vigorous and sprightly mother, and encourage mothers to accept a minimal birth interval of two years. They will help mothers understand that breast feeding is not only important for their child's nutrition (discussed above), but also related to avoiding unwanted pregnancy, and counsel mothers on the availability of different methods of birth control, and the advantages and disadvantages of each one. They will distribute condoms and contraceptive pills to households that request them per program norms, refer women to clinics for all other birth control devices, and record or update regularly the birth control status of women of childbearing age. Supervisors will ensure the availability of condoms and contraceptive pills to promoters for distribution to local households, and summarize promoter data for area/regional reports.

4. Support Techniques

The Project will carry out simultaneously two techniques for providing support to the delivery modes and services described above. One is called rapid response, and the other is service improvement. In fact, both involve improving service delivery, but the first has a special purpose, which is to begin having impact in the short term in a few areas, without having to delay during the development of the more detailed programs of training, educational materials, and budget/commodity support that will be the core of the Project.

a. Rapid Response

Our institutional analysis has found that a number of PVOs are ready, with a minimum of carefully defined support, to participate immediately in the Project. Also, SESPAS has identified a number of child survival activities that could be accelerated or supported in the near term.

The child survival services that lend themselves to the rapid response technique are those that (1) are more widely known and practiced, (2) which do not require extensive inputs of technical training and materials, and (3) those that are already becoming operational under related projects (or for which training and educational materials already exist as a result of previous health/nutrition projects). These are nutrition education, ORT, immunizations, and child spacing.

For the PVOs, the kinds of support that are most needed (to be verified in the final Institutional Analysis report) are technical assistance in service delivery, training of staff, and educational materials. In a few cases, financial support is required for staff expenses or expendable supplies.

It is likely that a significant portion of the immediate support would be channelled to CARITAS and to affiliated organizations such as the Women for Barrio Rights project run by Sister Maria Coleman, a trained nutritionist. Her program, located in Santo Domingo, includes a heavy component of nutrition education based on local foods, organization of neighborhood youth and preschool teachers to weigh children in her Weighing and Consultation Centers, and other services of simple medicines and first aid for children. She would like to expand into more basic health services such as ORT, outfit more of her centers, and improve her educational program for mothers. With RD\$30,000 in funds or equipment/supplies she could extend to ten more neighborhoods with an upgraded program.

CARITAS's Applied Nutrition Education Program could be expanded early in CY 1988 by initiating operations in Barahona, expanding to an additional 40 communities in the San Juan/Azua area, and establishing a broader program in the Archdiocese of Santo Domingo (which includes rural and urban areas). The Diocese of Barahona has existing plans and partial funding to launch the ANEP program there, and could begin training of local supervisors and promoters in January. A good stock of educational materials has recently been built up under the program, but may need to be augmented. In the Southwest, CARITAS/ANEP training could also be attended by promoters from SSID, FUDECO, and parish-level PVOs with their own programs. Funds would be needed for supplementing staff salaries, incentives for volunteer promoters, and costs associated with training.

The institutional analysts have made a preliminary identification of 15 private organizations (9 in the Capital, and 3 each in Regions IV and VI) that would be candidates for early support.

SESPAS is working on the details of its National Plan for Child Survival (PLANSI), and will seek counterpart funding for that program, and accelerated support from the Child Survival, Expanded Immunizations, and Family Planning Projects in the following areas:

- o Training, beginning with key headquarters and Regional staffs in ORT, immunizations, and nutrition education;
- o Development of promoters' manuals and educational materials in immunizations and ORT; and
- o Training of Regional staffs (including promoters) in Child Spacing.

USAID will work with local consultants (using PD&S funds) to further specify the target agencies and resource needs that will constitute the Rapid Response, and with SESPAS to develop its plans and presentation to the Technical Secretariat for part of the planned counterpart amount. These activities will take place during the interim between the signing of the Grant Agreement with the TSP, and the selection and arrival of the C/PVO. Upon its arrival, the C/PVO team will validate these plans, and begin immediate action to provide resources.

This Rapid Response effort will be a gesture of good faith on the part of the Project, taking advantage of the best programs and existing resources that are in the field at this time. It is likely that these responses will be geared largely to service centers, in urban or otherwise accessible areas, where, with the removal of one or two constraints, and a minimum of training, a child survival service that is compatible with the aims of the project can be expanded or upgraded. It is estimated that 10 to 20 percent of the resources in selected budget categories will be applied in this technique (See Section III-D, Project Inputs).

At the same time, the C/PVO will be expected to mobilize rapidly to begin the more broad-reaching effort to improve services, described below.

b. Service Improvement: Supporting Technical and Administrative Services for Implementing Agencies

Service Improvement by the C/PVO will provide the service delivery providers with the following administrative skills:

- Capability to develop job descriptions, performance standards and a supervisory system;
- Capability to develop and conduct staff training

- Capability to develop and implement a program information, reporting and evaluation system;
- Capability to conduct program resources planning, including establishment and monitoring of logistics systems to assure an adequate amount of supplies at all points of delivery; and
- Financial management and controls.

In order to support and improve child survival services so that they are compatible with successful efforts in other countries, the C/PVO, an experienced and internationally recognized provider of health and child survival and Project management, will provide a range of supporting services to strengthen the delivery capabilities of SESPAS and the participating local PVOs who will carry out the implementing tasks. The C/PVO will be responsible for making sure that key supportive administrative functions are fulfilled in a timely way. In many cases, the C/PVO will carry out these functions by using its own personnel, and in other cases it may contract the function to other qualified organizations. These support functions are described below:

(1) Program Planning and Identification of the Target Population

The C/PVO will fill in the details of the needs assessment conducted for this Project in Regions IV, VI and the selected marginal barrios of Santo Domingo, to more precisely identify the target population for each child survival intervention, and to verify the numbers, location and accessibility of the persons who should be offered services under the Project.

Secondly, the C/PVO will verify and update the list of nongovernmental institutions which provide health or social services to communities in the Project area that was provided in the Project's Institutional Analysis. These institutions will be contacted to confirm their interest in participating in the Project. For those organizations that desire to participate and meet the criteria for participation, the C/PVO will solicit their program requests, and when necessary will introduce the entities to a program planning methodology which will permit them to define what child survival services they will offer, to whom, by what means, on what time schedule, with which resources and, finally, how the impact of the effort will be evaluated. Utilizing this sub-grant application process, the C/PVO will select the entities that will deliver services with Project resources. With SESPAS, the C/PVO will work primarily at the regional office level (with participation where essential of key headquarters staff) to determine action plans, staffing requirements, training needs, and other resource requirements to establish the initial program in the target regions. This plan will be the basis for SESPAS' request to the Technical Secretariat for budgetary support, including funds from the Local Currency Program.

(2) Developing Selection Criteria for Participating Institutions

There are three categories of institutions that are eligible to be service providers under a sub-grant arrangement with the C/PVO.

Category one consists of SESPAS, through the Executive Unit of the National Plan for Child Survival (PLANSI), which will be the principal provider in the Project. However, for SESPAS to receive funds under the Project, it must present to the Project Executive Committee and the Technical Secretariat the program plan cited above. The plan will have to meet the criteria established by the Executive Committee with advice from the C/PVO.

Category Two consists of PVO providers that have a substantial service delivery network and staff capable of delivering the interventions proposed by the Project. These PVOs will be eligible to receive Project resources and TA under a sub-grant with the C/PVO. Category Two PVOs that meet the selection criteria will be assisted through access to the Project's training programs, technical assistance, educational materials and some funds for improved operations.

Category Three PVOs are small provider organizations who, once they meet the selection criteria, will have access to the Project's training facilities, educational materials and technical assistance. However, funds will not be provided to these PVOs.

The C/PVO, in consultation with the Executive Committee and USAID, will develop criteria for selecting participating provider organizations. For instance, illustrative criteria for a Category Two private provider might include:

- Have a service delivery capacity of paid or volunteer workers at the community level to implement at least one child survival intervention;
- Have a service population of at least 500 households;
- Work in the geographic area covered by the Project, preferably not in some area covered by other providers;
- Have a core staff capable of preparing a program plan, with TA from the C/PVO, and implementing the plan according to the agreed upon schedule;
- Have data collection capacity and formally agree to participate in the Project's information system; and
- Meet A.I.D. standards for accounting, reporting and financial controls.

(3) Contracting for Support Services, Including Procurement of Project Equipment.

In addition to utilizing its own personnel, the C/PVO may subcontract for services using USAID approved contracting procedures. For instance, the C/PVO may wish to contract for the development of training materials or mass media educational messages. The C/PVO will also be expected to procure most Project equipment and supplies (except for those needed immediately upon the C/PVO's arrival, which USAID might procure in advance), arrange shipping and conduct in-country arrival checks, inventories, storage and distribution to end users. (See Annex 9, Procurement Plan).

(4) Provide Technical Assistance and Information.

The C/PVO shall provide technical assistance and information to the implementing agencies or subgrantees in the following health and administrative areas:

- o Diarrheal disease control, maternal/child nutrition, and infectious respiratory diseases;
- o Health services planning, programming and budgeting;
- o Training methods, curriculum development and development of training materials;
- o Management information systems and evaluation;
- o Social marketing and mass media publicity and users education;
- o Self-financing mechanisms for program sustainability;
- o Commodity procurement; and
- o Supervisory systems.

Technical assistance will be provided by a combination of long term C/PVO personnel and short term advisors. TA from relevant centrally-funded Project such as PRITECH and HEALTHCOM will be requested as needed. (See Annex 8, Technical Assistance Plan).

The C/PVO will provide up-to-date technical information on the specific interventions promoted by the Project by means of in-service training programs, technical bulletins, or other means they may devise.

(5) Developing and Producing Educational Materials

Educational materials will be developed under the supervision of the C/PVO to explain the value and use of each of the services to be

delivered by the Project. The Project will draw upon already developed and tested materials whenever possible, particularly the growth monitoring educational materials prepared by CRS and Caritas Dominicana in the Applied Nutrition Education Project. New materials will be developed as needed based on an assessment (which will be conducted during Phase One of the Project) of existing materials in the DR and elsewhere.

In all cases, the educational materials will be developed using social marketing criteria, tested and put into final before broad scale training of the promoters and supervisors. The materials will be designed to prompt the promoter to deliver uniform messages that will assist the listener to adopt the desired improved health behaviors. By making the materials available to the promoters and supervisors during training, they will have ample time to practice, receive coaching and gain confidence in the use of the materials before returning home. In the development of the educational materials, the C/PVO will either carry out the task with its own personnel or subcontract the function with a qualified firm.

(6) Designing and Implementing Staff Training

Training of staff to carry out the Project will be directed at three major groups: (1) health workers and their supervisors, (2) medical personnel (mainly from SESPAS) who will be providing curative and support services to the community health workers and their clients, and (3) administrators of health programs in the private and public sectors who will participate in the Project.

As each of these trainee groups has different needs and points of departure due to their prior training and experience, they will be trained through different systems, under the direction of the C/PVO. The common elements in the training will be (1) basic content regarding child survival technology, (2) training methodology which emphasizes hands-on, adult learning techniques rather than extensive lecturing or reading requirements, and (3) training in program organization, supervision and administration which will assure the trainees' familiarity with their role in the overall delivery system. Wherever possible, staff of public and private agencies will be trained together, assuring uniformity of content of messages, and offering an opportunity for improved field coordination and sharing of experience.

The content will be developed in a set of training materials that carry forward in learnable modules the basic messages and treatments of the program in each intervention or type of service. For the training directed at medical personnel, the materials and methods will be developed in cooperation with the Dominican Pediatric Society, following an assessment of the present state of knowledge and practice among doctors and nurses treating infants, and children, as well as obstetricians/gynecologists treating expectant and lactating mothers.

The training for health workers will be developed in cooperation with the training arm of SESPAS (CENACES) and the training staffs of the principal PVOs involved in public health. The courses will be ongoing, building on what had been previously taught to the various health staff. Initial training will last approximately 1 to 2 weeks followed by courses every 3 months of 1 to 3 days. At each successive session, additional topics will be learned, or more depth of information and skill will be imparted in topics already covered. In addition to imparting new skills and knowledge, the staff training program will also serve to monitor and supervise program implementation. These periodic training sessions will also serve as a focal point to discuss program implementation problems and allow trainers to evaluate health personnel progress in absorbing and utilizing information given to them. Additionally, the supervisors of promoters will receive special training to equip them with the skills to deliver training sessions directly to their promoters and community groups as well as perform on the job training with the promoters.

The C/PVO will develop a cadre of lead or master trainers, based on assessments and observed performance. These lead trainers will work with each training organization (with frequent tests with the trainee groups) to prepare training methods and content modules. The lead trainers will in turn train other trainers within the implementing agencies. The ultimate objective is a training network which continues within each executing agency, using a consistent set of materials and training methods. The C/PVO will be responsible for setting up the system, bringing in subject-matter specialists as well as advisors in training methods and materials. As the training system is established and beginning to be extended, the C/PVO will conduct periodic assessments to ascertain whether the content and methods are being maintained, whether modifications are required, and whether content and methods are being transferred as efficiently and effectively as expected.

One of the most challenging efforts of the C/PVO will be to establish a standard of content and methods during the start-up period, to develop and test the approach and begin selection and training of trainers, and then to expand the coverage of the system without sacrificing quality. Consistency and quality of training will be one of the key instruments in the success of this Project, and the ability to quickly mount a large-scale effort will be a key measure of the C/PVO's performance.

(7) Upgrading Supervisory System.

The C/PVO will assist SESPAS and the participating PVOs to improve their supervision of community-based workers. The supervisory system will be designed and instilled in the field staffs to provide coaching and on-going, on-the-job training of promoters. Building on clear job descriptions and lines of communication, the supervisory system will establish work performance objectives for workers at each level. Evaluation of worker

performance will be based upon an information system that tracks the effects of the program on the target population in terms of improved health. In other words, each promoter will be evaluated, among other things, according to the degree to which the population under his/her jurisdiction conforms to the health behaviors stressed by the program (i.e. children with immunization cards up-to-date, mothers who breastfeed and limit the use of bottle, etc.). Thus, information obtained through the Project MIS will be reviewed to determine which service delivery workers are (or are not) performing within the accepted norms of the program.

To strengthen their performance, as suggested in the "Lessons Learned" (See Annex 3), supervisors' basic supervision skills will be enhanced, including ways to motivate workers to perform better.

In the SESPAS rural health delivery systems, community-level supervisors are located at or near rural clinics and are responsible for supervising 6-10 promoters, depending on geography and population density. Under this Project, a "delivery team" concept will be established, utilizing the community level supervisors and promoters as the basic work team. The performance of individual promoters will be combined to determine the performance of the team as a whole, thus permitting a comparison of performance among teams. Different incentive systems which reward high quality performance will be tested as part of Phases Two and Three of the Project.

Lastly, to assist supervisors to perform their job responsibilities, several alternatives will be examined to assist them in buying motorcycles, instead of donating vehicles to them, with its well known consequences. The Project will test alternative funding schemes that promote operator responsibility and vehicle longevity.

(8) Designing and Organizing A Logistics Support System

The purpose of the logistics support system is to assure a smooth flow of equipment, supplies, and other support materials through the health delivery system. Beginning in Phase One, the C/PVO will carry out the initial major procurement of Project equipment and supplies. Included in this procurement will be office equipment for the C/PVO, supplies needed to develop training and educational materials, vehicles and work related equipment for field staff, such as scales for weighing of children in the growth monitoring component of the program (See Procurement Plan in Annex 9). Once the initial procurement orders have been placed, the C/PVO will set up a logistics system for receiving, inventorying, storage, and distribution of Project equipment and supplies. The system will establish a central storage area and assure timely delivery of supplies to participating agencies, who will be charged with the responsibility to assure that community level workers receive the necessary educational materials, reporting forms, scales and ORT supplies for their daily work.

Since training is a major function of the Project, the logistics system will make sure appropriate training sites are selected and that transportation and living costs reach the participants in a timely basis. The C/PVO, in coordination with the Health Systems Management project team, will work with SESPAS to establish a well-controlled yet responsive mechanism at the Regional Offices to make payments for approved expenses to all individuals being trained under the project. This will be a covenant of the Grant Agreement, with a time limit of 120 days after signing the Agreement.

(9) Designing and Implanting an Information and Reporting System.

The information and reporting system will be developed with TA from the C/PVO and will provide information in two broad areas: health actions and impact, and administrative support. Administrative support information systems include financial accounting and reporting, procurement status and receiving reports, inventory of properties, status of Project supplies, and vehicle use and repair. There is ample experience in the development and functioning of these reporting mechanisms which shall be instituted by the C/PVO in consultation with USAID and other user groups.

The health information system will be an integral part of the overall health system. The information system will provide timely information relevant to each service delivery level in the program, starting with promoters and supervisors, and rural clinics and other service delivery centers, and regional offices and ending with decision makers at the central or national level. Unlike many information systems that have been reviewed for inclusion in this Project, the proposed information system will be designed to reinforce the family, promoter and supervisory behaviors stressed by the Project. For example, mothers will be instructed on the use and importance of their child's growth chart and immunization record giving them the necessary knowledge to take corrective action when a child stops gaining weight. A record of promoter visits to the family will be maintained in the home so that it is accessible to the supervisor for review. Family records will be simplified so as to permit the promoter to record major interventions and highlight the next scheduled events, i.e., immunizations due and prenatal checkups for pregnant mothers. Like the growth chart which indicates the growth of a children to a mother, the family records will give the promoter a health status profile of all the families under her jurisdiction.

The following is a proposed list of minimum health information and reporting instruments that will be managed by the promoter. The promoter will be introduced to each instrument during his/her training and supervisors will reinforce their application during scheduled supervisory visits.

The promoter will prepare a Community map showing each household, major public buildings (clinics, schools and churches), roads and paths, and resources, such as water pumps, garbage dump and irrigation

canals. The map will help the promoter visualize her service area, the location of his/her clients, and will allow her to plan her visits. The map will be used to identify households with children under the age of 5, pregnant mothers, malnourished children and others who need special attention from the promoter.

The promoter will establish and maintain a Family Health Record system consisting of at least the following information: name and birth date of every family member residing in the household, years of education, immunization status and date of vaccination (for each targeted vaccination), parity of all women of child bearing age, pregnancy status of women of child bearing age at the time of the visit, family planning method, date of last pap smear, certain environmental and socio-economic information (e.g., type of sanitation and water system, connection to electricity and gas lines, radio/TV in the household). Accompanying this record will be a duplicate copy of child growth charts of the family. This record will accompany the promoter when a house is visited. These data are among the most important for the Project in that they form the basis for program monitoring and evaluation.

A Vital Events Register will also be maintained by the promoter. Births and deaths will be reported in the information system as they occur.

