5110453 PD-ABB-304 67242

AID 1025-1 (7-71) (FACE SHEET)

NONCAPITAL PROJECT PAPER (PROP)

PAGE 1 of ___ PAGES

I. PROJECT IDENTIFICATION

1. PROJECT TITLE: Rural Health Delivery Systems - Accelerated Program Development

APPENDIX ATTACHED: [X] YES [ ] NO

2. PROJECT NO. (M.O. 1095.2)

3. RECIPIENT (specify): [X] COUNTRY Bolivia [ ] REGIONAL ___ [ ] INTERREGIONAL ___

4. LIFE OF PROJECT: BEGINS FY 1975 ENDS FY 1977*

5. SUBMISSION: [X] ORIGINAL May 30, 1975 DATE [ ] REV. NO. ___ DATE CONTR./PASA NO. ___

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

A. FUNDING BY FISCAL YEAR	B. TOTAL $	C. PERSONNEL (1) $	C. PERSONNEL (2) MM	D. PARTICIPANTS (1) $	D. PARTICIPANTS (2) MM	E. COMMODITIES $	F. OTHER COSTS $	G. PASA/CONTR. (1) $	G. PASA/CONTR. (2) MM	H. LOCAL EXCHANGE CURRENCY RATE: $ US ___ (U.S. OWNED) (1) U.S. GRANT LOAN	(2) COOP COUNTRY (A) JOINT	(2) COOP COUNTRY (B) BUDGET
1. PRIOR THRU ACTUAL FY												
2. OPRN FY 1975	252	96	36	-		31	125	96	42		CY'75	58.9
3. BUDGET FY											CY'76	87.0
4. BUDGET +1 FY												
5. BUDGET +2 FY												
6. BUDGET +3 FY												
7. ALL SUBQ. FY												
8. GRAND TOTAL	252	96	36	-		31	125	96	42			146.9

9. OTHER DONOR CONTRIBUTIONS * Implementation

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

III. ORIGINATING OFFICE CLEARANCE

1. DRAFTER: J.N. Becht/N.Ruther/ADiaz — TITLE: Public Health Planning Advisor — DATE: 5/2/75

2. CLEARANCE OFFICER: PROJ. HAD actio V J.Oleson — TITLE: Director — DATE: 6/4/75

CON CAP ECOM: WWhiting

IV. PROJECT AUTHORIZATION

1. CONDITIONS OF APPROVAL

2. CLEARANCES

BUR/OFF.	SIGNATURE	DATE	BUR/OFF.	SIGNATURE	DATE

3. APPROVAL AAs OR OFFICE DIRECTORS

SIGNATURE ___ DATE ___

TITLE ___

4. APPROVAL A/AID (See M.O. 1025.1 VI C)

SIGNATURE ___ DATE ___

ADMINISTRATOR, AGENCY FOR INTERNATIONAL DEVELOPMENT

PD-ABB-304

PROJECT PAPER

TITLE: Accelerated Program Development for Rural Health Delivery Systems

Part I. Project Summary and Recommendations

A. Summary

Approval of a $252,000 grant in FY 1975 is recommended to finance the implementation of the Accelerated Program Development (APD) activities described below. The Government of Bolivia (GOB) will be the grantee. The executing agency will be the Ministry of Social Welfare and Public Health (MOH) at the national level, the Regional Health Office of Santa Cruz (RHO/SC) of the MOH at the regional level, and the Montero Health Center Hospital (DHC/Montero) of the MOH at the district level.

The amount of the proposed project is $398,000. Of this total, $252,000 (63.0%) would be in AID grant assistance, $135,400 (34.0%) in GOB counterpart funding in the years 1975 and 1976 of which about $10,000 would be GOB contribution in CY 1976 above the MOH budget levels for FY 1975, and $11,500 (3.0%) from other local sources. All AID funds will be obligated in FY 1975 to carry out activities over an eighteen (18) month period beginning about June 1, 1975 and extending through November 30, 1976. (See Annex I for detailed financial schedule.)

B. Project Description

1. Sector Goal: To raise the standard of health of rural low income groups, particularly the young.

2. Project Purpose:

a. To initiate the development of a rural public health planning, organizational and implementation capability within the GOB Ministry of Health (MOH) as a basis for the design and possible implementation of a comprehensive health delivery system (RHDS) in rural Bolivia.

b. To initiate the implementation of a RHDS in a test area (Montero, Dept. of Santa Cruz) in order to gain experience in order to better design and implement the RHDS on a wider scale if initial experience indicates the feasibility of such a program.