The promoter will complete a Promoter's Activity Report on a monthly or quarterly basis summarizing his/her activities, vital events, and the health status of the families in the catchment area. At the family level, growth monitoring cards, immunization record cards, and promoter home visit card will be kept.

The Supervisor will receive the Promoter's Monthly or Quarterly (to be determined by the C/PVO) Activity Report, compile and compare the information for his/her impact area and forward the information to the regional level. Promoters who report performance within or above the acceptable norms will be congratulated and those who fall below the norm will be visited more frequently to rectify the problems encountered.

The C/PVO is encouraged to consider the introduction of computers to facilitate the processing of this volume of information. Computers when applied to data processing similar to what is proposed here, are known to save time, reduce errors and save money in the long run. Before the information system is computerized, the C/PVO will present to USAID the results of a feasibility study which assesses the contribution of the computer compared to a manual system in terms of cost, speed, operator personnel and long-term maintenance.

Another key element of the Project's information system will be a bi-monthly newsletter to be distributed to all persons and organizations working in any way with the Project. The purpose of the newsletter is to

diminish the isolation often experienced by field workers who do not have the opportunity to understand how the work that they do contribute to a large health improvement effort. By highlighting outstanding performance, the newsletter will provide an incentive for other supervisors and workers to follow. Also, the newsletter will provide updates on technical information presented in simple form. Using a newspaper-like format, the newsletter will have feature stories, recipes for low-cost nutrition meals, training schedules and other administrative information, and ample pictures of familiar places and people engaged in child survival activities.

(10) Designing and Overseeing an Evaluation System

Building upon the data available through the information and reporting system, the C/PVO will design and oversee an evaluation system that complies with A.I.D.'s Health Information System requirements for child survival Projects. Under this recently developed system, Tier I information will be made available from the Project Information and Reporting System described in the section above. However, until the information and reporting system has proved reliable on a broad scale, the Project will estimate Tier I information through a sentinel or sample site information system. This system will be phased out as the Information System becomes operational. Tier II information, which deals with health service delivery coverage and the quality of those services, will be addressed to some extent by the Information and Reporting System. However, special studies will be conducted to verify this data through observation and interviews. It is contemplated that these studies will be carried out by CENISMI, a Dominican research group with ties to SESPAS and the Robert Reid Cabral Children's Hospital of Santo Domingo.

A process and impact evaluation is scheduled at the mid-point of the Project (1989). Based on this evaluation, Project management or design modifications can be made. Also, based on the findings, additional funds may be requested to allow replication of the Project in other regions of the country. Tier III information, which deals with demographic indicators and effects of the program on these, will be conducted at the completion of the Project through an updated Demographic Health Survey.

The final evaluation will follow the AID Evaluation Supplement to Handbook 3, as well as answer the information requested by A.I.D.'s Health Information System. An extended Lessons Learned section of the PES will be developed for sharing the experienced gained under the Project with other A.I.D. Missions that are planning or operating similar Projects.

(11) Operational Research

Operational research will be carried out by the C/PVO through CENISMI and in coordination with participating institutions. Some operational research will be conducted before implementation of certain Project

activities. Other research, focusing on technical, managerial and administrative aspects of the Project, will be carried out under normal conditions and within the context of the program.

Specific topics to be addressed will be determined during Project implementation, depending on Project needs and priorities at the time. In this way, the operational research component will not only supply the Project with needed information to meet the Project's objectives, but will also encourage both professional and auxiliary personnel to develop a critical approach regarding Project implementation and eventual Project modification. More practical recommendations and solutions are expected as a result of the Project staff's direct involvement.

Examples of types of research that might be conducted are: knowledge, attitudes and practices of the community and local health personnel regarding acute respiratory ailments; cost effectiveness of the program; nutritional enrichment of oral rehydration packets and home solutions; and alternative incentives for community health promoters.

The matrix on the following pages illustrates how the key functions and resources will be applied in each of the child survival services.

(12) Expanding Mass Media Publicity.

To create awareness and increase utilization of the services offered by the Project, the C/PVO will develop on its own or under contract three forms of mass media publicity: posters, newspapers articles, and radio and television spot educational messages. At least one poster will be developed to support each of the major interventions in addition to posters that encourage support for the community health worker or promoter as a person families can depend upon to improve the health of their children. Well placed newspaper articles will inform decision makers of the Project, its purpose and accomplishments. While radio and TV educational messages will encourage use of the Project's services stressing the importance of immunization, breast feeding, prenatal care and birth spacing, all educational messages and publicity will be designed using social marketing techniques and post tested to verify comprehension by the intended audience.

(13) Building and Maintaining Linkages with Other PVO and Donor Activities Including Peace Corps.

USAID is aware of the availability of considerable resources from PVOs and other agencies for child survival activities during the next few years. Not only have the major donors been identified, but also, by means of the institutional analysis, a sizable number of PVOs and community development entities that deliver health and social services in the target area have been catalogued. To make maximum use of the resources available through the Project and those in the hands of existing groups, coordinating

committees will be established at the central and regional levels of the delivery network. At the central level, the Project's Executive Committee to coordinate activities between the major partners including the SESPAS, the C/PVO, USAID and the major PVOs, such as CARE, CRS, and FUDECO. Also, the C/PVO staff will maintain technical liaison with the child survival activities to be initiated by UNICEF and PAHO. By means of the International Health Donors' Committee in Santo Domingo, UNICEF, PAHO, IDB and A.I.D. already meet to share information on future investments and plans that affect members' programs. This donor forum is expected to continue for the life of Project.

At the regional level, the Regional Coordinating Committee will contain representation of the major implementing private and public sector providers and will serve as a body to facilitate implementation of Project activities.

Both the Executive and Regional Coordinating Committees will receive regular reports from the Project's information system. Any difficulties in implementation will be openly discussed and resolved.

The Peace Corps program in the DR has been involved in this Project from the beginning of its design and Peace Corps Volunteers (PCVs) have participated with the collection of background information. Given the fact that the Peace Corps in the DR is already involved in child survival activities, the C/PVO and the implementing organizations will be encouraged to seek PCV participation in the Project. Health volunteers can serve in a wide variety of service delivery and administrative roles imparting skills to their counterparts.

Child Survival Project
Summary Activities Matrix

Function or Resource	Child Survival Service				
	Maternal-Child Health and Nutrition (MCH/N)	Diarrheal Disease Control (DDC)	Acute Respiratory Infections (ARI)	Birth Spacing (BS)	Immunization (IM)
Training	Community Health Workers (CHW); Supervisors (SUP); Medical Personnel (MP); Administrators of Health Programs (Admin)	CHW; SUP; MP; Admin	CHW; Sup, MP; Admin	Coordination and integration with Family Planning Project training	Coordination and integration with SESPAS' EPI Program training
IEC (Information, Education, Communication)	Social Marketing (SM); Mass Media; Individual Counseling (IC)	SM; Mass Media; FIC; Oral Rehydration Units (ORU)	SM; Mass Media, IC	Coordination and integration with Family Planning Project	Coordination and integration with SESPAS' EPI Program
Logistics	Equipment (Scales) distribution and maintenance; educational material distribution; vehicle maintenance	ORT Distribution (to be coordinated with SESPAS, UNICEF and private sector); educational material distribution; vehicle maintenance; establishment and upkeep of ORU	Equipment (thermometers) and medicine distribution (aspirin for CHW; antibodies for MP); educational material distribution; vehicle maintenance	Coordination and integration with Family Planning Project	Coordination and integration with SESPAS' EPI Program

Child Survival Project
Summary Activities Matrix

Function or Resource	Child Survival Service				
	MCH/N	DDC	ARI	BS	IMM
Commodities	Vehicles, scales; educational materials; reporting forms; PL-480 commodities	ORS packets to be provided by SESPAS, UNICEF and the private sector; Oral Rehydration Unit commodities (rocking chairs, limited kitchen utensils) to be supplied by SESPAS, UNICEF and the private sector	Medicines (antibodies, aspirin) to be provided by PVOs, private sector, UNICEF and SESPAS; educational materials; equipment to be supplied by private sector and SESPAS	Supplied through Family Planning Project	Supplied by EPI Program
Technical Assistance	Project to provide approximately one person/month of short-term TA in each area of service. In addition, Project to utilize centrally funded short-term TA (PRICOR, HEALTHOOM, FRITECH, Nutrition Projects, etc.); long-term TA to be provided by C/PVO including a specialist in Epidemiology.			Project will coordinate with Family Planning Project TA and use centrally funded TA.	Project will coordinate with EPI program and PAHO TA.
Monitoring and Evaluation (M-E); Operational Research (OR)	OR to be determined by C/PVO; M-E to use A.I.D. Child Survival Tier I, II, III M-E Core Indicators			To be coordinated with Family Planning Project, OR, MIS and DHS	To be coordinated with SESPAS, EPI, MIS

MCH/N = Maternal/Child Health/Nutrition
 DDC = Diarrheal Disease Control
 ARI = Acute Respiratory Infections
 BS = Birth Spacing
 IMM = Immunizations

D. Project Inputs

This section provides a summary of the principal inputs for the Project. Additional discussion and tables related to the financing of the project are in Financial Analysis (Section V-E), and in Annex 10.

1. A.I.D. Resources for Project (US\$4,652,000)

a. Project Administration (US\$2,144,000)

The C/PVO will be expected to provide a project management and technical assistance team that includes three groups: (1) resident expatriate manager/technicians; (2) short-term subject matter specialists, and (3) locally hired technicians and administrators. Each group is discussed below, followed by mention of other professional services that will be needed on-site.

(1) Resident Expatriate Staff

This will include a Chief of Party (42 person/months), acting essentially as the Project Director, and reporting to the Executive Committee. This person will be a manager based in Santo Domingo, with overall technical coordination responsibilities to oversee design, planning, and content matters. Two Regional Child Survival specialists (42 person/months each) will also be part of the resident team, to be based in Regions IV and VI. Each member of the resident staff will work on the Project for 42 person-months.

(2) Short-term Specialists

Short-term expertise is expected to be required in the following areas and levels of effort:

Training Methods and Curriculum Development (6 person-months): This individual will work on establishing the training system, including the identification and retraining if needed of lead trainers to conform to the training approach and scope of training activities demanded by the Project.

Training Materials Development (4 person-months): Working with the methods/curriculum specialist, this person will provide guidance to the in-country training team in developing training materials for each of the target groups of trainees.

Management Information/Evaluation (6 person-months): This expert will advise all participating entities on the design, operation, appropriate use of electronic data processing, and uses of a management information system that supports operational research, management decisions, and evaluation requirements.

Mass Media/Publicity (4 person-months): This person will help to develop public information campaigns in various media, logos and other means of identifying the project and its messages, and giving them wide exposure.

Child Health (3 person-months): This person will augment the expertise of the resident team, being a source of current knowledge of solutions to special problems that may arise in relation to ORT, nutrition, infectious diseases, and related matters.

Procurement/Logistics (1 person-month): This individual will provide support in the design of the logistics system, and backstop the procurement efforts of the Project.

(3) Local Staff

We anticipate that the C/PVO will require the services of the following locally recruited personnel:

Financial/Procurement Management: This person's job is to control the project accounts, and advise PVO's on financial management; and to supervise and track procurement activities. Working for this person will be one fulltime accountant, a half-time auditor, and an administrative assistant.

Clerical and other Support: The C/PVO will require at least two secretaries/typists (one bilingual), and a messenger/driver.

In addition, the C/PVO will require a number of other specialized services for significant periods of time, including those of senior trainers, materials developers and producers, and information system/computer specialists. The C/PVOs applying for assistance will be given the option of engaging these services by the method they see as being most cost/effective, whether as additional staff, under individual purchase orders, or through organizational subcontracts.

Other inputs to be financed by these funds include the USPSC Project Manager, evaluations, and audits.

b. Service Delivery (US\$2,508,000)

(1) Rapid Response

The A.I.D. resources that will be provided to selected agencies immediately on project startup total US\$487,000, allocated as follows:

(a) Commodities (US\$311,000)

These funds will be primarily used for advance purchase by USAID of all project vehicles, and scales to weigh children, and miscellaneous light field equipment or office equipment for PVOs.

b. Educational Materials (US\$121,000)

These funds will be used to print existing educational materials, principally from the ANEP, for use by existing PVO and SESPAS nutrition teams.

c. Budget Support (US\$40,000)

Grants will be made to selected community-level PVOs, and to larger ones like Caritas and FUDECO to finance promoter expenses and planned service expansion of selected activities.

d. Training (US\$15,000)

Short intensive training will be given to service center staffs and promoters in proven existing technologies, such as growth monitoring, ORT and breastfeeding.

(2) Service Improvement

The major, long-term effort of the C/PVO working with the delivery system will utilize Project resources totalling US\$2,021,000 in the following manner:

(a) Training (US\$1,262,000)

Approximately 4,000 persons will be trained under the project, including 1,500 promoters and 1,400 medical personnel and other health practitioners. A.I.D. funds will be used for development of the training program and related training and educational materials, payment of lead trainers to test the training design and train other trainers, and social marketing/mass media campaigns.

(b) Commodities (US\$143,000)

Included here are the computers and word processors for the MIS and training materials development activities, audio-visual equipment, growth monitoring records, cassette players and supplies for use by promoters.

(c) Budget Support (US\$360,000)

These funds will be to support incremental cash requirements of PVOs applying for subgrants. Based on submitted proposals, these subgrants will be used for limited additional staff, consultant help, stipends or other expenses for for volunteer workers, etc.

(d) Management and Evaluation Information (US\$256,000)

While many of the resources identified above will have institutional strengthening effects, particularly the training, the funds allocated here are primarily focused on a key management and evaluation tool for the project, the community-based management information system. These funds will be used for technical assistance and supplies to be used in data collection and analysis.

2. GODR Resources for Service Delivery (the equivalent of US\$3,350,000)

a. Rapid Response

The GODR will allocate the equivalent of US\$187,000 of counterpart funds as follows:

(1) Training (US\$82,000)

This will be used to begin training Regional SESPAS personnel in the approach and content of the program.

(2) Budget Support (US\$105,000)

These funds will be used primarily for supplies related to the services to be provided immediately, mainly ORS and medicines for AKI.

b. Service Improvement

The GODR will dedicate the equivalent of US\$3,163,000 to the program, allocated as follows:

(1) Training/Social Marketing (US\$1,168,000)

Counterpart funds will finance the per diems of trainees, and expenses of trainers (including specialized training of medical personnel by the Dominican Pediatric Society) for the training mentioned above, and contributions of time or space by local media to the social marketing activities.

(2) Budget Support (the equivalent of US\$1,995,000)

This includes the counterpart contribution from the Local Currency Program to support SESPAS expenses directly related to this Project, and estimated in-kind contribution of promoters' time, space to hold training workshops and conferences, etc.

The Tables on the following pages show the budget of the Project displayed in accord with the major activities, and a summary budget by inputs.

TABLE 1
CHILD SURVIVAL
SUMMARY BUDGET BY MAJOR ACTIVITY

INPUTS	AID			COUNTERPART			GRAND TOTAL
	FX	LC	TOTAL	LC	IN KIND	TOTAL	
<u>Project Administration</u>							
Techn. Assist.	1,318	576	1,894				1,894
Evaluations	100	100	200				200
Audit		50	50				50
	<u>1,418</u>	<u>726</u>	<u>2,144</u>				<u>2,144</u>
<u>Service Delivery</u>							
<u>Rapid Response</u>							
Commodities	309	2	311				311
Educ. Materials		121	121				121
Budget Support		40	40	55	50	105	145
Training		15	15	82		82	97
Subtotal	<u>309</u>	<u>178</u>	<u>487</u>	<u>137</u>	<u>50</u>	<u>187</u>	<u>674</u>
<u>Service Improvements</u>							
Training:							
Salaries and Perdiem		286	286	1,143		1,143	1,429
Educational material		916	916				916
Social Marketing		60	60		25	25	85
Commodities	120	23	143				143
Budget Support		360	360	1,045	950	1,995	2,355
Mgt & Eval. Info		256	256				256
Subtotal	<u>120</u>	<u>1,901</u>	<u>2,021</u>	<u>2,188</u>	<u>975</u>	<u>3,163</u>	<u>5,184</u>
TOTAL	<u>1,847</u>	<u>2,805</u>	<u>4,652</u>	<u>2,325</u>	<u>1,025</u>	<u>3,350</u>	<u>8,002</u>

1
2
1

50

Table 2
CHILD SURVIVAL
SUMMARY BUDGET BY INPUTS
(US\$000)

Grand Inputs	A. I. D.			Counterpart			Grand Total
	FX	LC	Total	LC	In Kind	Total	
Technical Assistance	1,382	832	2,214				2,214
Training	56	1,403	1,459	1,225	25	1,250	2,709
Commodities	309	20	329				329
Budget Support (Subgrants)		400	400	1,100	1,000	2,100	2,500
Evaluation	100	100	200				200
Audit		50	50				50
TOTAL	<u>1,847</u> =====	<u>2,804</u> =====	<u>4,652</u> =====	<u>2,325</u> =====	<u>1,025</u> =====	<u>3,350</u> =====	<u>8,002</u> =====

IV. PROJECT IMPLEMENTATION

A. Organization and Implementing Responsibilities

This section focuses on the role of each participant in the program including USAID, the coordinating PVO, executing PVOs, SESPAS central level and regional offices, and other GODR organizations. The chart on the following page illustrates the organization of the Project.

USAID will review the proposals received from qualified PVOs interested in being the coordinating PVO. Their proposals will refine and flesh out the major design elements discussed above. USAID, in consultation with the GODR, will select the C/PVO from the applicants for assistance. A PSC Child Survival Specialist will function as Project Officer in the Health and Population Division to monitor the action plans and implementation by the C/PVO of the Project. This individual will participate in planning, meetings of key committees, and operational research and evaluations.

The Coordinating PVO will have detailed design and operational responsibility for all Project components under a cooperative agreement with A.I.D. that allows for substantial involvement by A.I.D. in reviewing/approving staffing, subcontracts, plans, and training or educational materials.

The Executive Committee consisting of SESPAS and local PVO representatives will serve as an advisory board to the project and Coordinating PVO. Its function will be to review and advise on implementation plans for the entire Project, and Project budgets. They will oversee implementation, attempt to resolve conflicts between the parties and suggest corrective actions.

Implementing PVOs will be subgrantees or receive in-kind support to carry out the field services of the Project.

SESPAS will implement services in the selected regions with their own budget and local currency counterpart resources, supplemented by the technical advice, materials, and training support offered by the C/PVO.

Community groups, health committees, church groups, mothers' clubs, will help to promote the program, with assistance from PVO and SESPAS promoters and supervisors, and receive education and other services from the Project.

The chart on the following page illustrates the Project structure.

B. Implementation Plan: Schedule of Principal Events

Phase I - Rapid Response and Installation of C/PVO (Months 0 - 6).

During this phase, USAID will assist SESPAS and the PVOs to carry out a series of activities to deliver child survival interventions in a short time frame. These actions will build upon the existing capabilities of the participating organizations. USAID will also select the C/PVO. The following tasks will take place:

1. Project Authorization signed (USAID) September, 1987
2. Project Agreement signed (USAID) September, 1987
3. Issue Request for Application to Int'l PVOs (USAID) October, 1987
4. Issue PIO/C for initial procurement (USAID) October, 1987
5. Contract local firm to prepare rapid response programs with PVOs October, 1987
6. Organize Executive Committee October, 1987
7. Prepare Coop. Agreement (USAID) November, 1987
8. Contract CS Advisor (USAID) November, 1987
9. Deadline to receive C/PVO applications November, 1987
10. Review and select C/PVO (USAID) December, 1987
11. Review rapid response proposals submitted by SESPAS and PVOs December, 1987
12. C/PVO Long Term Staff arrive; Est. office, hire local staff Jan-Feb, 1988
13. C/PVO to fund rapid response programs February, 1988
14. ST TA arrives to work with SESPAS & PVOs to:
 - Complete definition of interventions
 - Establish implementation plan
 - Finalize TA, training and procurement plansMarch, 1988

Phase II - Service Improvement Start Up

(Months 7-10)*

During this phase the rapid response actions will be implemented with funding provided through the C/PVO. The C/PVO will also begin work on the longer term service improvements:

1. Issue Procurement No. 2 (C/PVO) March, 1988.
2. Assess SESPAS and PVO information, logistics, and supervisory systems. March, 1988.
3. Provide TA to PVOs and SESPAS in program planning/application for subgrants of AID and LC funds March, 1988.
4. Est. information, logistics and supervisory systems. March-Dec., 1988.
5. Development of field test and reproduce training and educational materials for staff and beneficiaries March-Dec., 1988
6. Develop mass media education/publicity campaign material April, 1988
7. Finalize implementation plan for services and training delivery in Reg. IV, VI and Santo Domingo. April, 1988
8. SESPAS and PVOs to make formal application for project and LC subgrants April, 1988
9. Select training centers April, 1988.
10. PVOs and SESPAS to select and pre-test supervisors and promoters for training May-June 1988

Phase III - Service Improvement Implementation

(Months 11-48)

This phase is dedicated to the in-depth training and retraining of provider personnel in all interventions in a sequential manner. Personnel will receive full sets of equipment and education materials to be fully functional. Support systems will be installed and working

1. Commence in-depth training of provided staff July, 1988

2. Distribute support materials July, 1988
3. Implement information, logistics and supervisory systems July, 1988
4. Complete implementation of the administrative improvements proposed by the Health Systems Management project in Regions IV and VI August, 1988
5. Conduct mid-term evaluation Sept - Oct., 1989
6. Develop plans for replication in new health regions. Oct - Nov., 1989

Phase IV - Program Expansion

To be determined by Project evaluations and funding available.

C. Project Monitoring/Evaluation are discussed in some detail above in the Service Improvement Section. The C/PVO will be expected to develop a more detailed evaluation plan for USAID approval.

D. Conditions, Covenants and Negotiating Status

The initial grantee will be the Technical Secretariat, which has agreed in writing to appoint USAID as its agent to manage the AID funds, most of which will be dedicated to the Cooperative Agreement with the C/PVO. Under this arrangement, there is no need for conditions precedent, other than a legal opinion and the appointment of a TSP representative to participate in the Executive Committee. The Government of the Dominican Republic should covenant to support for child survival, and agree:

1. To promptly approve, provide adequate budgets and allocation of local currency to all participating public and private agencies during the life of Project period;
2. To establish within SESPAS no later than 120 days after signing this agreement a decentralized revolving fund arrangement in the selected regions that will allow for timely payment of support costs for field personnel.
3. To allocate, by year 3 of the Project, sufficient operating funds from the SESPAS budget to sustain recurring costs of materials and maintenance of equipment in the target regions. The Health Systems Management Project within SESPAS can assist in the design and establishment of this mechanism.

V. PROJECT ANALYSES

A. Technical Analysis: Key Factors in Child Mortality and Morbidity and Preferred Interventions

This section provides a description of the key factors affecting child survival and how they interact, and of the technologies that are most frequently and feasibly applied to these factors and will be applied in this Project.

1. Malnutrition and Infection: The Vicious Cycle

Health for a child starts before birth. The birth weight (B.W.) of a child is the most important factor in its chances for survival. Those infants born with low B.W. of less than 5.5 pounds (2500 gms), experience higher mortality through the first year of life and beyond.

A poor nutritional state of the mother, both before and during pregnancy, is the most common cause of low B.W. of an infant. A women's nutrient and caloric needs rise during pregnancy and increase further when breast feeding. Therefore, a women who does not allow her body to recover from the nutritional loss has handicapped the life of her newborn from the start. This, along with numerous pregnancies and short birth intervals, are important risk factors for low B.W. babies.

Nutrition plays a major role in the survival of a child during the 4-6 month period between birth and the weaning period when supplementation of breastmilk begins. It is at this time that breastfeeding is of major importance. During this time period the birthweight will double, as all internal organs grow and develop. This is the most critical time of a child's growth process, when health is very sensitive to interruptions due to either inadequate nutrition or infection. Breastmilk particularly aids in providing a balanced diet and natural protection from diseases. Breastfeeding is essential. Infants who are weaned early or never breastfed at all are at significantly higher risk of illness, malnutrition and death.

Beyond the age of 6 months, breastfeeding alone will not meet the nutritional needs of an infant, as most nutrient needs double. Change in body organs during this time and an increased exposure to outside environmental factors all play a part in the basic readiness and need to accept solid foods. The new supplemental diet introduces the child to common contaminants in foods and water, while greater mobility brings him in touch with a range of new diseases carried by children and adults. Also, the passive immunity inherited from the mother has begun to decline. As a result, the weaning period is marked by frequent illness. These illnesses include both respiratory and diarrheal diseases, as well as the major childhood contagious diseases (measles, pertussis, etc.).

It is at this time that the child's diet changes from biologically determined to socially determined. Essential nutrients are often lacking in traditional weaning diets. These diets frequently lack protein, vitamin A, and E, and as a result they are at increased risk of malnutrition during the weaning period. Foods for young children have to be of high nutritional density, with more calories per given amount, because while their needs are high, their stomachs are small. Growth monitoring plays a fundamental role in detecting malnutrition during this time period, indicating a child's immediate nutritional status and health risk.

The strong interaction between disease and malnutrition stems from both biological and social causes. While many diseases raise a child's metabolic rate, thus raising their food requirements, certain parasitic organisms compete for the ingested food, and diarrheal diseases work to inhibit food absorption. Many times these diseases occur together, posing an even greater risk to the child. Socially, when a child is sick, the parental response may be to stop feeding the child, thus further decreasing the child's nutritional status.

The lack of essential nutrients leads to the body's inability to fight off and resist disease. The child becomes caught in a vicious cycle that becomes a downward spiral: malnutrition reduces resistance to disease, and illness results in less food intake, and worsening nutrition status, with higher vulnerability to disease. As the cycle proceeds, both the severity and duration of disease have been shown to increase, leading to the higher infant mortality rate among children who receive an inadequate diet.

To combat the cycle discussed above, this project will rely on the growth monitoring intervention as its major point of contact with the family. Through growth monitoring, promoters will be able to observe declines in the child's growth or health in time to take corrective action through either education of the mother or referral to a health facility, thereby preserving the normal growth of the child. The response time under accepted growth monitoring technologies has been shown to be brief, thus enabling the child to resume growth rapidly. Growth monitoring has been used in the Catholic Relief Service/Caritas Applied Nutrition Education program with considerable success here in the Dominican Republic. Through the monthly weighing visits of the promoters to the homes of high risk children (under 2 years of age and/or in second or third degree malnutrition), the promoter is able to observe firsthand the practices and habits of the mother with her child as well as provide advice to the mother regarding its improved care.

Up to the 1970s, the established strategy among donor agencies to combat malnutrition in the Third World was to improve the overall diet of the country through improved food supply and distribution. However, this strategy was based on the assumption that economic growth and industrialization were prerequisites to overall health improvements. As these assumptions were not borne out in the early 1980s, and infant malnutrition persisted, a new approach was needed.

Within the earlier strategy, it was thought that programs should focus on identifying only the seriously malnourished, using the nutrition surveillance technique. Growth monitoring differs from nutrition surveillance. Nutrition surveillance was implemented through SESPAS to screen and identify malnourished children to be referred to other programs such as nutrition recuperation centers or feeding programs.

During the 1980s, there was a general shift of attitude regarding the mother's role in improved nutrition and health status. It was thought that diseases could be anticipated and prevented if the mother was educated and if a primary health worker system were available to consult with them. In addition to the availability of the primary health care system, it is now thought that monthly weighings, with promoters giving advice to the mothers and monitoring the child's growth up to 2 years of age is the preferred strategy.

The promoter is generally a member of the community, and is concerned about the welfare and health of community members. The promoter's work is to follow up on each case to assure that the mother is doing all she can for the child's health in a broader sense. In this respect, growth monitoring emphasizes that children should gain weight each month, rather than categorizing them as to their nutritional status.

2. Diarrhea

The primary cause of infant and child death in the world today is diarrheal disease. It is also one of the major contributors to childhood malnutrition and one of the most frequent causes of childhood illness.

Oral rehydration therapy (ORT) is a means for combating these life threatening diseases through the simple combination of sugar and salt that forms the solution, and through continual feeding during the diarrheal episode, many lives have been saved. The solution of sugar and salt act to replenish the electrolytes and water lost from the body during a diarrheal episode. Although this simple solution does not cure diarrhea, it can be absorbed even during the course of the illness, allowing the body to restore and maintain its critical fluid balance until the infection subsides. Continued feeding during this period also aids in the fight against malnutrition.

ORT is easy to use at home because it can be mixed using premixed packets or made from common home ingredients, which are inexpensive and readily available. ORT has been a major medical advancement in child survival, second only to the advent of vaccines.

During the 1970s, improvements in water and sanitation were thought to be the preferred strategy to combat diarrhea and parasites. Inadequate quantities and quality of water and absent or inadequate sanitary facilities are the principal causes of diarrhea. Due to the high cost involved, donor

agencies began looking at other ways to combat diarrhea. They redefined their objective to prevent death from the dehydrating effects of diarrhea through replacing fluids and electrolytes rather than waiting for water sanitation projects to prevent the diarrhea itself. Feeding is also stressed in order to control the severity of the nutritional impact on the child.

While ORS is effective, the most immediate means to combat dehydration, DDC also must promote diarrheal case management, emphasizing not only ORS, but also proper nutrition during the diarrhea episode and beyond.

The effective distribution of ORS packets is critical to the success of the program. The Dominican Republic has a good network of pharmacies and private and public health centers that can be utilized in a distribution program. SESPAS is presently purchasing ORS packages 3 times a year to supply their hospitals, rural clinics, pharmacies and health personnel.

The Dominican Republic, like other countries, has set up Oral Rehydration Units. These units, principally attached to hospitals and rural clinics, are used when the child is brought in by the mother for diarrhea. Each unit contains the minimum amount of furniture, principally rocking chairs. The mother is taught how to mix and give the ORS solution to her child. The mother continues to give the solution to the child until she learns to do this on his/her own.

3. Acute Respiratory Infections

Acute respiratory infections claim more children's lives, with the exception of diarrhea, than any other single group of disease. Climatic conditions, overcrowding, and poor hygienic practices all play mayor roles in the causes of this disease.

ARIs are divided into 2 main categories, upper respiratory tract and lower respiratory tract infections. Bacterial infections of the lower respiratory tract are by far the most dangerous.

Children of young age, especially under one year, with low birth weight and poor nutritional status, run the greatest risk of becoming infected and dying from such ARIs.

In the past, ARIs were an area that had been overlooked by the international health community, possibly due to the lack of a simple solution such as ORT. However, increasing attention has been given to this area, with the four most important infections (measles, diphtheria, pertussis and tuberculosis) being targeted by the EPI. This increase in awareness and more medical improvements, along with better nutrition, sanitation and housing conditions, are all working together to produce a more rapid decline of ARI in developed countries. Similar efforts at early awareness and treatment are needed in the developing world.

In the Dominican Republic, the Project will concentrate its efforts on the education of mothers and effective case management and prevention of ARI. Utilizing the monthly visits for the growth monitoring portion of the program, promoters will be able to catch ARI in the early stages, assuring prompt attention either by proper case management by the mother or timely referral to a health facility. Relatively little has been done with ARI through the primary health facilities worldwide. Traditionally ARI was treated on a curative basis with physicians. The World Health Organization has outlined the principal components necessary to design and implement an ARI control program nationwide. This project follows those guidelines which are built into the activities discussed in Section III and Annex 3.

4. Disease Control

Through the World Health Organization's Expanded Program of Immunizations (EPI) and the virtual elimination of measles, diphtheria, pertussis, tetanus, poliomyelitis and tuberculosis in industrialized regions, the door has been opened to the developing world, putting this goal within their reach. The ability to control these diseases has been achieved, and it is now a question of the will to take the necessary steps. While progress continues to be made, most developing countries lag behind.

Because the targeted diseases strike in infancy, immunization must take place prior to the child's first birthday. Vaccinations must not be given too early, as they may be neutralized by the passive immunity inherited from the mother, thus leaving a brief period of time toward the end of the first year within which the child can be vaccinated.

Getting this message to the targeted audience is a critical step in the chain of events. The goals to be achieved are educating people on the importance of immunization to children's health, overcoming the misconceptions that discourage this, and explaining where and when these immunization services are available. It is a strategy that is simple, effective and low in cost. Universal coverage can be achieved and sustained; coordinated and systematic effects are required to support this goal. Each disease transmission can be brought to a virtual halt, meaning that even children that have not been vaccinated are sheltered from infections. Because, when a child contracts a disease and there is no one for him to pass it onto, the epidemic stops before it begins.

In the Dominican Republic, the social soundness surveys have found that the educational messages are not being delivered with the vaccines, and that a strong emphasis is needed so that mothers know why their children need immunizations, and what is vaccine is for.

5. Birth Spacing

Short birth intervals are a universal health risk for all children worldwide. It is a risk that effects every socioeconomic level as well. An interval of 2 years or more without pregnancy provides a simple preventative measure against such a major life risking factor.

Inadequate intervals between births affect also the health of the mother. Women who bear children frequently do not have adequate time to recover from the demands of a prior pregnancy and breastfeeding. They are often physically exhausted, which may cause the birth of a premature, underweight infant and result in inadequate breastmilk.

Premature and abrupt cessation of breastfeeding is also a mayor risk to the health of a child, especially when it coincides with a pregnancy. This added pregnancy jeopardizes the mother and her survival chances as well.

The culture, economics and politics of a nation have a major impact on any fertility behavior modification program. Although there is contraceptive technology available for couples to use to effectively plan births, programs must offer access to family planning information and concentrate education on the national, familial and individual motivation for it to be used.

Changes in goals and philosophy are required if deaths from high-risk fertility are to be significantly reduced. With all the positive effects on child survival that healthful spacing of births and bearing children at healthful ages provides, these changes deserve increased attention in order to improve the chances of child survival.

6. Conclusion

The technical aspects of the services to be provided are well known, and a number of them are already being practiced with positive effects in the Dominican Republic. Starting on this foundation, with additional technical improvements, training, and education of families, the Project stands an excellent chance of meeting its targets.

B. Institutional Analysis

The institutional analysis was designed to assess the capacity and interest to participate in the Project of public and private organizations that provide child survival services -- in essence, to test the assumption that existing networks could be built upon to provide the desired services, and that the kinds of support planned are appropriate to make the networks more effective. The purpose was to assess a number of factors, including existing services being provided and the size and kind of population served; the specific services, either supplementing or substituting for present activities, that the institutions might take on; and the needs of the

organizations that the Project would have to meet in order for them to operate effectively within the project.

Although the study includes information from Region V as a point of comparison (and future expansion area for the Project), this analysis will focus on the other three regions which will be the initial focus of the project. The above data show that Region V falls far behind the others in coverage in all services. This Section covers the PVO network. The SESPAS situation is discussed in the Background section, and in Annex 4 (Lessons Learned).

As of now, 97 organizations have been assessed, of which 53 are in the capital, 18 in Southern Region VI (Azua/San Juan de la Maguana), 13 in Southwestern Region IV (Barahona), and 13 in Eastern Region V (Higüey). Out of this total, 85 are providing either the services contemplated under the project, or related services that contribute to maternal and child health.

1. Existing Organizations and Services

The survey has covered a wide variety of service providers, including public health clinics and centers (including specialized facilities for nutrition and maternal/child health), public hospitals, and government community development programs. Private agencies include church health dispensaries (both Catholic and Protestant), and community organizations offering health services and education (along with other community development activities).

While estimates of population served are very rough (record-keeping is not widely practiced, especially in the private organizations), we find that the number of families with children in the target age range that are being served by the institutions differs widely according to the service involved. The table on the following page shows the coverage for each service for the 55 private institutions that gave estimates.

These partial data (excluding public sector institutions) show that the most widely provided services are nutrition-related services and "other related services". Under "other related services", many organizations provide subsidized milk, a nutritious meal, general pediatric medical examinations and treatment, medicines, and other education related to pregnancy and infant care. These are followed by treatment of ARI, oral rehydration and family planning. Falling far behind are pre-/post-natal care and immunizations, the latter presumably because it has been a major effort of SESPAS, and requires access to vaccines, a cold chain, and extensive training of vaccinators.

2. Characteristics and Interest Level of Organizations

There is a loose network of PVOs and community organizations in each health region that currently implement the six targetted child survival services. The majority of these fall into Category Three (small providers who

are candidates for training, educational materials and technical assistance) and a minority are Category Two (substantial providers with an outreach network and staff capable of delivering interventions). The smaller groups tend to use the service center rather than the outreach mode of delivery.

The Category Three PVOs and community groups often have strong credibility in their communities, giving them channels to directly reach the target group at the household level. They are highly independent, and coordinate little among themselves, relying on their own creativity and that of their volunteers, and dedication to service to accomplish what they can. Groups that are integrated under the framework of the Catholic Church (under CARITAS or the Pastoral Social) appear to have strong acceptance and impact in both urban and rural communities, but are also highly independent and variable in their capacities. Evangelical groups have similar relations that can be built upon.