3. Discussion: The GOB and Mission are considering the possibility of four major activities in support of the sector goal.

a. The creation of a low cost, comprehensive health delivery system in rural areas;

b. The creation of a viable management, technical support and planning system within the MOH;

c. The extension of potable water and sanitation systems in rural areas; and

d. A national program to combat malnutrition among the most vulnerable population groups.

Activities (a) and (b) would be initiated on an experimental, tentative basis as part of the Accelerated Program Development (APD) activities described in this Project Paper. They provide for: (i) the development of a plan for a comprehensive Rural Health Delivery System (RHDS) in the Montero district which will be reviewed and evaluated for possible replication in other areas; (ii) the design and use of a planning methodology which will assist the MOH in strengthening its capability to develop and implement effective, coordinated policies and programs for the integrated delivery of health programs; (iii) the actual provision of health services in a test area (Montero) in the Department of Santa Cruz; and (iv) the strengthening of the administrative capability of the MOH to implement on a broader scale the RHDS which may result from the APD.

In essense the APD is expected to provide the information, including comparative statistics and community response, to be used by the Mission in determining whether or not it is feasible to implement the recommended RHDS in other geographic areas. In this connection, the initial evaluation of the results of the APD, tentatively scheduled for July, 1976, should result in a Mission decision on whether or not to seek authorization of the proposed Rural Health Delivery System Loan and companion Technical Assistance Grant Project to implement the recommended RHDS in the initial area of focus of other USAID programs in Agriculture and Education, e.g. the Department of Cochabamba and certain areas of the Departments of Chuquisaca and Potosí. (See Annex 2 for the proposed regions and districts to be covered by the APD and Section II (p.9) for a description of the site selection procedure.)

Activity (c) may be carried out by a FY 1976 Rural Sanitation Loan which would provide potable water and/or sanitary human waste disposal facilities to some 420,000 people in the Departments of Cochabamba, Santa Cruz, and Chuquisaca. The APD health education effort would begin to build awareness of the need for and methods of basic sanitation.

Activity (d) would be carried out through a FY 1977 loan to finance a national nutrition program. Approximately half of the APD funds for basic research are devoted to nutritional questions at the national and district levels.

4. Accomplishments: At the termination of the APD period, i.e. by FY 1977, the major accomplishments are expected to include:

a. A planning methodology and design for a rural health delivery system including written procedures for determining the health goals to be reached, objectives, functional interventions and

concrete activities needed to reach the chosen objectives -all of which are shown, with supporting activities in Annex IV.

b. A functional plan for and some experimental results with the actual implementation of a comprehensive health delivery system in the Montero health district with emphasis on four inter-related, mutually supportive health interventions, i.e. communicable disease control and education, maternal child health assistance (including responsible parenthood services), nutritional education (including sample measures for increased protein intake) and improved environmental sanitation measures and education. (This plan will be based partially on the experience resulting from the actual delivery of health services in a test area);

c. A core of trained MOH and related personnel capable of planning and implementing a rural health delivery system;

d. A rural health information system for technical and administrative uses (e.g. use in epidemiological surveillance or accounting) to provide the:

i) basis for continued data collection, tabulation, storage and retrieval at the district level; and

ii) corroboration with national data.

This information system would enable the MOH planning groups to use the baseline data to project the possible impact of a full-scale RHDS in the Montero District and other rural areas on such factors as:

1) the incidence and prevalence of various communicable and diarrheal diseases;

2) infant and child morbidity/mortality rates;

3) maternal mortality and abortion rates and use of responsible parenthood practices;

4) average costs of in and outpatient services for MOH and patients; and

5) the relationship of health to non-health indicators such as income or education.

5. Major Activities: To reach these end of project targets, the APD will include:

a. In-service training of about 35 MOH selected employees from central, regional and local levels who will be involved in the planning, administration, and supervision of outreach personnel.