Estimated Service Coverage by PVOs

<u>Type of Service</u>	<u>Region/Population Served</u>				<u>Total Served</u>
	<u>Santo Domingo</u>	<u>Region IV</u>	<u>Region V</u>	<u>Region VI</u>	
Nutrition education, breastfeeding, growth monitoring	14,960	10,760	300	9,460	35,480
ORS distribution & education	9,310	6,600	210	880	17,000
ARI	6,250	15	115	450	6,830
Pre- and post-natal care, attention to pregnant mothers to prevent low birth wt.	1,880	350	55	210	2,495
Immunizations	375	450	115	-	940
Family planning/birth spacing	4,855	1,500	50	-	6,405
Other related services	5,480	30,500	1,080	360	37,760
TOTAL NUMBER OF ORGANIZATIONS:	29	10	7	9	55

With a few notable exceptions, the smaller PVOs are weak in all aspects of administration, from planning to record keeping (on themselves or their clients), to accounting for funds. Few have had any reason to be accountable outside the community for their resources or reporting on their accomplishments, hence they have had little motivation to keep records. Key personnel operate on a day-to-day basis, and records and work plans are filed in individual memories.

Virtually all of the organizations contacted expressed interest in participating in the Project, as shown in the table on the following page. This includes organizations already performing some form of child survival or related service, as well as others that have networks that would lend themselves to delivery of key messages or resources such as ORT. In the latter group are Mujeres en Desarrollo (MUDE) and the Asociación Dominicana para el Desarrollo de la Mujer (ADOPEM). MUDE works with rural women's groups on income generation, and ADOPEM has an established network of microentrepreneurs composed mainly of women heads of households in the poor barrios of Santo Domingo. These fall in Category Two, and would need assistance to start working in child survival matters.

3. Needs of Organizations

There is more than one viewpoint on the needs of the organizations that are current or potential providers of child survival services; the view from inside and the one from outside.

The organizations interested in participating in the project expressed their needs as follows:

<u>Region</u>	<u>No. Orgs.</u>	<u>Type of Assistance Needed</u>				
		<u>Tech.</u>	<u>Ed. Materials</u>	<u>Training</u>	<u>Funds</u>	<u>Other</u>
O (SD)	42	37	39	35	14	4
IV	18	18	16	17	3	1
VI	13	7	12	7	-	3

Interest in Participation Among PVOs

	Regional Location			<u>Total</u>
	<u>Santo Domingo</u>	<u>Region IV</u>	<u>Region VI</u>	
Organizations with some child survival service that wish to participate	32	17	9	58
Organizations with some CS services that are not interested	3			3
Organizations with related services that wish to participate	6	1	3	10
Organizations with no CS service that wish to participate	4		1	5
Organizations with no service and no interest	8			8
Total Interviewed	<u>53</u>	<u>18</u>	<u>13</u>	<u>84</u>

"Other" assistance in this case includes support for expanded physical facilities, visits by medical personnel to a community, and other resources beyond the scope of the Project. We find it surprising that very few organizations asked for funding as a high priority, while nearly all rated technical knowledge, training, and materials as a major need.

The analysts (many of them experienced in running and evaluating health and population projects) were asked to rate the organizations as candidates for participation in the project. In the three regions, only one or two per region were rated as inappropriate. At the same time, the analysts find that nearly all of the smaller organizations will require help with their administration and record keeping, as well as the technical support they perceive themselves as needing.

4. Conclusions

A review of selected initial surveys and summary data shows that:

1. There is a solid network of agencies that are providing many of the services planned under the Project.
2. In the capital, the project will rely almost entirely on private or community groups.
3. Many of the private organizations are accustomed to accomplishing a lot with a minimum of staff, space, and financial resources, and while many would like to improve, their needs are often modest. Most frequently they request help with training of staff and volunteers, educational and basic health materials, and technical advice on improving the quality of their services and educational programs. A few mention a need for funds, but this is often secondary to the needs mentioned above.
4. As few of the private organizations (except for a handful who have foreign donors assisting them) have any need to report data on their target population and the level of service they provide, establishment of regular record-keeping among these agencies will be a major focus of the Project.
5. Administrative capacity varies widely. Financial records, organizational effectiveness, planning etc. will need improvement in a number of service providers.
6. Motivation is high to participate in the Project, generally in areas already well known and established, such as nutrition and ORT. There is also willingness to get involved in the less well-known areas, such as ARI, pre-natal care,

vaccinations, and family planning. The consciousness of ARI and what to do about it is still low; vaccinations have been handled by national campaigns or at medical facilities; and family planning, for many groups (especially Catholic Church groups) is still a sensitive and limited area of involvement.

There is clearly a need to establish some norms for these services, as can be accomplished through a broad training program, a consistent set of educational materials, and simple, accurate messages and practices to be performed by centers that receive clients, and programs that have outreach activities to identify and reach families.

On most counts we find that the project design is properly focused on the organizations that have the potential to meet child survival needs, and that the kinds of support that are planned (training, materials with solid content, and a minimum of cash and equipment) are appropriate.

C. Social Soundness Analysis

Preliminary findings from the social soundness analysis, based on a survey of 400 families (almost exclusively mothers) in the target regions, are encouraging. They show that there is a strong desire for knowledge and improved practices that mothers, particularly younger ones, can apply to care for their children and to themselves during pregnancy and lactation. Ninety-five percent of mothers demonstrated interest and willingness to participate in the project. Based on the type of responses given related to mothers' acceptance and participation in the project, we estimate that 66% of the mothers interviewed are highly motivated and interested in actively participating in the project. However, a large percentage of these expressed the need for the project implementors to come and talk to the community before actual implementation and for the project to reach them in their homes.

The total child population under 5 years of age in the families visited was 602, with 432 living in urban areas (Santo Domingo and cities/towns in Health Regions IV, V, and VI) and 170 in rural areas. 80% of urban mothers and 72% of rural mothers were housewives. Surprisingly enough, the mothers' education level and formal schooling was higher than expected with only 7% urban and 21% rural mothers being illiterate. At least 51% of urban and 79% of rural families interviewed fell below the poverty line (DR\$293.20 monthly income according to "Indicadores Básicos 1986" published by ONAPLAN). Further, it is believed that more families actually fall below the poverty line due to the 30% to 40% rate of inflation experienced since the time of the ONAPLAN study.

The survey found that 75% of the children under 5 were ill in the two weeks preceding the interview. 198 families (33%) reported that at least one child had been sick while 101 families (17%) reported two or more children

sick. Principal illnesses were "gripe" or lower respiratory tract ailments (69% of the total child population under 5) and diarrhea (21%). These figures support the project's focus on Diarrheal Disease Control, Acute Respiratory Infections and Nutrition.

The use of health facilities when children are ill varies widely according to the Health region and urban/rural mix within each Health region. For example, 37% of the families take their children first to a private clinic while 39% go to a SESPAS Sub-Center when their child is ill. If not satisfied with the services given to the child, 41% then take the child to a private clinic and 31% go to a Hospital. In Health region IV, in the rural areas, 66% first go to a hospital, followed by 40% to a private clinic or physician if not satisfied as compared to rural Health region VI where 56% first take their children to a rural clinic followed by 54% to a private clinic or physician. One of the findings of the survey is that since the health promoters are perceived to be vaccinators, none of the mothers surveyed take their children to the health promotor, if one exists, in the community. However, in the urban areas of all regions, and especially in the capital, mothers were very interested in establishing a health promoter system in their communities.

In the barrios where the survey was carried out in the Santo Domingo, 26% reported having Church related health facilities, 22% reported having SESPAS health facilities and 22% reported having CONANI facilities. Of a total of 79 responses requesting mothers to list organizations supplying health services in Region VI, 45 had heard of SESPAS rural clinics and related facilities and 20 of Church related health facilities. Of 45 responses to the same question in Health region IV, 10 had heard of Church related health facilities, 10 of CARE health programs whereas 9 knew of SESPAS related facilities.

Some of the knowledge gaps are remarkable. A number of mothers interviewed admitted that they had no understanding of the vaccines that had been provided to their children by the national campaigns. They accepted them, but did not know what diseases were being prevented (or by association, what the consequences to their children would be if they were not vaccinated), and as a result, many said they would not take their other children to a medical facility to be vaccinated, because they didn't know what to ask for. Those who had seen a child deformed by polio on a TV spot did know what that was, and were more likely to seek that vaccine for their children.

Mothers were asked what topics should be included in the program. 37% were interested in learning about child growth and behavior, 18% felt that nutrition, ARI and DDC were sufficient, 11% were interested in hygiene, 10% in nutrition and 10% in family planning.

On the basis of the preliminary findings outlined above, it is believed that there is adequate existing demand for project interventions, that the project is focused on the proper health interventions, that education levels of mothers is adequate to enable the effective dissemination of information, and that there is recognition and acceptance among the population of the organizations identified for involvement in the project.

D. Economic Analysis

The main output of the project, from the economic point of view, is healthier mothers and children. The improved health (mental and physical) can be expected to result in immense social as well as strictly economic benefits.

Healthier children:

1. Cost less to maintain during dependent years;
2. Are physically and mentally better able to absorb/develop intellectual, social and work-related skills;
3. Produce more during productive years; and
4. Survive to be productive.

Healthier mothers with healthier children are better able to use their time with higher productivity in pursuits other than caring for sick children, including:

1. time for other family members;
2. enhanced participation in community activities; and
3. more productive in a wider range of economic activities.

While we have not put numbers on the project's economic benefits, which consist of substantial near-term cost savings as well as substantially improved economic productivity of healthier mothers and the healthier adults that targeted children will become, the benefits will easily outstrip the costs.

E. Financial Analysis

1. Financial Plan

The Project Budget by Major Activity is illustrated in Table 1, Section III-D. Over four years, total contributions to the project will be equivalent to \$8,002,000 as follows:

Table 3
Summary Budget by Source & Fund
and by type of Contribution
(US\$000)

AID Grant	<u>(000s \$)</u>	<u>% of total</u>
Foreign Exchange	1,847	23%
Local Currency	<u>2,805</u>	<u>35%</u>
	<u>4,652</u>	<u>58%</u>
Counterpart		
Local Currency	2,325	29%
In-kind	<u>1,025</u>	<u>13%</u>
	<u>3,350</u>	<u>42%</u>
	8,002	100%
	=====	====

From above it is obvious that the counterpart requirement of 25% is met by cash contributions alone and that the total counterpart contribution to the project amounts to 42%.

The Summary Budget by Input is shown in Table 2, Section III-D. The relative importance of inputs contemplated under the project and the percentages of those inputs to be financed by A.I.D. can be illustrated as follows:

Table 4
Percentages of Project Inputs
(US\$000)

	<u>Percent of AID's funding</u>	<u>Input as Percent of Total Financing</u>
Technical Assistance	46%	28%
Training	30	34
Commodities	10	4
Budget Support	9	31
Evaluation/Audit	5	3
	<u>100%</u>	<u>100%</u>
	====	====

A total of 76% of A.I.D.'s funds will go into Technical Assistance and Training. The sum of Technical Assistance is attributable to the Project Administration activity of the project but like all administrative overhead cost burdens, that could be allocated entirely to the operational components of Service Delivery. For purposes of understanding the proposed usage of A.I.D. allocated funds, however, administration is displayed as a separate activity. The majority of counterpart funds, on the other hand, will support the Budget Support and Training Inputs. See Annex 10 for a detailed breakdown of the proposed inputs.

The timing requirements for A.I.D. and counterpart contributions are shown in Table 5 on the following page.

Conclusions: The financial plan appears reasonable, complete and adequate to accomplish the project's proposed output objectives. The availability of counterpart financing on a timely basis is reasonably assured by virtue of the fact that it will be funded from PL 480/ESF local currency generations which are jointly programmed by AID and the CODR. In addition the establishment of a satisfactory decentralized revolving fund arrangement within SESPAS will be a covenant tied to A.I.D. approval of TSP's release of local currency for budget support to SESPAS.

Table 5
Projection of Expenditures by Fiscal Year
(US\$000)

Fiscal Year	AID			Counterpart			Total		
	FX	LC	Total	LC	IK	Total	FX	LC	Total
1988	436	356	792	233	103	336	436	692	1,128
1989	625	991	1,616	820	410	1,230	625	2,221	2,846
1990	470	982	1,452	820	410	1,230	470	2,212	2,682
1991	316	476	792	452	102	554	316	1,030	1,346
	1,847	2,805	4,652	2,325	1,025	3,350	1,847	6,155	8,002

2. Methods of Implementation and Financing

The Implementation and Financing Methods to be employed by the project are shown in Table 6. Only the Direct Payment Method of financing will be used and this is a preferred method under the Administrator's Payment Verification Policy Guidance.

To implement the project, AID will select, on a competitive basis, the most qualified and experienced US PVO to manage and coordinate all technical assistance, training and procurement activities except for a few actions implemented directly by AID. On-site continuous management of all these activities will be provided by the C/PVO Chief of Party and his staff and will be monitored on a day-to-day basis by a US-trained PSC contracted directly by AID.

Table 6
Implementation and Financing Methods
(US\$000)

	<u>Total Cost</u>	<u>Implementation Method</u>	<u>Financing Method</u>
Technical Assistance			
Coordinating PVO	1,754	Cooperative Agreem./PVO	Direct Payment
Management Info.			
System	256	Cooperative Agreem./PVO	Direct Payment
Project Manager	140	PSC	Direct Payment
Training	1,398	Cooperative Agreem./PVO	Direct Payment
Commodities- Rapid Resp.	311	USAID Direct - PSA	Direct Payment
Commodities- Serv. Imp.	143	Cooperative Agreem./PVO	Direct Payment
Budget Support	400	Cooperative Agreem./PVO	Direct Payment
Evaluation	200	Direct Contract/Ind. or Inst.	Direct Payment
Audit	50	Cooperative Agreem./PVO	Direct Payment

The evaluation activity, the PSC, and the rapid response commodity procurement will be contracted directly by AID.

Conclusions: All implementation and financing methods to be employed by the project are preferred methods under the Administrator's Payment Verification Policy Guidance and no justification is required. The methods selected appear to be well-suited to proposed project activities and the selection of a well-qualified and capable coordinating PVO should help assure achievement of the project's objectives.

3. Internal Control, Vulnerability and Audit

The principal implementing agent for this project will be a US registered PVO which, by definition, will have systems of financial management and internal controls which are adequate to account for and control AID funds. The C/PVO will also have sufficient local accounting and management

staff on-site to monitor the flow of funds and commodities to other participating PVOs and GODR institutions involved in project implementation. Possible weak points in the system include the use of local funds by GODR entities, payments of salaries and per diem for training, and the supply distribution system to be established to support field activities. The C/PVO Chief of Party and the AID PSC Project Manager will ensure that adequate accounting and internal audit systems are developed to monitor these and any other potential points of high vulnerability.

The C/PVO will be required to have the entire project audited once a year by an independent and qualified CPA firm acceptable to AID. Complete audit reports will be submitted to AID and reviewed by the Financial Analysis Division of the Controller's office. In addition, at least once a year, AID's own financial analysts will perform financial and compliance reviews on selected areas of project implementation and payment verification reviews of all disbursements to the project.

Conclusions: In spite of the considerable vulnerability to fraud, waste and misuse inherent in this type of field activity, reasonable levels of management and control are provided for in the project design and are expected to be adequate under the circumstances. Adequate levels of audit and financial review are provided for in the project design.

4. Recurring Costs

The project strategy is aimed at providing a "rapid response to the nation's malnutrition and childhood infectious disease problems by implementing a limited number of proven interventions in targeted communities" (Final Project Strategy, II,F,2). There is interest, however, in seeing to it that these interventions be sustained after the termination of A.I.D.'s assistance. To mitigate any recurrent cost implications, the project calls for the bulk of the recurrent costs i.e., payment of salaries and routine operating costs, to be paid by the participating organizations as part of their regular budget.

Nonetheless, the project will create some recurrent costs for participating organizations, including the costs of vehicle maintenance and repair, continuous in-service training, and provision of educational materials (See section II,C). Furthermore, there are some elements of the project that would contribute to a follow-on or replication effort, if desired, at the project's mid-term evaluation, including, e.g., the MIS and heavy training activities. While the one-time costs of these elements will be covered under the project, their continued implementation would result in some recurring costs for the local PVOs, SESPAS or other local entities.

In the case of SESPAS, these recurrent costs will be dealt with as part of the Health Systems Management project. The recurrent cost implications of the other organizations will be further studied during project implementation and the decision on replication taken depending on a finding that these costs can be borne by the participating entities.

Conclusion: At this time, the issue of recurrent costs after the A.I.D.-financed project terminates is not considered serious.

ANNEXES:

1. Logical Framework Matrix
2. STP/SESPAS Requests for Assistance
3. Tasks of Service Delivery Teams
4. Lessons Learned from Previous Health Projects
5. A.I.D. Child Survival Policy
6. Statutory Project Checklists
7. Institutional and Social Soundness Report by Entrena (Preliminary Findings)
8. Technical Assistance Plan
9. Procurement Plan
10. Detailed Cost Schedules

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project : FY1987-1991
PACD : Sept 1991
Date Prepared : Sept 11, 1987

Project Title & Number: Child Survival (517-0239)

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
<p><u>Program or Sector Goal:</u> To improve the health status of Dominican children</p>	<p>Child and infant mortality statistics which show reduced average infant mortality rates from as high as 90 per 1000 live births to 75 per 1000, and reduced child mortality rate from 18 per 1000 to 10 per 1000 by 1991 in the most severely health regions.</p>	<p>-Regional and national reporting systems</p>	<p>-Economic and climatic conditions remain stable or improve</p>
<p><u>Project Purpose:</u> -Improved delivery of child survival services by SESPAS and PVOs involved in public health</p>	<p><u>End of Project Status (EOPS)</u> -80% of rural (and 60% of Santo Domingo) target pop. receive services -80% of community health promoters receive regular supervision -Reduce malnutrition from 40% to 30 of child population -Low birth weights reduced by 50% -Diarrhea reduced by 20% -Infant mortality due to diarrhea reduced by 30% in under 5s -Increased use by mothers of proper diarrhea treatments -Decreased infant deaths due to acute respiratory infections -Mothers improve recognition & treatment of respiratory infect. -Improved access to immunizations and family planning services under separate but coordinated projects</p>	<p><u>Community/Project Info.Syst.</u> -Family visit records & summaries by region -Supervisor reports and observation/monitoring by C/PVO field staff. -Demographic data on target groups -Infant and child mortality rates; disease-specific mortality/morbidity data -Nutrition Surveillance Information -Field observation of families by CS staff</p>	<p>-Community based record system can be activated thru promoters -GODR support remains strong -SESPAS decentralizes financial responsibility to selected regional offices. -Staff remains stable once trained -Other donor assistance and coordination continues -C/PVO can establish effective working relationships and technical credibility with participating institutions.</p>

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Project Title & Number: Child Survival (517-0239)

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
<u>Outputs</u> -1,500 promoters and supervisors trained in technology and supervision, data collection & reporting -Reliable data collection system based in communities, and showing 80 validity established -1,400 medical personnel providing improved child illness diagnosis and treatment, prenatal care, and related services -Reduced referral of ill children to clinics due to early identification and treatment in the home -Increased public awareness of child survival problems, causes, prevention & treatment	<u>Output Indicators</u> -Consistent approach to child services (diarrhea, nutrition, respiratory infections) being applied cooperatively by SESPAS and PVO's, including educational materials, use of ORT, etc. -Data flowing regularly -Improved clinical performance for referred children following training -Number of children referred for clinical treatment of severe dehydration, malnutrition & respiratory infections decreases -Social marketing surveys show changes in responses over time -50% of Communities organized and actively supporting promoters' efforts.	-MIS system -Clinic reports -Spot checks on MIS system -Surveys of clinics -Clinical records correlated to project service deliv.	

Narrative Summary	Objectively Verifiable Indicators				Means of Verification	Important Assumptions
Inputs	(US\$ millions) A.I.D.		COUNTERPART	TOTAL	-Controller Records -C/PVO Reports -STP reports	-AID Funds will be available
	FX	LC	LC			
a. Technical Assistance	1.3	.8		2.1		
b. Training		1.4	1.2	2.6		
c. Co=odities	.4	.1		.5		
d. Project Support		.4	2.1	2.5		
e. Audits, evaluations	.1	.2		.3		
	<u>1.8</u>	<u>2.8</u>	<u>3.4</u>	<u>8.0</u>		

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República Dominicana

Secretaría de Estado de Salud Pública y Asistencia Social

"AÑO INTERNACIONAL DE LA VIVIENDA"

DES. 14152

SANTO DOMINGO, D. N.,

27 MAYO 1987

Señor
Henry H. Bassford
Director Agencia Internacional
para el Desarrollo-AID
SU DESPACHO.-

Distinguido Sr. Bassford:

El equipo técnico de esta Secretaría ha trabajado conjuntamente con el Dr. Lee Hougen en la revisión Programática de los Servicios de Salud rural a Nivel Nacional. Resultando como Urgente y Prioritario, diseñar e implementar un proyecto de Salud Rural que incluya acciones de Salud tales como: Inmunizaciones, Planificación Familiar, control de diarreas, promoción a la Nutrición, Prevención y tratamiento de infecciones respiratorias agudas.

En tal sentido me permito solicitarle su cooperación técnica y financiera de la Agencia Internacional para el Desarrollo para el diseño e implementación de un Programa de Salud Rural que actualizará las funciones del Promotor de Salud, con el objetivo básico de reducir la morbilidad y mortalidad Infantil y Materna, logrando un bienestar familiar y colectivo de la población dominicana.

La persona de enlace entre ambas instituciones lo será el Dr. Miguel Campillo, Director Nacional de Salud.

Agradeciéndole de antemano su acostumbrada colaboración, queda de Ud. muy atentamente,

Ney B. Arias

Dr. Ney B. Arias
Secretario de Estado de Salud Pública
y Asistencia Social

NBA/mg.

ACCIÓN:	
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DATE: 6-8-87	
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U. S. AID MISSION TO DOMINICAN REPUBLIC

AMERICAN EMBASSY, P. O. Box 22201
SANTO DOMINGO, DOMINICAN REPUBLIC

FOR U. S. CORRESPONDENTS:
U. S. AID MISSION
APO MIAMI 34041-0008

JUL 29 1987

Dear Dr. Arias:

The general purpose of this letter is to express our mutual understanding regarding the content and method of implementation of a program of action to reduce mortality and disease in children under five years of age. This program will be called The Child Survival Project.

Various studies conducted by ONAPLAN and other entities during the past two years have shown that the health status of many low income Dominican families has been deteriorating. Both public and private institutions working in public health have expressed their concerns about increasing rates of infant mortality and illness, particularly in certain border regions. Since April our staff has participated in a number of meetings with SESPAS and CENISME, and with voluntary private organizations such as CARE, Caritas, and SSID regarding this problem. In these meetings we have discussed the possibilities of supporting an integrated action program, focussed initially on regions having the most negative indicators.

The proposed Child Survival Project will be implemented through a Private Voluntary Organization and will support education and services in three key interventions: (a) oral rehydration therapy, (b) nutrition, and (c) infectious respiratory ailments. This four-year program will be focussed initially on the SESPAS Health Regions IV and VI, and selected barrios in the capital where child mortality indicators are highest. USAID will continue to support two complementary projects being implemented by SESPAS, one in family planning and one for immunizations, that are also also components of the child survival strategy.

His Excellency
Dr. Ney B. Arias
Secretary of State for Public Health and Social Assistance
Santo Domingo, D. N.

22

In order to assure the this program is well integrated, carefully planned, and applies the most recent knowledge of oral rehydration, nutrition, and prevention of respiratory diseases, and that it is organized rapidly to deliver services, the project will be managed by a coordinating internationally recognized private voluntary organization (PVO). The PVO will be selected competitively under A.I.D. regulations by a joint AID/CODR selection committee. Project funds will be channeled through the selected PVO under a cooperative agreement with A.I.D., financed with project funds. The coordinating PVO will be responsible for technical assistance, program planning, development of a training program, financial administration, logistic support, and monitoring and evaluation of the effectiveness and impact of the program. The coordinating PVO will, in turn, work with SESPAS and PVOs in program planning at the regional level, the application of educational materials, training of health and medical personnel at all levels, and delivery of services. SESPAS and participating PVOs will be eligible to receive commodity, training and technical assistance financed under the cooperative agreement with the coordinating PVO.

The materials and experience of the project will be available for national application. The delivery of education and services will be carried out through a combination of SESPAS field staff and private voluntary and community organization that are working in the target regions.

The grant funds presently available from A.I.D. are approximately US\$2.7 million. Under our present plan, these funds will be used by the coordinating PVO for technical assistance (both international and local), procurement of a limited amount of commodities (such as oral rehydration salts and scales for weighing children); training of field staff of the implementing agencies; and selected operational costs for service delivery. Counterpart contribution by the Dominican Republic will be partly financed by a proposed allocation of RD\$3,000,000 under the PL 480 Title I program, and by approximately RD\$1,000,000 of contributions in kind by the participating entities. We estimate that the in-kind support of the government will be about RD\$650,000, and of the private entities approximately RD\$350,000.

With these resources, and this method of implementation, we anticipate that the project will be able to achieve the following objectives:

1. Increased numbers of public and private field units operating successful child survival programs in the selected regions; and
2. 75 percent of primary health care personnel of SESPAS and participating PVO's, (including doctors, nurses, and health promoters) will have received short-term training in child survival interventions.

By 1991, we expect the following impact in the selected project areas:

1. Reduction of infant mortality from approximately 90/1000 to 75/1000.
2. Reduction of child and infant morbidity by 20 percent.

3. Reduction of malnutrition in children under five from 40 percent in 1985 to 25 percent;
4. Reduction of low birth weights to less than 15 percent of all births;
5. Increase in immunization coverage to 80 percent; and
6. Increase in the number of diarrhea episodes treated with oral rehydration therapy to 75 percent from an estimated current use rate of 20 percent.

Our schedule for completing the plans for this project, and the documentation required by A.I.D., is as follows:

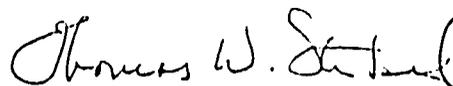
July-August 1987:	Complete field studies and design of project.
September 1987:	Obtain project approval and sign agreement with GODR.
January 1988:	Complete the competitive selection of the coordinating PVO and sign cooperative agreement.
February 1988:	PVO arrives in country.
May 1988:	Detailed plan completed; field operations begin.

So that we may obligate these funds for use in the Dominican Republic during this U.S. government fiscal year (which ends on September 30, 1987), we propose to make a government-to-government grant to the Technical Secretariat of the Presidency. Under the terms of the proposed grant agreement, the Technical Secretariat agrees to authorize AID to act as agent in the competitive selection of the coordinating PVO and to sign the cooperative agreement which will be financed with project funds.

We have discussed this arrangement with Ing. Guillermo Caram, the Technical Secretary of the Presidency, and he has concurred with this procedure.

In order to formalize this understanding, please indicate your agreement by signing the two originals of this letter, and returning one to A.I.D.

Sincerely,



Thomas W. Stukel
Director

Concurred: *Ney B. Arias L.*
Ney B. Arias L.
Secretary of the Presidency

Date: 24 JUL 1987

U. S. AID MISSION TO DOMINICAN REPUBLIC

AMERICAN EMBASSY, P. O. Box 22201
SANTO DOMINGO, DOMINICAN REPUBLIC

29 JUL. 1987

FOR U. S. CORRESPONDENTS:
U. S. AID MISSION
APO MIAMI 34041-0008

Estimado señor Secretario:

El propósito general de esta carta es expresar nuestro mutuo entendimiento en relación al contenido y método de ejecución de un programa de acción para reducir la mortalidad y morbilidad infantil y de niños por debajo de cinco años. Este programa se llamará Proyecto de Supervivencia Infantil.

Varios estudios llevados a cabo por ONAPLAN y otras entidades durante los últimos dos años han demostrado que el estado de salud de muchas familias dominicanas de escasos recursos se ha estado deteriorando. Las instituciones tanto públicas como privadas que realizan programas en salud pública han expresado su preocupación sobre las crecientes tasas de mortalidad y morbilidad infantil, particularmente en ciertas regiones fronterizas. Desde abril nuestro personal ha participado en varias reuniones con SESPAS y CENISME, y con organizaciones voluntarias privadas tales como CARE, Caritas y SSID con relación a este problema. En estas reuniones hemos discutido las posibilidades de apoyar un programa de acción integrada, inicialmente enfocado a las regiones con los indicadores más negativos.

El Proyecto de Supervivencia Infantil propuesto será implementado mediante una organización voluntaria privada y propiciara la educación y los servicios en tres intervenciones claves: (a) terapia de rehidratación oral, (b) nutrición, y (c) infecciones respiratorias agudas. Este programa de cuatro años estará enfocado inicialmente a las Regiones de Salud IV y VI de SESPAS, y barrios seleccionados en la capital (Región 0) donde los indicadores de mortalidad son más altos. La Misión de la A.I.D. continuará apoyando dos proyectos complementarios que están siendo ejecutados por SESPAS, uno en planificación familiar y otro para inmunizaciones que también son componentes de una estrategia de supervivencia infantil.

Su Excelencia
Dr. Ney B. Arias L.
Secretario de Estado de Salud Pública
y Asistencia Social
Secretaría de Estado de Salud Pública
y Asistencia Social
Santo Domingo, D.N.

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Para asegurar que este programa esté bien integrado, cuidadosamente planificado y aplique las más recientes conocimientos sobre rehidratación oral, nutrición, y prevención de enfermedades respiratorias, y que sea rápidamente organizado para la entrega de servicios en un corto plazo, preferimos que el proyecto sea administrado por una organización voluntaria privada (OVP) coordinadora internacionalmente reconocida. La OVP será seleccionada competitivamente bajo las regulaciones de la A.I.D. por un comité de selección conjunto de la A.I.D. y el GORD. Los fondos del proyecto serán canalizados mediante la organización voluntaria privada seleccionada bajo un acuerdo cooperativo con la A.I.D., financiado con los fondos del proyecto. La OVP coordinadora tendrá a su cargo la asistencia técnica, planificación global del programa, desarrollo de un programa de adiestramiento, administración financiera, compras, apoyo logístico, y control y evaluación de la efectividad e impacto del programa. La OVP coordinadora trabajará, a su vez, con SESPAS y las OVPs en la planificación del programa a nivel regional, la aplicación de materiales educativos, adiestramiento del personal de salud y médico a todos los niveles, la entrega de servicios y evaluación. SESPAS y las OVPs participantes serán elegibles para recibir suministros, adiestramiento y asistencia técnica financiados bajo el acuerdo cooperativo con la OVP coordinadora.

Los materiales y la experiencia del proyecto estarán disponibles para su aplicación en todo el país. La entrega de servicios y educación se llevará a cabo mediante una combinación del personal de campo de SESPAS y las organizaciones voluntarias privadas y comunitarias que trabajan en las regiones seleccionadas.

Los fondos de la donación actualmente disponibles de parte de la A.I.D. son alrededor de US\$2.7 millones. Bajo nuestro propuesto plan, estos fondos serán utilizados para la asistencia técnica (tanto internacional como local), compra de una cantidad limitada de suministros y equipo (tales como sales de rehidratación oral y balanzas para pesar niños); adiestramiento del personal del campo de las agencias ejecutoras; y algunos costos limitados de operación seleccionados para la entrega de los servicios. La contribución de la República Dominicana estará parcialmente financiada por una asignación propuesta de RD\$3,000,000 bajo el programa de la PI-480 Título I, y por aproximadamente RD\$1,000,000 de contribuciones en especie por parte de las entidades participantes. Nosotros estimamos que el aporte en especie del gobierno será de alrededor de RD\$650,000 y el de las entidades privadas como de RD\$350,000.

Con estos recursos, y este método de ejecución, anticipamos que el proyecto podrá alcanzar los siguientes objetivos:

1. Incrementar la cantidad de unidades de servicio (clínicas, clubes de madres, etc.) tanto públicas como privadas que ofrecen programas de supervivencia infantil exitosos en las regiones seleccionadas; y
2. 75 por ciento del personal involucrado en atención primaria de salud en SESPAS y en las participantes OVPs, habrá recibido adiestramiento a corto plazo en intervenciones de supervivencia infantil.

Para 1991 esperamos los siguientes tipos de impacto en las regiones seleccionadas;

1. Reducción de la mortalidad infantil en las regiones seleccionadas de aproximadamente 90/1000 a 75/1000.
2. Reducción de la morbilidad infantil en un 20%;
3. Reducción de la malnutrición en los niños por debajo de 5 años de un 40% en 1985 a un 25%;
4. Reducción de los nacimientos de bajo peso a menos de un 15% del total de nacimientos;
5. Aumentar la cobertura de inmunizaciones a un 80 por ciento;
6. Aumentar el número de episodios de diarrea tratados con terapia de rehidratación oral de la actual tasa de 20 por ciento a 75 por ciento.

Nuestro calendario para completar los planes para este proyecto, y la documentación requerida por la A.I.D., es el siguiente:

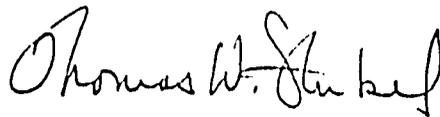
julio-agosto de 1987:	Terminar los estudios de campo y diseño del proyecto.
septiembre de 1987:	Obtener la aprobación del proyecto y firmar el acuerdo con el GORD.
enero de 1988:	Terminar la selección competitiva de la OVP coordinadora y firmar el acuerdo cooperativo.
febrero de 1988:	Llega la OVP al país.
mayo de 1988:	Terminación del plan detallado, comienzan las operaciones de campo.

A fin de poder obligar estos fondos para ser utilizados en la República Dominicana durante este año fiscal (que termina el 30 de septiembre de 1987), nos proponemos hacer una donación de gobierno a gobierno al Secretariado Técnico de la Presidencia. Bajo los términos del propuesto acuerdo de donación, el Secretariado Técnico acuerda autorizar a la A.I.D. a actuar como agente en la selección competitiva de la OVP coordinadora y de firmar el acuerdo cooperativo que será financiado con fondos del proyecto.

Hemos tratado este arreglo con el Ing. Guillermo Caram, Secretario Técnico de la Presidencia, y él está de acuerdo con este procedimiento.

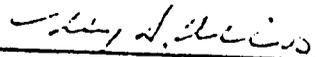
Para poder formalizar este entendimiento, le agradeceré indicar su
concurrancia firmando ambos originales de esta carta y devolviéndonos uno.

Muy atentamente,



Thomas W. Stukel
Director

Aprobación:



Dr. Ney B. Arias L.
Secretario de Estado de Salud Pública
y Asistencia Social

U. S. AID MISSION TO DOMINICAN REPUBLIC

AMERICAN EMBASSY, P. O. Box 22201
SANTO DOMINGO, DOMINICAN REPUBLIC

FOR U. S. CORRESPONDENTS:
U. S. AID MISSION
APO MIAMI 34041-0008

JUL 29 1987

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His Excellency
Ing. Guillermo Caram
Technical Secretary of the Presidency
National Palace
Santo Domingo, D. N.

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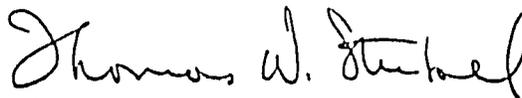
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May 1988:	Detailed plan completed; field operations begin.

So that we may obligate these funds for use in the Dominican Republic during this US. government fiscal year (which ends on September 30, 1987), we propose to make a government-to-government grant to the Technical Secretariat of the Presidency. Under the terms of the proposed grant agreement, the Technical Secretariat agrees to authorize A.I.D. to act as agent in the competitive selection of the coordinating PVO and to sign the cooperative agreement which will be financed with project funds.

We have discussed this arrangement with Dr. Ney B. Arias L., Secretary of State for Public Health and Social Assistance, and with the principal PVOs that work in public health, and they have concurred with this procedure.

In order to formalize this understanding, please indicate your agreement by signing the two originals of this letter, and returning one to A.I.D.

Sincerely,



Thomas W. Stukel
Director

Concurred: _____

Ing. Guillermo Caram

Technical Secretary of the Presidency

Date: AUG 5 - 1987

U. S. AID MISSION TO DOMINICAN REPUBLIC
AMERICAN EMBASSY, P. O. Box 22201
SANTO DOMINGO, DOMINICAN REPUBLIC

29 JUL. 1987

FOR U. S. CORRESPONDENTS:
U. S. AID MISSION
APO MIAMI 34041-0008

Estimado señor Secretario:

El propósito general de esta carta es expresar nuestro mutuo entendimiento en relación al contenido y método de ejecución de un programa de acción para reducir la mortalidad y morbilidad infantil y de niños por debajo de cinco años. Este programa se llamará Proyecto de Supervivencia Infantil.

Varios estudios llevados a cabo por ONAPLAN y otras entidades durante los últimos dos años han demostrado que el estado de salud de muchas familias dominicanas de escasos recursos se ha estado deteriorando. Las instituciones tanto públicas como privadas que realizan programas en salud pública han expresado su preocupación sobre las crecientes tasas de mortalidad y morbilidad infantil, particularmente en ciertas regiones fronterizas. Desde abril nuestro personal ha participado en varias reuniones con SESPAS y CENISME, y con organizaciones voluntarias privadas tales como CARE, Caritas y SSID con relación a este problema. En estas reuniones hemos discutido las posibilidades de apoyar un programa de acción integrada, inicialmente enfocado a las regiones con los indicadores más negativos.