This will be complemented by training roughly 40 to 50 rural outreach workers (including upgrading and increasing the scope of work of malaria erradication workers) and training approximately 25 technical nurses.

b. Protection (through vaccination, health education, including nutrition, sanitation, etc. and primary MCH care including responsible parenthood) of a representative sample consisting of about 30% of the Montero district target population now estimated at 150.000 people, against major endemic and/or communicable diseases as a basis to test the viability of some key components of a possible low RHDS that could be replicated in other areas.

c. Construction, minimal renovation and utilization of the administrative wing of the Montero District Hospital and of the Santa Cruz Regional Medical Center. (See Annex V for plan of Montero administrative wing.)

d. Identification, design and initiation of a series of baseline studies in the APD area to support long and short range program and research efforts. At the local level, Bolivian personnel will work with US advisors in determining the way in which to gather statistics in the following categories: epidemiology, demography, health attitudes and behavior, economic conditions and educational factors. Concurrently, CONEPLAN will conduct sample surveys nationwide to test the replicability of the APD effort in other areas. Approximately $8.000 of the APD funds included in the baseline studies project element will support a national nutrition study to provide complementary data as well as a basis for a possible 1977 loan proposal.

More specifically the studies to be conducted during the APD implementation period are expected to provide better answers to the following questions:

1) What is an effective and efficient method by which the MOH can realistically plan and develop a comprehensive rural health service system in Bolivia?:

a) Who should be involved in the planning process and what short training should they receive?

b) What are the implementation alternatives and which is the most feasible one?

2) What kinds of health services should be provided, and how should these services be organized, administered and delivered?:

a) What is the most effective way of delivering these services at the lowest possible cost in the test area and in other areas? In this connection, what are the budgetary implications at the national, departmental, community and individual levels for an expanded program both during and following disbursement of any AID loans for RHDS?

b) Who are the most appropriate personnel for delivering these services (MOH and/or other agencies)?

c) What should be the role of the community in the administration and financing of rural health services?

3) What are the appropriate roles of the national, regional and district offices of the MOH in the administration and delivery of rural health programs?:

a) What roles should other appropriate agencies (public, private and voluntary) play?

b) What are the basic requirements for the design of health information, administrative and technical support systems?

4) What might be the expected impact of improved health services in rural areas on the improvement of health status of the population? and this in turn on:

a) Structure and the demand for family planning services?

b) Individual capacity to work and family income and expenditure patterns?

c) Learning capacity of children and attendance at school?

5) In what areas is additional information (research) needed for health planning? How should this information be obtained and by whom?

6) What should be Bolivia's approach to assuring an adequate supply of low cost pharmaceuticals (drugs and vaccines) to the rural health delivery system?

7) How can reliable vital statistics be obtained on an efficient and regular basis?

8) Is it feasible at this time to develop a realistic strategy and appropriate program interventions toward the reduction of malnutrition, and if so, of what should these consist?

6. Technical Assistance: In support of these activities the APD will provide the following US-local technical assistance under the supervision of the Mission's Humanitarian Assistance Division (HAD) Chief.

a. The Public Health Administration Advisor (PHAA), (Central MOH level), located in La Paz will assist the MOH to:

1) initiate for current and future program purposes an analysis of the existing administrative structure of the MOH and recommend the appropriate remedial measures to:

a) streamline its budgetary documentation process;

b) promote the recruitment of its administrative and technical personnel by a merit system technique;

c) strengthen and broaden its supervisory and evaluation process;

d) develop a health manpower policy with emphasis on the requirements for implementing a low cost, comprehensive rural health delivery system; and

e) reduce the under-utilization and duplication of health facilities.

2) develop an administrative and operational manual required for implementation of the planned RHDS; and

3) develop a health information collection, tabulation storage and retrieval system, including coordination with CONAPAN's nutrition information effort.

b. The Public Health Advisor (PHA) located in Santa Cruz will assist the MOH at the regional level in:

1) the formulation of a planning and development methodology for a comprehensive rural health delivery system;

2) the design and implementation of appropriate research projects to develop in the target area health planning statistics which may have relevancy at the regional and national levels;

3) developing a plan to test the actual delivery of a low cost RHDS in Montero;

4) the design and implementation at the project site of in-service training programs for health planners and related personnel including outreach workers, traditional practitioners and district, regional and national level counterparts;

5) the evaluation of progress of the APD program;

6) coordination of health activities at the regional and district levels with those of other sectors (agriculture, education, community development) to secure an integrated approach and contribution to Bolivia's socio-economic development in the project area; and

7) the actual delivery of the low cost RHDS in Montero, where the RHDS will be tested.

c. The Assistant Public Health Advisor (APHA) located in the Montero area will:

1) assist the PHA in carrying out the above mentioned activities;

2) act for the PHA as needed;

3) participate in the field operation by assisting in the implementation, and evaluation of all related health activities.

d. The services of short-term advisors will be used primarily as the needs arise. The primary work areas anticipated include:

1) economic impact studies;

2) demographic projections; and

3) design of long-term research and health information systems.