El Proyecto de Supervivencia Infantil propuesto será implementado mediante una organización voluntaria privada y propiciará la educación y los servicios en tres intervenciones claves: (a) terapia de rehidratación oral, (b) nutrición, y (c) infecciones respiratorias agudas. Este programa de cuatro años estará enfocado inicialmente a las Regiones de Salud IV y VI de SESPAS, y barrios seleccionados en la capital (Región 0) donde los indicadores de mortalidad son más altos. La Misión de la AID continuará apoyando dos proyectos complementarios que están siendo ejecutados por SESPAS, uno en planificación familiar y otro para inmunizaciones, que también son componentes de una estrategia de supervivencia infantil.

Su Excelencia
Ing. Guillermo Caram
Secretario Técnico de la Presidencia
Palacio Nacional
Santo Domingo, D.N.

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Para asegurar que el programa esté bien integrado, cuidadosamente planificado y aplique las más recientes conocimientos sobre rehidratación oral, nutrición, y prevención de enfermedades respiratorias, y que sea rápidamente organizado para la entrega de servicios, el proyecto será administrado por una organización voluntaria privada (OVP) coordinadora internacionalmente reconocida. La OVP será seleccionada competitivamente bajo las regulaciones de la A.I.D. por un comité de selección conjunto de la A.I.D. y el CORD. Los fondos del proyecto serán canalizados mediante la organización voluntaria privada seleccionada bajo un acuerdo cooperativo con la A.I.D., financiado con los fondos del proyecto. La OVP coordinadora tendrá a su cargo la asistencia técnica, planificación global del programa, desarrollo de un programa de adiestramiento, administración financiera, compras, apoyo logístico, y control y evaluación de la efectividad e impacto del programa. La OVP coordinadora trabajará, a su vez, con SESPAS y las OVPs en la planificación del programa a nivel regional, la aplicación de materiales educativos, adiestramiento del personal de salud y médico a todos los niveles, la entrega de servicios y evaluación. SESPAS y las OVPs participantes serán elegibles para recibir suministros, adiestramiento y asistencia técnica financiados bajo el acuerdo cooperativo con la OVP coordinadora.

Los materiales y la experiencia del proyecto estarán disponibles para su aplicación en todo el país. La entrega de servicios y educación se llevará a cabo mediante una combinación del personal de campo de SESPAS y las organizaciones voluntarias privadas y comunitarias que trabajan en las regiones seleccionadas.

Los fondos de la donación actualmente disponibles de parte de la A.I.D. son alrededor de US\$2.7 millones. Bajo nuestro propuesto plan, estos fondos serán utilizados para la asistencia técnica (tanto internacional como local), compra de una cantidad limitada de suministros y equipo (tales como sales de rehidratación oral y balanzas para pesar niños); adiestramiento del personal del campo de las agencias ejecutoras; y algunos costos limitados de operación seleccionados para la entrega de los servicios. La contribución de contrapartida de la República Dominicana estará parcialmente financiada por una asignación propuesta de RD\$3,000,000 bajo el programa de la PL-480 Título I, y por aproximadamente RD\$1,000,000 de contribuciones en especie por parte de las entidades participantes. Nosotros estimamos que el aporte en especie del gobierno será de alrededor de RD\$650,000 y el de las entidades privadas como de RD\$350,000.

Con estos recursos, y este método de ejecución, anticipamos que el proyecto podrá alcanzar los siguientes objetivos:

1. Incrementar la cantidad de unidades de servicio (clínicas, clubes de madres, etc.) tanto públicas como privadas que ofrecen programas de supervivencia infantil exitosos en las regiones seleccionadas; y

2. 75 por ciento del personal involucrado en atención primaria de salud en SESPAS y en las participantes OVPs, habrá recibido adiestramiento a corto plazo en intervenciones de supervivencia infantil.

Para 1991 esperamos los siguientes impactos en las regiones de proyectos seleccionadas:

1. Reducción de la mortalidad infantil en las regiones seleccionadas de aproximadamente 90/1000 a 75/1000.
2. Reducción de la morbilidad infantil en un 20%;
3. Reducción de la malnutrición en los niños por debajo de 5 años de un 40% en 1985 a un 25%;
4. Reducción de los nacimientos de bajo peso a menos de un 15% del total de nacimientos;
5. Aumentar la cobertura de inmunizaciones a un 80 por ciento; y
6. Aumentar el número de episodios de diarrea tratados con terapia de rehidratación oral de la actual tasa de 20 por ciento a 75 por ciento.

Nuestro calendario para completar los planes para este proyecto, y la documentación requerida por la A.I.D., es el siguiente:

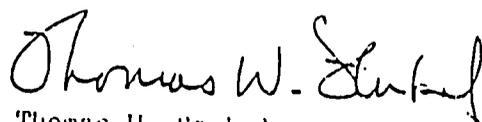
julio-agosto de 1987:	Terminar los estudios de campo y diseño del proyecto.
septiembre de 1987:	Obtener la aprobación del proyecto y firmar el acuerdo con el CORD.
enero de 1988:	Terminar la selección competitiva de la OVP coordinadora y firmar el acuerdo cooperativo.
febrero de 1988:	Llega la OVP al país.
mayo de 1988:	Terminación del plan detallado, comienzan las operaciones de campo.

A fin de poder obligar estos fondos para ser utilizados en la República Dominicana durante este año fiscal (que termina el 30 de septiembre de 1987), nos proponemos hacer una donación de gobierno a gobierno al Secretariado Técnico de la Presidencia. Bajo los términos del propuesto acuerdo de donación, el Secretariado Técnico acuerda autorizar a la A.I.D. a actuar como agente en la selección competitiva de la OVP coordinadora y de firmar el acuerdo cooperativo que será financiado con fondos del proyecto.

Hemos tratado este arreglo con el Dr. Ney B. Arias L., Secretario de Estado de Salud Pública y Asistencia Social, y con las principales OVPs que trabajan en salud pública y todos están de acuerdo con este procedimiento.

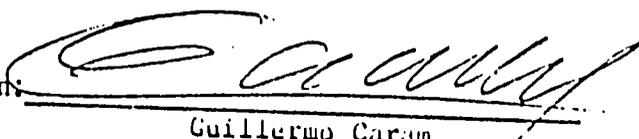
Para poder formalizar este entendimiento, le agradeceré indicar su concurrencia firmando ambos originales de esta carta y devolviéndonos uno.

Muy atentamente,



Thomas W. Stukel
Director

Aprobación:



Guillermo Caram
Secretario Técnico de la Presidencia

- 5 AGO. 1987

ANNEX 3

Detailed Objectives and Related Tasks of Service Delivery Teams

This Annex provides a set of detailed objectives for each primary child survival service, and an illustrative description of the specific tasks and activities that Project designers expect to see SESPAS and PVO promoters and their supervisors performing by the third year of the Project in each one. Included in the tasks are the data collection and reporting associated with each service.

OBJECTIVES

The target population of approximately 500,000 low-income children under the age of 5 and their families will be given access to education and services. This is expected to result, by 1991, in the following status of target families and operational characteristics of the delivery system:

Maternal and Child Nutrition

(Status of families)

- o Grade I, II and III malnutrition reduced from 40% to 25% of the child population;
- o Low birth weight rates reduced by 50%;
- o Exclusive breastfeeding up to four months and continued breastfeeding during weaning by 70% of benefiting mothers;
- o Improved weaning practices will be carried out by 50% of benefiting mothers;
- o 70% referral to a health facility staffed by a physician or nurse of all pregnant women and newborns;

(Project Operations)

- o 90% of community health promoters trained in Growth Monitoring Promotion (i.e., accurate weighings and recording, and appropriate educational messages given to mothers);
- o Decrease in the number of severely malnourished cases referred to the health facilities due to improved problem identification and treatment taking place in the family.

Diarrheal Disease Control/ORT

(Status of families)

- o Diarrhea prevalence reduced by 20%;
- o 60% of diarrhea episodes treated with ORT;
- o 80% of Project mothers who can demonstrate correct preparation and use of ORS packets or home remedies;
- o 70% referral of all severe malnutrition, diarrhea and ARI cases;
- o Infant mortality due to diarrhea decreased by 30% in the under 5 population;
- o 50% of Project mothers continue feeding during diarrhea episodes;
- o 80% of Project mothers discontinue dangerous drug use during diarrhea episodes;

(Project operations)

- o Decrease in the numbers of severely dehydrated diarrhea cases referred to health facilities due to early identification and treatment in the home;
- o 80% of the target population will have increased access to ORS packets;
- o Oral Rehydration Units installed in 100% of public sector health clinics;
- o 80% of health workers trained in proper diarrhea case management;
- o Increase in the number of physicians, interns and medical students using oral rehydration instead of intravenous treatment; and
- o Increased number of pharmacists recommending ORT use for rehydration

Acute Respiratory Infections

(Status of families)

- o Decrease infant mortality due to ARI by 15% in children under 5;
- o 90% of children immunized against measles and 80% mothers immunized for tetanus;

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- o 70% of Project mothers will be able to recognize, know and practice appropriate prevention and timely management/treatment of ARI cases;

(Project Operations)

- o Increase case management capability to 80% in health facilities;
- o Increase appropriate drug prescriptions and use at clinic level;
- o 80% of health personnel trained in appropriate management of ARI.

General/Overall

- o 80% of the target rural population (and 60% in Santo Domingo) covered by all services;
- o Establish a reliable community health record system in 90% of all target communities;
- o 80% reliability of all information collected;
- o 80% of the community health workers receive regular supervision;
- o 50% of all communities organized with their own community health committees;
- o 80% of target rural communities (and 60% in Santo Domingo) are covered by either SESPAS or PVOs and are benefiting from a consistent approach to child survival.

TASKS OF DELIVERY TEAMS

Growth Monitoring and Education

Promoters:

- o Weigh (and potentially measure) all infants and children under 5 years old and plot these measures on a growth chart which will be located in two places: the household of the participating family, and in the family health records that will stay with the promoter;
- o Encourage up to three or four meals per day rather than the usual one or two (depending on the family's economic situation);
- o Educate mothers about the value of exclusive breast feeding (meaning only mother's milk) for the first four months of life and prolonged breastfeeding during weaning;

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- o Demonstrate preparation and conservation of proper weaning foods;
- o Orient the mother as needed to the use and preparation of baby bottles (yet the orientation of the program will be to discourage their use whenever possible);
- o Introduce locally available vegetables and fruits into children's diets; and
- o Record (by family) indications of improved feeding practices (extended breast feeding, additional meals, foods added to diet).

Supervisors:

- o Conduct spot checks on homes to see if feeding practices are changing, and check validity of promoter reports;
- o Recommend incentives or awards for promoters whose target families are showing notable progress; and
- o Once validated, summarize indicator data for area or regional management information system.

Maternal and Child Health/Nutrition: This service includes maternal nutrition, infant and child nutrition, and food supplementation.

Maternal Nutrition:

Promoters:

- o Identify pregnant women and monitor them for signs and symptoms of pregnancy complications such as edema or vaginal hemorrhage and refer complications to the nearest medical facility;
- o Refer pregnant women for regular prenatal check-ups at the nearest medical facility;
- o Educate pregnant women regarding personal hygiene and care of breasts during lactation, so as to reduce infant diarrhea;
- o Suggest that pregnant women and mothers consume vegetables and fruit which are locally available and are often not eaten;
- o Teach mothers about the importance of increased fluid and food intake during lactation; and
- o Record information about the onset of pregnancy, medical or health problems reported by women, and referrals made.

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Supervisors: These individuals will perform three tasks:

- o Coordinate the transfer of complicated pregnancy cases to rural clinics or hospitals;
- o Monitor households to determine whether required promoter tasks are being performed, and refer those who are performing their work at an unacceptable standard to trainers for continuing education if necessary; and
- o Verify promoters' reports with clinics and spot checks with pregnant women, and summarize data for area managers.

Food Supplementation:

Promoters:

- o Identify infants and children with moderate to severe malnutrition (Gómez II/III);
- o Refer children to rural clinics or nutrition rehabilitation centers for food supplementation;
- o Monitor supplemental feeding of these malnourished children; and
- o Track and record growth/weight data on progress of children in rehabilitation, and on return home.

Supervisors:

- o Visit families systematically in the area of a promoter to determine through empirical methods whether the above tasks are being performed; and
- o Provide information on availability and proper distribution of PL-480 or other supplemental feeding to the families under their aegis through rural clinics or other facilities, should that become necessary.

Diarrheal Disease Control (DDC):

Promoters:

- o Treat diarrhea and other minor infections within the promoter's competency;
- o Distribute ORS envelopes to families and child caretakers under their aegis to ensure they have a stock of 4 on hand to treat their children's diarrhea should it occur;

- o Identify signs and symptoms of acute diarrheal disease and complications such as signs of dehydration and anorexia;
- o Refer infants and young children with severe diarrhea and dehydration to clinics;
- o Educate mothers how to identify diarrhea per WHO standards (3 or more loose watery stools within 24 hours) and when to take their children to health professionals for care;
- o Educate mothers about basic causes of diarrhea and their relation to hygiene practice (i.e., handwashing, proper feces disposal, proper food handling and storage);
- o Promote exclusive breastfeeding for the first four months of life, followed by good weaning practices;
- o Educate mothers in the dangers of antidiarrheal drugs;
- o Educate mothers in appropriate dietary management of acute diarrhea;
- o Educate families in the preparation and use of ORT solution prepared with home ingredients through flip charts or leaflets, and in-home practice;
- o Identify whether ORT was applied correctly during the last episode;
- o Test family members' competency in the preparation and use of ORT and reeducate when necessary; and
- o Note in the family records (or preferably the growth chart) the number of diarrhea episodes of each child under 5 years of age experience since the last home visit.

Supervisors:

- o Ensure that harmful local traditional remedies are not being perpetuated by promoters as an alternative to ORT;
- o Perform outreach to mothers' clubs and local schools for teaching teachers and school children ORT use and diarrhea control principles;
- o Perform on site monitoring to assure that errors are not being made by mothers in mixing ORS solutions and feeding is continued during the child's bout of diarrhea; and
- o Summarize promoters' reports on diarrhea episodes and treatments (with salts or home-prepared remedies) after validation of reports.

Acute Respiratory Infections (ARI):

Promoters:

- o Recognize the signs and symptoms that distinguish between mild, moderate and severe cases of ARI, record cases in the family record, and in severely ill ARI cases, refer them to rural clinics for treatment;
- o Teach families to recognize respiratory symptoms that require taking the child to medical facilities, i.e., fast breathing, noisy breathing, nasal flaring and cyanosis;
- o Administer simple treatment measures such as ORT solutions and aspirin for mild ARI cases;
- o Educate families regarding home treatment for mild and moderate cases of ARI such as continued breast feeding and/or feeding, hydration, moist home environment, home remedies and proper intake of anti-microbials when prescribed.
- o Educate families regarding transmission and prevention of ARI, including their relationship with environmental factors such as crowding, especially at night and damp house sites and construction;
- o Help families understand that some of the causes of severe, (and often fatal) respiratory infections can be prevented by immunizations, i.e., pertussis, tuberculosis, measles and diphtheria; and
- o Record reported or observed cases of ARI among families served.

Supervisors:

- o Assure that promoters are properly recognizing cases, providing simple treatments, preventative education, and referring serious cases for medical attention;
- o Verify, summarize, and pass along data on cases, treatments, and where necessary, call for additional training or medical support;
- o Ensure that local traditional remedies are not being perpetuated by promoters as treatment for ARI; and
- o Follow up on supply lines to assure that promoters have the minimum equipment and medicines necessary to treat mild ARI cases (i.e., aspirin, functioning thermometer, ORT packages, etc.)

Not all promoters and supervisors will provide all of these services or tasks at the outset of the Project. A phased program of skills development will be designed by the C/PVO to build up to the full array of services and education described above.

The following services will be provided in conjunction with the Expanded Program of Immunizations and the Family Planning Services Expansion Project. Those Projects will provide the necessary staff training in these skills.

Immunization: This activity will be aimed at achieving timely vaccination coverage in children under 4 years of age. The basic program of vaccinations includes BCG, DPT 1-3, Polio 1-3 and measles. Promoters will distribute vaccination cards in all households assigned to them. Alternatively, vaccinations will be accurately recorded in the appropriate space of the growth charts that will be left in the home (See the Section on Nutrition). Families will be taught to post them on their doors in plastic program envelopes. Each time any member of the family is vaccinated (either by a physician or by a campaign) they are instructed to present their card in order for the vaccination date to be recorded. If the family member does not have his/her vaccination card at the time of vaccination, the health professional will give a vaccination certificate that the family members will take with them to the home and place in the plastic envelope with their permanent vaccination card. At the time of the promoter's regular visit, he/she will enter the vaccination date in the appropriate cell of the permanent card, and in their own records for supervisors to summarize and pass on.

Birth Spacing

Promoters:

- o Help mothers understand that short birth intervals are associated with low birth weight children, increased risks of the child deaths, and a less vigorous and sprightly mother;
- o Encourage mothers to accept a minimal birth interval of two years;
- o Help mothers understand that breast feeding is not only important for their child's nutrition (discussed above), but also related to avoiding unwanted pregnancy;
- o Counsel mothers on the availability of different methods of birth control, and the advantages and disadvantages of each one;
- o Distribute condoms and contraceptive pills to households that request them per program norms;
- o Refer women to clinics for all other birth control devices; and

- o Record or update regularly the birth control status of women of childbearing age.

Supervisors:

- o Ensure the availability of condoms and contraceptive pills to promoters for distribution to local households, and summarize promoter data for area/regional reports.

Lessons Learned from Prior Health Projects
Relevant to Child Survival Project

In the design of the Child Survival Project (517-0239) several evaluations of similar Projects were reviewed with an eye towards identifying lessons learned that should be considered in its design. The two most relevant Projects that relate to the objectives of the child survival Project are the Health Sector Loans I and II (517-U-028 and 517-U-030). The major component of the Health Sector Loan I centered on the establishment of a low-cost rural health delivery system using village level health promoters and supervisors to reach some 1.8 million persons not covered by the existing public health system as of early 1970. Prior to the signing of the first health sector loan in October, 1975, the Secretariat of State of Public Health and Social Welfare (SESPAS), had very few trained personnel to deliver any form of health care to the rural population of the country. With assistance from the loan, promoters and supervisors were trained to deliver immunizations, family planning advice and contraceptives, and refer persons with more complicated health problems to a network of newly built rural clinics and hospitals. The promoters also provided health education to promote proper nutrition, encourage better sanitation practices, and collect information on vital statistics from the communities in which they worked. In 1976, there were 867 promoters in the Basic Health Services Program (SBS) and by August 1981, the program was considered "fully operational" with a high of 5,400 promoters on the job. The Health Sector Loan II (517-U-030) signed in November of 1978, provided additional funding which when added to the resources of the Health Sector Loan I permitted the attainment of the above growth.