7. Target Group: The vast majority of the population in the target area are subsistence farmers who are poor, not only economically but in their condition of health. As a general rule, the population in the APD test area has only limited access to health facilities and relies on traditional community health practitioners or home remedies for many of the services they receive. The typical rural family consists of five to nine members often including grandparents and other relatives. The housewife, if in the childbearing years, is either pregnant, has just given birth, or has recently suffered an abortion. Probably as many children have died as are still living with the family. Children usually go barefooted and members of the family seldom bathe.

The family generally lives in a one or two room adobe house with unplastered walls, thatched roof, and dirt floor and screens are a rarity. The house offers little privacy and often is shared with the domestic animals. The family food intake is normallly unvarying and unnourishing, consisting mostly of staples, and the majority of the family is infected with respiratory and parasitic diseases.

For statistical indicators specific to the APD test area, see Annex VII.

Part II. Project Background

A. Development of Proposal

1. History

In early 1974 the Mission began an intensive Assessment of the health sector. The Assessment indicated the severe health problems encountered by rural dwellers, the lack of adequate health services and related deficiencies in sector planning, administration and technical support. A simultaneous evaluation carried out by an interagency GOB team arrived at similar conclusions, recommending greater attention to rural areas and the regionalization (decentralization) of health program planning and implementation functions. These priorities coincided with existing Congressional and AID mandates to reach rural, low income people and improve administrative capabilities of the executive agencies. A GOB strategy statement, which will formalize its commitments, is expected to be ready during the third quarter of CY 75.

Early in the evaluation process recognition was given to the probable need for major activities in rural health systems and sanitation. It also was recognized that, although the Assessment and other studies indicated the desireability of supporting a comprehensive rural health delivery system, there was little experience with such systems. Thus it seemed advisable to try out any such system on a relatively small scale initially. It was decided that an accelerated program development grant would be an appropriate mechanism to initiate such a small scale effort and to begin to prepare the MOH for its expanding sectoral responsibilities. The project was initially proposed in the FY 75 Congressional Presentation as part of the on-going Family Care project.

2. Supportive Studies

a. Health Sector Assessment

The Mission's Health Sector Assessment (HSA), which was completed in January, 1975, provided the primary basis for the country strategy and the design of this project. This study identified eight key problems or needs within the health sector:

- improved management and comprehensive health planning;
- personnel development;
- reorganization of the public health technical infrastructure;
- rural health institutional development;
- sanitary facilities improvement;
- expanded family planning services;
- critical disease abatement; and
- nutrition improvement.

In addition, a comprehensive and integrated health services approach was determined to be the most effective way of dealing with Bolivia's

major health problems. The proposed APD addresses the first four areas directly, serving as the first phase of action in their development. Through its research and education efforts, it also provides much of the information required to further develop projects which will focus on the last four areas.

b. Report of the Interministerial Commission

A simultaneous evaluation carried out by the GOB Interministerial Commission provided the other major input into the development of the present project proposal. The Commission strongly recommended that greater attention be given to rural health needs and that significant planning and administrative functions be decentralized to the regional level. The Commission also recommended the creation of a single national health service.

Bolivia's major health problems were identified as high incidence of infant mortality, malnutrition and communicable diseases. The principle constraints to overcoming these problems include the lack of a system to deliver health services to the rural areas, lack of a national nutrition policy and programs, inadequate financing, the lack of comprehensive planning, ill-trained personnel, poor sanitary conditions (particularly potable water), and ineffective administrative systems.

c. Site Selection Methodology

Early in the development of the HSA it was recognized that due to the extreme diversity and extensiveness of Bolivia's territory and to the lack of adequately trained personnel, a rural health development program could not cover adequately all areas of the country simultaneously A process of selecting priority areas would therefore have to be undertaken. This was accomplished in two phases -- the first by USAID to develop and test a methodology, and the second by the Interministerial Commission. Both groups followed basically the same procedures: (i) identifying potential project areas; (ii) determining relevant criteria for comparison; (iii) rating each area on a predetermined scale for each criterion; (iv) placing a weighted value on each criterion; and (v) multiplying the weighted value by the relative scores and adding the total scores for each area.

The results and priority areas for both exercises are given in Annex III. Northern Santa Cruz (Montero) received the highest score in the USAID HSA, and was rated second by the Interministerial Commission. The Commission's first choice, Tarija was to receive similar assistance from UNICEF. The Yungas region was not considered because it was not included in the USAID programs in agriculture or education.

B. Related Activities

1. Government of Bolivia

a. Program Activities

The MOH is engaged in the regional development plans for the Departments of Tarija and Chuquisaca which are being funded largely by UNICEF and the Departmental Committees for Development. Other than this effort, financial constraints have limited MOH activities in rural areas to meeting less than 5% of rural health needs -- and these in a non-comprehensive way.

b. Geographic Area

The colonization area north of the city of Santa Cruz, with its center in Montero, has been selected as the site of the APD project. MOH activities in this area have been no more or less than other areas, i.e. some facilities and personnel but inadequate equipment, supplies, drugs, etc. and little attempt at comprehensive programming. Other organizations have contributed more to health development. The Departmental Public Works Committee (C.OO.PP.) of Santa Cruz has financed and built community water systems and some health centers in the rural areas. The Methodist Church has been actively involved in comprehensive public health programming for more than eight years, primarily in the town of Montero, the Yapacaní colony and lately in the town and surrounding areas of Portachuelo. Its experience in health programming strengthened the reasons for the selection of the area for the APD project.

2. USAID

The present project proposal marks a significant shift in USAID and predecessor agency health program strategies. For the first time the Mission has decided upon a comprehensive approach, though on a limited geographic scale, to deal with Bolivia's complex and interrelated health problems. In contrast, past programs have been characterized by institutional development around single-purpose issues. These have included the Interamerican Public Health Cooperative Service (SCISP, 1942-62); the National Institute of Occupational Health, the National Institute of Communicable Diseases, the Planning Office of the MOH, and CORPAGUAS (1962-67); and the Family Care project (MCH/responsible parenthood, 1968-74). The second major distinction is the emphasis on regional planning and development, employing a systems analysis approach to determine the content and design of specific programs, which should better reflect local needs and characteristics. Past approaches have concentrated on bringing predetermined technological solutions to the central agency level.

Implementation of a FY 1974 USAID financed Sub-Tropical Lands Development Loan (511-T-050) is presently underway. The project seeks to increase the productivity and incomes of about 11,000 migrant campesino families who will be living in the San Julian and Chané-Piraí areas, about 90 kilometers north of Montero (which is also within the scope of the Agriculture Sector Loan I signed on FY 1975). These families

will be affected by the results of the APD and subsequent health programs.

3. Other Donors

No other international donors or local institutions have expressed interest in financing this particular project. The principal organizations, however --WHO/PAHO, UNICEF, C.OO.PP., the Methodist Church and CARITAS -- are very interested in being involved with the development of the project. Presently, UNICEF is implementing in Chuquisaca and Tarija its Social Development Project which includes a health component under which UNICEF is financing an environmental sanitation activity, equipment and materials for a Maternal Child Health sub-activity, and training of personnel in health related subjects. However, these UNICEF activities are not comprehensive in scope and implementation, as planned under the APD.

Coordination of the APD activity with the activities of other donors, including WHO and UNICEF, will be carried out through the Coordinating Committee mentioned under Part III of this paper. Periodic meetings will be held to exchange information on the projects' experience, and relevant personnel (from the MOH, C.OO.PP., UNICEF, etc.) involved in the projects will exchange visits to gain first hand knowledge on the implementation status of the related activities.

The C.OO.PP. of Santa Cruz wishes to complement its economic development activities with health and educational development, and is scheduled to finance part of the APD's proposed construction. The Methodist Church in Montero is willing to assign its health personnel to the proposed project, as are the Mennonite Central Committee and Maryknoll Order. Likewise, CARITAS has agreed to provide Food-for-Peace rations to the Mothers' clubs incorporated into the project.

Part III. Implementation Arrangements

A. Administrative Plan

1. Executing Agency

As mentioned earlier, the Ministry of Health (MOH) will be the administrative agency for this project. At the national level the focus of responsibility for project implementation will lie with the Head of the National Directorate of Public Health, who will seek the necessary cooperation and support from the Sectorial Planning Office and the National Directorate of Administration. In addition, the Head of the National Directorate will organize a project steering committee to oversee all APD activities. It will be composed of the heads of each of the above three units, the two Sub-Secretaries of the MOH and the Regional Planning Office of CONEPLAN, in addition to the USAID Project Manager. The only organizational changes at the Ministerial level required by the project are the establishment of functional units

for physical facilities, human resources and applied research within the Planning Office.

At the regional level the responsible GOB offices will be the Head of the MOH's Regional Health Office (Unidad Sanitaria) and at the district level the Director of the MOH's Health Center Hospital in Montero.