The SBS program only operated in rural areas of the country as the urban component planned in the Health Sector Loan I was phased out soon after its inception. The Santo Domingo urban Project had very high promoter attrition and was terminated by SESPAS because of perceived duplication of services, especially with other GODR programs and the health services provided by the major hospitals.

The most complete assessment of the work and effectiveness of the SBS health promoters is contained in the May 1983 evaluation of the Health Sector Loans I and II conducted by Management Sciences for Health (MSH). The evaluation findings are summarized as follows:

USAID Health Sector Loans I and II helped initiate and expand a rural health delivery system in the Dominican Republic based on about 5,400

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promoters. Accessibility to primary health care was extended to about 2,100,000 rural people who previously did not have easy access to these services.

The strong or positive features of the SBS were:

- a) The increased coverage to the rural population, as mentioned above.
- b) A possible (likely) decrease in the rural areas served by the SBS of:
 - i) the infant mortality rate,
 - ii) the mortality rate for children aged 1 to 4 years, and
 - iii) the fertility and birth rates,
- c) The existence of a health infrastructure in the rural areas, mostly devoted to preventive medicine;
- d) Strong community involvement in the SBS;
- e) A high rate of immunization coverage in the rural area and
- f) Salary support from the government to maintain the SBS, showing the government's strong commitment to rural health and preventive medicine, as opposed to urban, hospital-based medicine.

The weak or negative features of the SBS were:

- a) Low productivity of promoters and supervisors with little tangible output in areas other than immunizations and, possibly family planning;
- b) A weak or nearly non-functional supervisory system;
- c) Minimal efforts at continuing education and re-training;
- d) Unreliable data collection and weak information system, which hinders systematic, constructive evaluation of the SBS.
- e) Logistics problems; and
- f) Lack of flexibility due to little decentralization of authority to the regional level.

The SBS has developed for the Dominican Republic an infrastructure for the delivery of preventive health programs (in 1983), capable of reaching approximately 90% of the rural population. For the amount of money spent on

recurrent costs, however, the program should be achieving a lot more. However, largely because of poor support systems supervision, the SBS is not meeting its potential. If the supervision can be improved and the promoter re-inspired to help solve the health problems of their communities, the SBS will save the Dominican Republic huge costs in direct health services provided at higher levels.

Although not entirely reliable, figures for mortality and birth rates already show some improvement in the target areas. Immunization rates are excellent for a "horizontal" program. The SBS, however, generally lacks maintenance, except for salaries and vaccines. There is little reiteration of the service philosophy, continuing education, or effective supervision. SBS productivity appears to have declined in the past 2 years and is in need of resuscitation. With some effective regionalization, retraining of supervisors and promoters, and with increased attention to information and logistics support systems, however, SBS should be able to continue to improve the health status of the Dominican people.

The MSH evaluation concluded with a series of recommendations and alternatives for upgrading the SBS. In the interest of showing how the new child survival Project is planning to address these recommendations, the recommendation will be repeated below followed by a brief explanation of what remedial action is planned in the new Project.

1. SBS Status Recommendation:

To make the SBS program effective, it must be consolidated and led back to its original objectives and goals from its present almost directionless state. Except for immunizations, the SBS' preventive goals have largely been forgotten. Improving management support to the existing infrastructure will make it possible to revive other preventive programs and to expand the functions and coverage for the system.

Response:

After more than four years of decline, SESPAS has decided to reactivate the former SBS program. On August 12, 1987, the Secretary of Health announced the creation of the National Child Survival Plan which will deliver child survival interventions throughout the SESPAS infrastructure. It is recognized that, particularly in the light of the recent (summer 1987) turnover of nearly 100% of the promoters and supervisors, that the rural health system needs to be completely revamped and strengthened. The Child Survival Project together with resources from the Family Planning Services Expansion (517-0229) and the Immunizations (517-0242) Projects will provide a major source of the technical assistance and financing to carry out the recommendation.

2. Field Personnel Recommendation:

Promoters and supervisors should be qualified people chosen because of their dedication to the goals of the SBS. Those personnel who do not fit these criteria should be replaced. The formal continuing education program and improved supervision should be used to identify any incompetent people.

Response:

This recommendation has been followed by SESPAS using a selection methodology that is not likely to support the purpose of the program. During the summer of 1987, SESPAS fired all the promoters and supervisors associated with the rural health program. The rationale for this action was a feeling that the promoters were "too political" and were not serving the needs of the program. Unfortunately, the new promoters were selected by the local branch offices of the party in power without the use of job descriptions or employment criteria. Mixed information has reached the USAID office as to the results of this practice. Some persons claim that the new promoters are "better", other feel they may not have even the minimum entry level qualifications (i.e. able to read and write). In view of this development and the key role that promoters and supervisors play, USAID proposed to request SESPAS to update the job descriptions for promoters and supervisors and establish minimum job entrance criteria. The promoters and supervisors will be tested against this criteria prior to entering training. Those persons who cannot meet the criteria will not be allowed to proceed to training paid for under the Project and should be replaced with a more qualified person.

3. Supervision Recommendation:

The supervisory system needs to be made into a true supervisory system. Retraining (or in some cases, training) the supervisors and maintaining a continuous retraining program for them should be a priority. If a supervisor cannot be trained, or retrained, he or she should be replaced.

Response:

The Child Survival Project proposes to revive and strengthen the supervisory system so that it becomes a mechanism for quality control, assuring that services are delivered according to program norms. Supervisors will be trained in supervision and to function as trainers of promoters. Promoters who cannot fill their role will be requested to assume another position in the Project or their agency, or leave the program.

4. Salary Recommendation:

Salary support for promoters and supervisors should receive high priority and should continue at this point if at all feasible. An extensive financial analysis of the SESPAS operating budget might identify other areas where budgetary savings could be achieved at less cost in terms of health

services delivery. If it is necessary to withdraw salary support at a later time, alternate financing through the community should be explored, and might even be preferable.

Alternative financing for promoters should be explored in case budget support has to be cut back. Possible alternatives might be direct community financing through quotas or the establishment of a community pharmacy run by the promoter and the health committee.

Response:

This recommendation was made at a time when SESPAS was considering discontinuing the RD\$50.00 per month stipend to each promotor. This action was not taken. Nevertheless, the recommendation to study alternative sources of funding for the present or future promoters remain valid and will be dealt with by the Project as a way of reducing recurring costs.

5. Rural Coverage Recommendation:

The system should be extended to other rural areas so as to cover as much of the rural area as feasible. This coverage would include rural areas in the vicinity of rural clinics as well as more remote areas (communities under 400 population) not presently included in the system. It is estimated that this additional coverage would require about 1,200 additional promoters and 120 additional supervisors.

The SBS should not be extended to the urban or peri-urban areas until the rural system is well into the "consolidation" phase. However, some preliminary studies and/or experiments in the peri-urban areas should be made, as these are areas of great need.

Response:

The recommendation implies that SESPAS should be the organization to expand health coverage. At this time, USAID does not agree with the recommendation in the light of the general deterioration and politicization of the SESPAS rural health system. Instead, the Mission recommends strengthening the existing SESPAS staff and infrastructure and complementing their present coverage with assistance to PVOs who are presently engaged in child survival activities. This strategy should increase coverage without increasing SESPAS' recurrent cost problem. PVOs will clearly have recurrent cost problems as well; however, they rely more on the use of volunteers at the community level and their overhead is generally lower. PVOs will also receive assistance on alternative forms of financing under the Project.

In urban areas, the Mission proposes to support the existing urban PVOs as opposed to recommending the extension of SESPAS to the barrio level.

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6. Staff Transportation Recommendation:

Improve the transportation system possibly including bicycles, as well as more efficient use of motorcycles and vehicles, so as to allow better supervision and better backup by people in various preventive programs such as nutrition and maternal and child health.

Response:

By its very nature, the child survival program will operate in remote areas, making transportation of supervisors a key element for success. The Project proposes to provide a limited number of vehicles to the SESPAS regional and central offices which participate in the Project as well as to the major PVOs who will also participate. Vehicles will be assigned to pools which will, in turn, support a group of service delivery specialists (i.e. family planning and MCH, nutrition and ORS) thus facilitating a team supervision concept rather than a one-vehicle-one program concept. Transportation for supervisors will be in the form of motorcycles. However, the Project will experiment with a transportation stipend to the supervisor so that he/she may buy their own motorcycle with the understanding that it will be used to support the supervisor on the job. The stipend will also cover cost of fuel and maintenance for work related travel.

7. Information System Recommendation:

The information and data collection systems need simplification, rationalization, and better supervision to make evaluation possible.

Response:

The information and reporting system to be developed under the Project will far exceed the SBS system. The information system will, in effect, become an integral part of the promoter's work allowing him/her to visualize the health status of the people they serve and gauge their own productivity. The information system will be able to gather the data required for reporting child survival statistics to A.I.D./W and will be complemented by selected in-depth studies needed for evaluation purposes. Four person months of TA are dedicated to this function.

8. Logistics Recommendation:

Logistics problems, such as the supply of cotton, alcohol, forms, thermoses, and transportation expenses for the promoters should receive priority attention.

Response:

The logistic system will be revamped making the supervisor responsible for the availability of supplies, information forms, and

educational material at the community level. At the regional level specific personnel will be trained in the ordering storage distribution of supplies on a timely basis. Four person months of TA are dedicated to this function.

9. Clinic Staff Training Recommendation:

Orientation and reorientation programs at regular intervals are required for personnel assigned to the rural clinics (including especially the physician on his year of rural service).

Any attempts should be made to incorporate this training in community and preventive medicine into the medical school curriculum.

Since the rural clinics are the backup for the promoters and the SBS, the drug supplies need to be improved at the rural clinics in order to improve the quality of care. Minimal laboratory services should also be considered for the rural clinics.

Response:

The Project recognizes the important role that rural health clinics with their medical staff play in the child survival Project. Consequently, the rural clinic physicians (known as pasantes) will be trained in child survival techniques by such groups as the Dominican Pediatric Society. The pasantes will be brought into the planning process of those supervisors and promoters that work in the catchment area of the rural clinic. While the Project does not contemplate the distribution of drugs at this time, it is important to establish effective referral services to the rural clinics where general medical care and selected medicines will be available. The Project does not plan to provide laboratory equipment to the rural clinics due to the frequent turnover of their staff; however, such a request will be considered based on its merits once the Project is underway and key rural clinics have been identified.

10. Water/Sanitation Recommendation:

Continue support of expanded water and sanitation systems, with health education.

Response:

The child survival Project has targeted its resources to the selected primary interventions supported by A.I.D./W and UNICEF. The Project, nevertheless, fully recognizes that water is an important component to a child survival strategy. Therefore, the Project plans to seek the participation of SESPAS regional offices and PVOs who are also working in such areas as sanitation, water, income generation, complementary feeding and agricultural production on their own. The institutional analysis of PVOs in the target

area indicates that there are PVOs who are already engaged in these activities and who, in turn, are eager to enter into child survival services. This is the kind of complementarity that the child survival Project is striving for.

The MSH evaluation concludes with a general set of observations and recommendations. The full evaluation is on file in the Health and Population Division of USAID/DR.

A Summary of Relevant A.I.D. Policies
on Which The Child Survival Project is Based

Immunization Strategy

Under a mandate of the U.S. Congress, A.I.D. is working closely with the World Health Organization's Expanded Program on Immunizations (EPI), to reach the target of 80% coverage for six vaccines: polio, measles, diphtheria, pertussis, tetanus and tuberculosis. In addition, in the Americas, A.I.D. has joined with the Pan American Health Organization to interrupt transmission of wild polio virus, thereby eradicating poliomyelitis from the Americas. The Government of the DR, in collaboration with A.I.D. and the Pan American Health Organization has recently signed the Country Plan of Action. This strategy calls for universal immunization coverage for children less than one year of age by 1991 through a combination of public campaigns and infrastructural development.

Diarrheal Disease Control Strategy

A.I.D.'s goal, in conjunction with host countries and other international donors, is universal access to ORT, using a combination of ORS packets and home-available solutions, and appropriate use of ORT for diarrhea in all children under five. Explicit world targets are:

1. ORT accessible to virtually every child who needs it by 1990.
2. 45% appropriate use of ORT by 1990.
3. Two million lives saved from diarrheal deaths.

Key elements of the strategy to achieve these targets are: 1) policy dialogue with key decision makers; 2) infrastructural development; 3) use of the private sector; 4) local production of ORS packets; and 5) development of comprehensive national diarrheal disease prevention and control program.

Nutrition Sector Strategy

A.I.D.'s nutrition sector strategy is to integrate specific nutrition interventions into Health, Agriculture, Population, Education, Food Assistance and other agency programs. These interventions in the health sector include growth monitoring, infant feeding programs with special emphasis on encouraging breast feeding and improving weaning habits, targeting food aid, maternal nutrition enhancement, and addressing micronutrient deficiencies such as vitamin A, iron and iodine.

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Population Strategy

A.I.D.'s goal, in collaboration with host governments and international donors is to make a wide variety of family planning services universally available to those who voluntarily choose to use them. Key elements of the strategy include: 1) strengthening the host country capability to determine and address policy issues; 2) developing service delivery capability via technical assistance, training, provision of commodities, and management improvement; 3) developing and using multiple delivery systems including community based distribution, clinic based services and contraceptive social marketing, via both the public and private sectors; 4) enhancing research ability in both policy and programmatic areas; 5) disseminating family planning information and education, including natural family planning; and 6) promoting research on new contraceptive methods.

Health Research Strategy

A.I.D.'s Health Sector Policy Paper calls for a program of applied and basic research to meet the health needs of the world's peoples. A.I.D. will encourage initiation or expansion of appropriate biomedical research activities in developing countries. Collaborative efforts between host country and U.S. research institutions will be especially encouraged. But medical advances, such as vaccines, are only useful if they can reach the population affected. Realizing that Child Survival calls for a massive extension of coverage, the sector health policy supports operational research to improve the delivery of services and monitor its effectiveness. Finally, Child Survival programs, which extend services beyond the clinic directly to the household, require intimate knowledge of local health seeking behaviors so that health behavioral research has become a priority, both to describe the local setting and to design programs that will be accepted and effective.

Health Financing Strategy

A.I.D.'s draft policy on health financing is to concentrate policy dialogue and program assistance on promoting sustainable health programs. A.I.D. places special emphasis on encouraging the development of self-sufficient cost-effective programs and the use of private sector approaches where possible. Policy dialogue is directed towards improving resource allocation, improving quality and availability of services, shifting financing of personal curative services to those willing to pay, and ensuring that public funds are available for preventive health services that benefit the public as a whole.

5C(2) - PROJECT CHECKLIST
CHILD SURVIVAL PROJECT

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded from Development Assistance loans; and B(3) applies to projects funded from ESF.

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

A. GENERAL CRITERIA FOR PROJECT

- 1. FY 1987 Continuing Resolution Sec. 523; FAA Sec. 634A. Describe how authorization and appropriations committees of Senate and House have been or will be notified concerning the project. CN was forwarded to Congress August 5, 1987 expiration date is August 20, 1987.
- 2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance, and (b) a reasonably firm estimate of the cost to the U.S. of the assistance? YES
- 3. FAA Sec. 611(a)(2). If legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance? No further legislative action is required.
- 4. FAA Sec. 611(b); FY 1987 Continuing Resolution Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.) N.A.

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

N.A.

6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.

Project is not susceptible to execution as part of regional or multilateral project.

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

As this is a child survival project focusing on health issues it does not directly relate to industry and commerce issues.

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

A U.S. Private Voluntary Organization will be selected to be the coordinating entity in-country.

9. FAA Secs. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

The Project Grant Agreement requires that the country contribute a total of US\$2,325 million in cash and 1,025 in in-kind assistance.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No, U.S. does not own excess foreign currency.

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11. FY 1987 Continuing Resolution Sec. 521. N.A.
If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?
12. FY 1987 Continuing Resolution Sec. 558 N.A.
(as interpreted by conference report).
If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities (a) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (b) in support of research that is intended primarily to benefit U.S. producers?
13. FY 1987 Continuing Resolution Sec. 559. NO
Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

14. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (a) stress the importance of conserving and sustainably managing forest resources; (b) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (c) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (d) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (e) help conserve forests which have not yet been degraded, by helping to increase production on lands already cleared or degraded; (f) conserve forested watersheds and rehabilitate those which have been deforested; (g) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (h) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (i) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (j) seek to increase the awareness of

Yes. A negative environmental recommendation has been recommended,

U.S. government agencies and other donors of the immediate and long-term value of tropical forests; and (k) utilize the resources and abilities of all relevant U.S. government agencies?

15. FAA Sec. 119(g)(4)-(6). Will the assistance (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas? N.A.
16. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)? N.A.
17. FY 1987 Continuing Resolution Sec. 532. Is disbursement of the assistance conditioned solely on the basis of the policies of any multilateral institution? NO.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria
- a. FAA Secs. 102(b), 111, 113, 281(a). Describe extent to which activity will (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and

insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

Self-help efforts will be supported by improving the knowledge of young mothers in the care and feeding of their children under 5 years in order to decrease abnormally high child mortality rates.

- b. FAA Secs. 103, 103A, 104, 105, 106, 120-21. Does the project fit the criteria for the source of funds (functional account) being used? YES.
- c. FAA Sec. 107. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?
- d. FAA Secs. 110, 124(d). Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)? Yes, country will contribute 42% of total project costs.
- e. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority? Local PVOs and community and regional health providers will be directly benefitted by training and supplies procured by the project; their clients are the rural and urban poor in the projects target area.

- f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government. Institutional development of local PVOs improves and utilizes the country's intellectual resources
- g. FY 1987 Continuing Resolution Sec. 540. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? NO.
- Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations? NO.
- Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? NO.
- h. FY 1987 Continuing Resolution. Is the assistance being made available to any organization or program which has been determined to support or participate in the management of a program of coercive abortion or involuntary sterilization? NO.
- If assistance is from the population functional account, are any of the funds to be made available to voluntary family planning projects which do not offer, either directly or through referral to or information about access to, a broad range of family planning methods and services? NO.
- i. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? YES.

j. FY 1987 Continuing Resolution. How much of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

All funds will be channelled through a PVO; those PVOs controlled by black, hispanic, Native Americans and/or women will be encouraged to submit applications.

k. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project (a) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (b) take full account of the environmental impacts of the proposed activities on biological diversity?

N.A.

l. FAA Sec. 118(c)(14). Will assistance be used for (a) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (b) actions which significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas?

NO.

m. FAA Sec. 118(c)(15). Will assistance be used for (a) activities which would result in the conversion of forest lands to the rearing of livestock; (b) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undegraded forest lands; (c) the colonization of forest lands; or (d) the construction of dams or other water

NO.