A Coordinating Committee will also be establish at the regional level which will have representation from the above two units as well as from other participating agencies, e.g. C.OO.PP. of Santa Cruz, the Rural Education Division of the MOE, the National Community Development Service, relevant personnel from WHO and UNICEF, the Methodist Church, and CARITAS/CRS.

At the present time, one of the major obstacles to the MOH participating effectively in this and other decentralization/regionalization projects is its limited number of trained administrative personnel at regional and district levels. One of the major purposes of this project is to diminish this obstacle by expanding the numbers and strengthening the capacities of sub-national personnel while developing more adequate support systems for their work.

Tentatively, as part of the project the GOB will be requested to:

a. Create at the central MOH level an executive committee which would coordinate the development of regional health programs, with a clear definition of responsibilities and authorities;

b. Create functional and consolidated planning units for physical resources, human resources and research within the Office of Sectorial Planning of the MOH, defining their functions and allocating the necessary financial and physical resources;

c. Complete and publish the final report of the Interministerial Commission, which should include adequate analysis and programatic recommendations;

d. Obtain working agreements (sub-contracts with MOH) with the C.OO.PP./SCZ re construction and regional planning, the Methodist Church re personnel and facilities in Montero, and the Medical School in Cochabamba re medical students for survey research;

e. Provide for and implement the obligatory registration of activities of all private, voluntary and religious entities functioning in the health sector;

f. Create 35 positions for technical nurses (2 year course) in CY 1977 and an additional 240 public health related positions in CY 1978;

g. Create at the national level an Interministerial Executive Committee to develop an efficient and effective system for provision of pharmaceutical supplies (drugs, vaccines, etc.) to the public and autonomous health sub-sectors;

h. Create at the national level an Interministerial Executive Committee to develop a food and nutrition policy and an appropriate mechanism to implement it; and

i. Establish regional health planning offices in the Departments of Santa Cruz, Tarija and Chuquisaca, directly responsible to the respective Directors of the Unidades Sanitarias.

2. AID's Administrative Plan

The Mission will establish a Project Implementation Committee which will be in force throughout the life of the project. The Committee will be presided over by the Chief of HAD, who will be responsible for the execution and monitoring of the project for AID. Other members of the Committee will include the Program Officer, a Capital Development Officer and representatives from HRD, RDD and CDD as needed.

3. Social Soundness and Role of Women

The project areas which includes Spanish-speaking long time residents and Quechua-speaking colonists, will allow the APD to assess the RHDS' impact and acceptability in two distinct socio-cultural groups. The research component of the APD will analize the contributions and/or resistance to the HRDS which may be expected from these two groups. To the extent possible the research findings will include an analysis of the economic health and educational status of both men and women in the research area.

While the research component will attempt to compare the differences and similarities of the roles that men and women may take in a RHDS, the operational component will rely heavily on women. The Mothers' Clubs will provide an important vehicle for the provision and testing of services. Additionally, most of the outreach workers and traditional practitioners involved are expected to be women. Special efforts will be made to select female physicians and officials from the MOH to participate in the APD efforts.

A third social issue deals with the extent of community participation in planning, management and evaluation of the local RHDS. The proposed APD will attempt to identify and determine the relative effectiveness of different forms of community involvement in the various activities of the project. For full comparison of effectiveness, these different forms of involvement will require evaluation over a time period longer than the APD life of 18 months. These evaluations will start during the life of the APD project and will continue during the implementation phases of the proposed health delivery services loan and companion grant project.

4. Implementation Plan

A detailed project implementation plan will be developed within two months of the arrival of the PHAA and the PHA who will work in concert with MOH counterparts in carrying out the project. We feel the project is more likely to succeed if those assigned to implement it have participated in the planning stages. Accordingly, the details of how the project will actually be implemented will be worked out by the MOH and other personnel participating in the project. In this way, the project will promote the attitudinal changes necessary to its full success.

The project will follow a system analysis approach to be tested by this experimental activity. This process requires that certain steps be followed in the development of the plan. These steps are schematically identified in Annex IV. The information and experience obtained during each phase will be used to develop the details of the following phases. Tentatively, the project implementation plan will include the following major steps:

a. In June, 1975 the national and regional coordinating committee will be formed to further refine the project.

b. Task forces will be appointed within one month of the arrival of the PHAA and PHA to deal with the major aspects of the project. These might be broken down to include research, training, service delivery, administrative systems, budget and procurement, and/or others. Each task force will develop and execute its plan of action with advisor assistance.

B. Evaluation Plan

This project will be evaluated annually starting on or about July, 1976. This initial evaluation will be crucial to determine whether or not the Mission should seek authorization of the proposed Rural Health Delivery Services Loan and companion Technical Assistance grant project to implement the RHDS.

Progress will be measured against the indicators at the sector goal, purpose and output levels as contained in the Logical Framework, Annex VI

It is hoped that after the first year of project implementation, we will have enough experience to test the validity, soundness, relevance and practicability of the design and indicators of progress at all levels of the project. Since one of the major elements of the project is the development of baseline data and statistical indicators, we hope to be able to refine, add and delete target indicators as well as improve the means of verification as better information becomes available.

The annual evaluation will be carried out by a team composed of the Project Manager, up to five project counterparts, a USAID Capital Assistance Officer, a representative from the USAID Controller's Office, the USAID-financed contract advisors and the USAID Evaluation Officer. Any required assistance from AID/W or other which may be required to conduct the annual evaluation will be determined shortly before the evaluation.

TENTATIVE FINANCIAL SCHEDULE *

INPUTS	AID	GOB	OTHER	TOTAL
1. U.S. Technical Assistance	96,000	7,200	-	103,200
Health Administration Advisor - Central Level (12 m/m)	30,000	7,200 1/	-	37,200
Public Health Administration - Field (18 m/m)	46,000	-	-	46,000
Short Term Advisors (6 m/m)	20,000	-	-	20,000
2. Commodities	31,000	5,000	-	36,000
Medical Health & A/V Equipment	6,000	-	-	6,000
Office Equipment	6,000	-	-	6,000
Vehicles **	-	5,000 2/	-	5,000
Supplies	6,000	-	-	6,000
Drugs	3,000	-	-	3,000
Vaccines	10,000	-	-	10,000
3. Other Costs	125,000	103,200	31,500	259,700
Logistic Support for Technical Advisors	41,500	-	-	41,500
Assistant Public Health Advisors (24 m/m)	20,000	-	-	20,000
Secretarial Help (12 m/m)	7,500	-	-	7,500
Baseline Studies	20,000	-	-	20,000
Mothers' Clubs	5,000	-	-	5,000
Training	10,000 3/	2,100	-	12,100
Facility Improvement	15,000	20,000 5/	-	35,000
Travel and Per Diem	6,000	-	-	6,000
Personnel Costs	-	101,100 6/	11,500 7/	112,600
TOTAL	252,000	135,400	11,500	398,900
PERCENT	63%	34%	3%	100%

1/ Office space and utilities for T.A. advisors.
2/ Maintenance and gas for duration of project
3/ Includes costs of initiating 2-yr. nurse training program; does not include travel, per diem and advisor costs for seminars.
4/ Include administrative wing in Montero (Annex V) and renovation of regional office in Santa Cruz.
5/ Pediatric wing in Montero by Comité de Obras Públicas.
6/ Includes current personnel assigned full time to the project plus salaries of new personnel for CY 1976.
7/ Methodist Church in Montero, personnel currently employed who will be assigned to the project.

* One time grant to be disbursed over an eighteen month period, May 1975 - October 1976 inclusive.
** To be granted from Mission excess stocks.