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control structures which flood relatively undegraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

2. Development Assistance Project Criteria
(Loans Only)

N.A.

- a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.
- b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?
- c. FY 1987 Continuing Resolution. If for a loan to a private sector institution from funds made available to carry out the provisions of FAA Sections 103 through 106, will loan be provided, to the maximum extent practicable, at or near the prevailing interest rate paid on Treasury obligations of similar maturity at the time of obligating such funds?
- d. FAA Sec. 122(b). Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?

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3. Economic Support Fund Project Criteria

N.A.

- a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA?
- b. FAA Sec. 531(e). Will this assistance be used for military or paramilitary purposes?
- c. ISDCA of 1985 Sec. 207. Will ESF funds be used to finance the construction, operation or maintenance of, or the supplying of fuel for, a nuclear facility? If so, has the President certified that such country is a party to the Treaty on the Non-Proliferation of Nuclear Weapons or the Treaty for the Prohibition of Nuclear Weapons in Latin America (the "Treaty of Tlatelolco"), cooperates fully with the IAEA, and pursues nonproliferation policies consistent with those of the United States?
- d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

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ANNEX 7

ENTRENA REPORT CAN BE FOUND IN OFFICIAL PROJECT FILE AT USAID/DR

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TECHNICAL ASSISTANCE PLAN

To assure success in achieving the Project's stated objectives, Project resources will be granted to a qualified PVO with demonstrated experience in managing child survival programs in developing countries. The PVO will serve as the coordinator of all A.I.D. financed activities and, therefore, will be known as the "C/PVO". The C/PVO will be selected by open competition using a list provided by the Bureau of Food and Voluntary Agencies (FVA) of known PVOs who have managed child survival programs. The selected C/PVO will receive a Cooperative Agreement which will allow them to also receive, distribute and account for the financial resources of the Project. The justification for the selection of a PVO and the use of the Cooperative Agreement as the assistance instrument is explained in Section of the Project Paper.

The primary tasks of the C/PVO are presented in Section III-C of the Project Paper and, therefore, will not be repeated here. This Annex provides the timetable by which the C/PVO will be selected and granted the Cooperative Agreement and a brief description of the responsibilities and selection criteria for several of the key technical advisors.

A. Schedule

<u>Major Events</u>	<u>1987</u>
1. Issue Request for Application to PVOs.	October 16.
2. Deadline to receive C/PVO Applications.	November 30.
3. Review Applications and Select C/PVO.	December 18.
4. Award Cooperative Agreement to C/PVO.	December 31.
	<u>1988</u>
5. C/PVO Long Term resident staff arrive to establish office.	January.
6. Hire core local staff.	February.
7. Short Term TA arrives to work w/SESPAS and PVOs to:	March.
- Complete definition of each intervention.	
- Establish implementation plans.	
- Finalize TA, training and procurement plans.	

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8. C/PVO hires staff or contracts firm to develop training, educational and publicity materials. March.

B. Responsibilities of Key Long Term Staff

1. Chief of Party

This person will act as Project Director on behalf of the C/PVO, reporting to the Executive Committee of the project which is composed of representatives of the TSP, the participating PVOs and the SESPAS Director of the National Child Survival Plan. The Chief of Party serve for 3 1/2 years, and will be a manager with overall technical coordination responsibilities to oversee the design, planning and content matters of the project. Also, the Chief of Party will be responsible for monitoring all financial arrangements including the issuing of subgrants financed with project funds.

The minimum qualifications for this position are at least of five years experience in the management of child survival or primary health programs in LDCs. The Chief of Party should have a minimum of FSI R-3, S-3 Spanish and English language proficiency, but higher levels of proficiency are preferred. He/she should be a content specialist in one or more child survival interventions and experienced in management information systems and project/program financial accounting procedures.

2. Regional Technical Advisors

To facilitate implementation of all facets of the projects at the regional level (Regions IV and VI), the C/PVO will provide two advisors to be based in Barahona and San Juan de la Maguana for 3 1/2 years. The role of the Regional Advisor is to work with SESPAS and the PVO regional staff to assure the implementation of planned project activities including training, instalation and use of the MIS and supervisory and logistics systems. The Regional Advisor will work closely with the Regional Coordinating Committee whose membership includes all the PVO and key SESPAS staff working in child survival.

The minimum qualifications for the Regional Advisors are experience in one or more child survival interventions, fluency in Spanish at an FSI R-3, S-3 level, and academic training at a least an BA or MA level in an appropriate field of study (Harvard people had some more specifics on these people that we may wish to include). A medical/health background is preferred, but not essential. The Advisor must be willing to travel throughout the region and maintain contact with all participating institutions. The Regional Advisors may be either US, third country or Dominican nationals.

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The Santo Domingo Office of the C/PVO will also house a core business office for the project composed of the following suggested full time locally hired staff positions:

- Financial/procurement Management Specialist who will head up the business office.
- Accountant to keep track of all funds that pass through the C/PVO to other PVOs and SESPAS.
- Auditor who will travel throughout the project area to monitor the use of project funds, particularly those used for training.
- Administrative Assistant to assist with procurement, in-country shipment and logistics.

In addition, the C/PVO will hire or sub-contract expertise in staff training, training materials development, educational materials development for beneficiaries and mass media publicity and social marketing. The size and composition of these staff are left to the discretion of the C/PVO based on their experience and preferred approach to staffing these technical areas. Lastly, the C/PVO will acquire sufficient staff to develop and implement the MIS with data processing capability in Santo Domingo and in each of the two regional offices. As in other technical areas, it is recommended that local full time staff be hired for these positions.

3. Short Term Staff

The Chief of Party of the C/PVO will be responsible for defining the scope of work and scheduling the arrival of all short term consultants paid with project funds. The following list of specialists has tentatively been developed with the understanding that the C/PVO will identify the areas of expertise and length of time to be devoted to each area:

Training Methods and Curriculum Development (6 person-months): This individual will work on establishing the training system, including the identification and retraining if needed of lead trainers to conform to the training approach and scope of training activities demanded by the Project.

Training Materials Development (4 person-months): Working with the methods/curriculum specialist, this person will provide guidance to the in-country training team in developing training materials for each of the target groups of trainees.

Management Information/Evaluation (6 person-months): This expert will advise all participating entities on the design, operation, appropriate use of electronic data processing, and uses of a management information system that supports operational research, management decisions, and evaluation requirements.

Mass Media/Publicity (4 person-months): This person will help to develop public information campaigns in various media, logos and other means of identifying the project and its messages, and giving them wide exposure.

Child Health (3 person-months): This person will augment the expertise of the resident team, being a source of current knowledge, of solutions to special problems that may arise in relation to ORT, nutrition, infectious diseases, and related matters.

Procurement/Logistics (1 person-month): This individual will provide support in the design of the logistics system, and backstop the procurement efforts of the project.

C. Budget

Detailed cost schedules for the C/PVO are included in Annex 10.

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PROCUREMENT PLAN

With the exception of a limited number of items to be procured by USAID in advance of the arrival of the C/PVO, the C/PVO will be responsible for developing the specifications and procuring the bulk of the commodities needed in the project. The C/PVO will also arrange for shipment, insurance, receiving in Santo Domingo, storage, inventorying and distribution to the end-user. The USAID Mission will assist with customs clearance in the D.R. once the C/PVO has supplied the corresponding shipping papers and procurement documents.

The procurement plan calls for the development of specifications and the placement of purchase orders as early as possible to assure the time arrival of the needed items. Uniformity in types of equipment is stressed (i.e. computers, vehicles, AV equipment, office equipment) in order to facilitate maintenance and upkeep. In establishing specifications, the C/PVO should consider the availability of authorized factory representatives and trained maintenance personnel in the DR as well as access to spare parts and delivery time.

To facilitate the tracking of international procurements actions, the C/PVO is encouraged to initiate procurement on specific target dates as proposed in the Implementation Plan.

The C/PVO will procure locally and in the U/S/ on behalf of the project using USAID procurement regulations and procedures. The C/PVO will make payment to the vendors and will be reimbursed per the terms of the Cooperative Agreement. If a procurement requires a source and origin waiver or any other waiver, the C/PVO will first discuss the nature of the waiver with the Mission technical division and Management Office and, if agreed, will proceed to prepare the waiver. The Technical division will clear the waiver within USAID.

(B)

ILLUSTRATIVE LIST OF PROJECT EQUIPMENT

<u>Description/Quantity</u>	<u>Est. Cost^{1/}</u>	<u>Procure by</u>	<u>Source</u>	<u>Issue date</u>
Computer/Word Processors, monitors, printers and software for MIS (3)	26,000	C/PVO	US	Jul.88
Computer/Word Processor, monitor printers and software for C/PVO accounting and training materials development (2)	15,000	C/PVO	US	Apr.88
Calculators, desk top multifunction with tape and visual read out, 10 digit , AC/DC (6)	600	C/PVO	US	Apr.88
Typewriter, electronic spanish/english characters large carriage (5)	3,000	C/PVO	US ^{2/}	Apr.88
Copy Machines, heavy duty w/auto feed and reduction capability (2)	5,000	C/PVO	US ^{2/}	Apr.88
<u>Audio Visual Equipment</u> Cameras, VHS format color, auto focus w/ tripod (2) Color 19" Monitors (3) VCRs VHS format (3) Set of studio lights (1)	8,000	C/PVO	US ^{2/}	Apr.88
Supplies and tapes				
Vehicles, general passenger use, 4-2X4; 8-4X4 heavy duty \$16,000 each	192,000	USAID	US	Nov.87

(3)

<u>Description/Quantity</u>	<u>Est. Cost</u> ^{1/}	<u>Procure by</u>	<u>Source</u>	<u>Issue date</u>
<u>Office furniture</u> Executive desks and chairs (10) Secretary desks and chairs (3) Tables (6) Visitor chairs (30) Filing cabinets (4) Computer stands (5) Cabinets for supplies (3)	12,000	C/PVO	DR	Feb.88
Air Conditioners (8)	4,000	C/PVO	US	Apr.88
<u>Service Delivery Supplies</u> Scales (1500)	105,000	USAID	US ^{2/}	Nov.87
Cassette Tape players	9,000	C/PVO	US ^{2/}	Apr.88
Tapes and batteries (1500)				
Growth monitoring record books and carrying bags (1500)	19,500	C/PVO	DR	Apr.88

^{1/} Cost does not include shipping which is estimated at an average of 25% of the value of the goods.

^{2/} May require source and origin waiver (Code 935).

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DETAILED COST SCHEDULE
PROJECT ADMINISTRATION
(US\$000)

INPUTS	AID		COUNTERPART		GRAND TOTAL
	FX	LC	LC	IN KIND	
<u>Technical Assistance</u>					
PSC Coord. (A.Weeks)	140				140
Coordinating PVO:					
Salaries-chief of party, 2 regional advisors and eight local T.A. team	470	311			781
Overhead	217	145			362
Allowances-quarters, education	295				295
Others-Off. rental, off. equipment, supplies and furniture.	34	120			154
Logistical support	60				60
Furniture and appliances	60				60
Travel and transp.-International and in-country travel	42				42
	<u>1,318</u>	<u>576</u>	<u> </u>	<u> </u>	<u>1,894</u>
<u>Evaluation</u>					
To be performed by an external evaluation team, contracted by USAID	100	100			200
	<u>100</u>	<u>100</u>	<u> </u>	<u> </u>	<u>200</u>

DETAILED COST SCHEDULES
ANNEX 10

(1/1)

INPUTS	AID		COUNTERPART		GRAND TOTAL
	FX	LC	LC	IN KIND	
<u>Audit</u>					
To be performed by an external audit firm con- tracted by the C/PVO	—	50	—	—	50
		50			50
SUBTOTAL	<u>1,418</u>	<u>726</u>	—	—	<u>2,144</u>

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DETAILED COST SCHEDULE
SERVICE DELIVERY
(US\$000)

INPUTS	AID		COUNTERPART		GRAND TOTAL
	FX	LC	LC	IN KIND	
<u>Rapid Response</u>					
Educ. Materials-					
Printing		121			121
		<u>121</u>			<u>121</u>
Commodities					
Scales	111				111
Cassette tape play.	5				5
Growth Monit. Rec.	1	2			3
Vehicles	192				192
	<u>309</u>	<u>2</u>			<u>311</u>
Budget Support					
Part. PVOs (Subgrants to SSID, FUDECO, CARITAS, IDDI, PPS)		40			40
LC Counterpart Contrib.			55		55
In Kind counterpart contribution				50	50
		<u>40</u>	<u>55</u>	<u>50</u>	<u>145</u>
Training					
SESPAS Participants		5	55		60
PVO Participants		10	27		37
		<u>15</u>	<u>82</u>		<u>97</u>
SUBTOTAL	<u>309</u>	<u>178</u>	<u>137</u>	<u>50</u>	<u>674</u>

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INPUTS	AID		COUNTERPART		GRAND TOTAL
	FX	LC	LC	IN KIND	
<u>Service Improvement</u>					
Training					
Salaries and Perdiem:					
Perdiem:					
Nursers and auxi- liary workers			495		495
SESPAS Particip.			218		218
PVOs Participants			108		108
Health Educ.		5	57		108
MD Participants			95		62
					95
Salaries					
1 Training Dir.,					
2 training mat.					
dev. specialists,					
2 master trainers,					
art work, 2 secs.		224			224
Transportation					
In-country travel for trainers		17	39		56
Subgrant to DPS			50		50
Printing and supplies		21			21
Office Space		19			19
Contingencies			81		81
		<u>286</u>	<u>1,143</u>		<u>1,429</u>

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INPUTS	AID		COUNTERPART		GRAND TOTAL
	FX	LC	LC	IN KIND	
Educational Materials					
Printing		704			704
Salaries-1 Dir., 6 material dev. staff, 2 clerk typist		155			155
Perdiem and transp. for evaluators and material dev. Staff		35			35
Office Space		12			12
Office Supplies		8			8
Office Furniture		2			2
		<u>916</u>			<u>916</u>
Social Marketing					
Mass Media Educ. (TV, radio, pos- ters, etc)		60		25	85
		<u>60</u>		<u>25</u>	<u>85</u>
Commodities					
Training and Educ. functions support (2 veh.)	32				32
Cassette tape play.		33			33
Growth monit. recd's.	5	8			13
Three computers	25				25
Typewriter-calcu.	1				1
Casset.tapes and batteries		10			10
Office Equipment	16	5			21
Audiovisual Equip.	8				8
	<u>120</u>	<u>23</u>			<u>143</u>

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INPUTS	AID		COUNTERPART		GRAND TOTAL
	FX	LC	LC	IN KIND	
Budget Support					
Participants PVO (Subgrants to SSID, FUDECO, CONANI, IDDI, DPS, etc.)		360			360
LC Counterpart Cont.			1,045		1,045
IK Counterpart Cont.				950	950
		<u>360</u>	<u>1,045</u>	<u>950</u>	<u>2,355</u>
Management and Eval. Information					
Technical Assistance					
Salaries					
1 Dir, 1 Prog, 1 assist, 2 data processor.		150			150
Printing and forms		62			62
Supplies		22			22
Office Space		14			14
Office furniture		4			4
Perdiem and transp.		4			4
		<u>256</u>			<u>256</u>
SUBTOTAL	<u>120</u>	<u>2,021</u>	<u>2,188</u>	<u>975</u>	<u>5,184</u>
PROJECT TOTAL	<u>1,847</u>	<u>2,805</u>	<u>2,325</u>	<u>1,025</u>	<u>8,002</u>

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U. S. AID MISSION TO DOMINICAN REPUBLIC

AMERICAN EMBASSY, P. O. Box 22201
SANTO DOMINGO, DOMINICAN REPUBLIC

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ANNEX 11

FOR U. S. CORRESPONDENTS:
U. S. AID MISSION
APO MIAMI 34041-0008

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INITIAL ENVIRONMENTAL EXAMINATION

Project Location : Dominican Republic
Project Title : Child Survival
Funding : FY 1987 - \$2,750,000 - G
LOP - \$4,600,000 - G
Life of Project : Four (4) years
IEE Prepared by : W. H. Smith, Mission Engineer
Date : W. H. Smith 9/10/87

Environmental Action Recommended: Negative determination

Concurrence: Thomas W. Stukel, Director, USAID/DR

Thomas W. Stukel

Date: 9/24/87

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I. EXAMINATION OF NATURE, SCOPE, AND MAGNITUDE OF ENVIRONMENTAL IMPACTS

Contributing to USAID's goal of improving the health of children in the Dominican Republic, the Child Survival Project will deliver selected services in three targeted geographic regions. The purpose of the four year Project is to improve the quality and expand the coverage of child survival services offered by SESPAS and PVO's. This will be measured by reduced average infant mortality rates from as high as 90 per 1000 live births to 75 per 1000 and reduced average child mortality rates from 18 per 1000 to 10 per 1000 by 1991 in the most severely affected health regions selected by the Project. The target population of approximately 500,000 low-income children under the age of 5 and their families will be given access to education and services in maternal-child nutrition, diarrheal disease treatment, and acute respiratory infections, shown to be the principal threats to young children.

No major physical works are planned under the project and no additional land or water use will be required.

II. RECOMMENDATIONS FOR ENVIRONMENTAL ACTION

The proposed project will not have an impact on the natural environment of the DR, and will have a positive impact on the human environment by improving the health of Dominican children. It is recommended that the Mission Director approve a Negative Determination for this project.

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IMPACT IDENTIFICATION AND EVALUATION FORM

Impact
Identification
and Evaluation.
(see 1/)

Impact Areas and Sub-areas

A. LAND USE

- 1. Changing the Character of the land through:
 - a. Increasing the Population N
 - b. Extracting Natural Resources N
 - c. Land Clearing N
 - d. Changing Soil Productive Capacity N
- 2. Altering Natural Defenses N
- 3. Foreclosing Important Uses N
- 4. Jeopardizing Man on His Works N

B. WATER QUALITY

- 1. Physical State of Water N
- 2. Chemical and Biological States N
- 3. Ecological Balance N

C. ATMOSPHERE

- 1. Air Additives N
- 2. Air Pollution N
- 3. Noise Pollution N

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D. NATURAL RESOURCES	
1. Diversion, Altered Use of Water	N
2. Irreversible, Inefficient Commitments ...	N
E. CULTURAL	
1. Altering Physical Symbols	N
2. Change of Cultural Traditions	N
F. HEALTH	
1. Changing a Natural Environment	N
2. Eliminating an Ecosystem Element	N
G. GENERAL	
1. International Impacts	N
2. Controversial Impacts	N
3. Larger Program Impacts	N

-
- 1/ N - No environmental impact.
 - L - Little environmental impact.
 - M - Moderate environmental impact.
 - H - High environmental impact.
 - U - Unknown environmental impact.

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