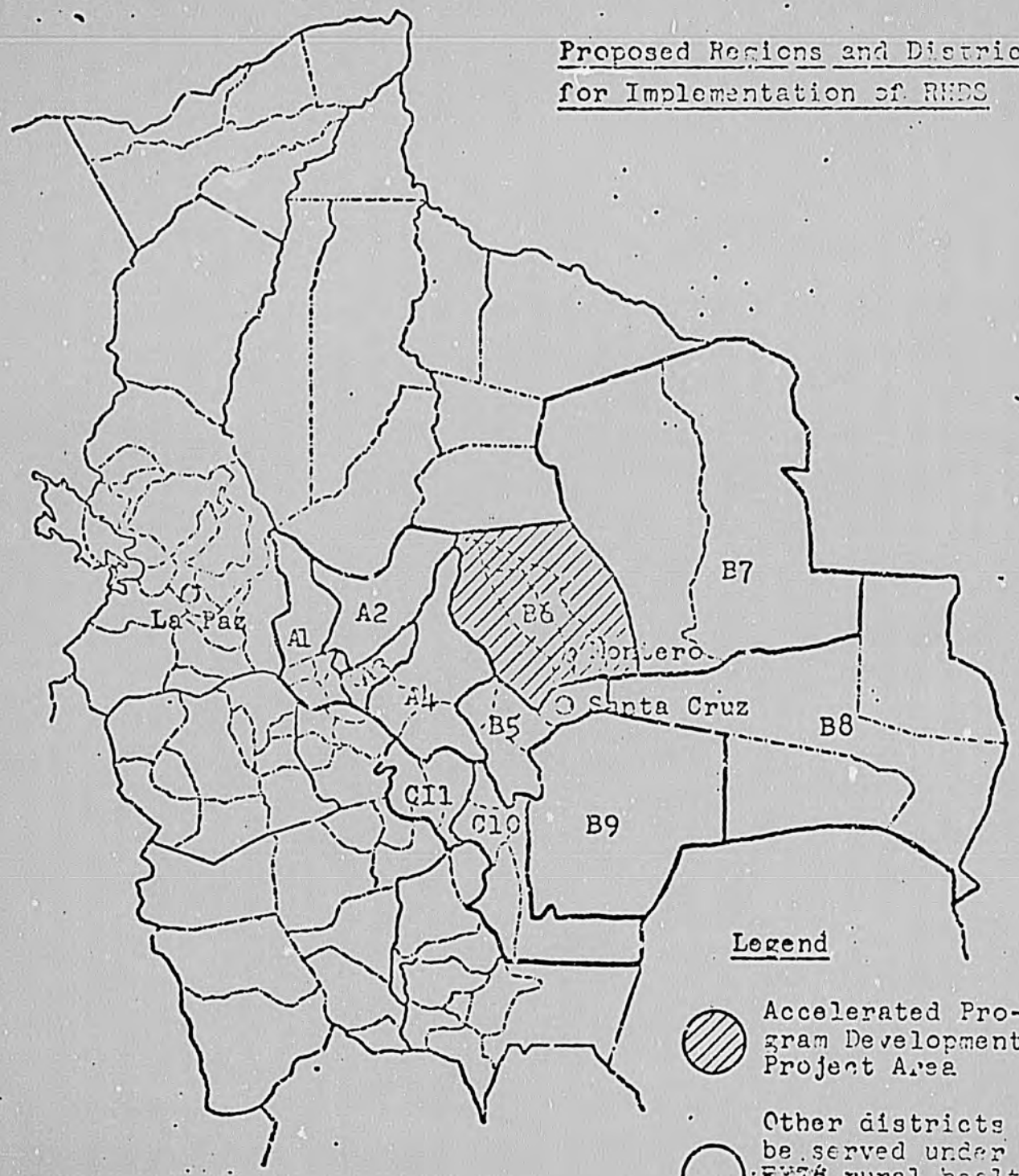
Regions

A. Cochabamba
B. Santa Cruz
C. Chuquisaca

Districts

1. Quillacollo (286,170)
2. Villa Tunari (73,740)
3. Punata (208,800)
4. Aiquile (123,960)
5. Samaipata (128,710)
6. Montero (106,680)
7. San Ignacio (53,[illegible])
8. Roboré (43,[illegible])
9. Camiri (75,340)
10. Monteagudo (11[illegible],[illegible])
11. Sucre (140,370)

() Estimated rural population, 1973



- Selection of Priority Areas for Rural Health Delivery Systems.

AREAS RURALES POTENCIALES

CALIFICACION POR USAID-M.P.S.S.P.*

CRITERIOS	1 LAGO	2 VIACHA	3 YUNGAS ALTO BENI	4 VALLE ALTO	5 VALLE CENTRAL	6 CHAPARE	7 ANDRES ETC	8 CHARCARIA	9 UNCIA	10 BETANZOS	11 TUPIZA	12 CHUQUISACA	13 TARIJA	14 MONTEAGUDO	15 CAMIRI	16 TAPACARI	17 RIBERALTA	18 REYES	VALOR RELATIVO
1 POTENCIAL ECONOMICO	3	15	45	3	3	45	3	15	3	3	3	45	6	6	45	45	3	45	15
2 ACCESIBILIDAD	8	6	6	8	6	6	4	5	5	5	4	4	6	8	2	2	2	2	20
3 INTEGRACION INTERSECTORIAL	15	3	3	15	15	15	15	15	15	15	3	45	45	45	15	45	3	45	15
4 APOYO ECONOM LOCAL	175	175	35	35	35	175	175	175	175	175	35	35	525	7	35	35	525	525	175
5 APOYO DE LA COMUNID	15	3	45	3	3	15	15	15	15	15	3	3	6	6	45	45	45	45	15
6 APOYO UNIVERSITARIO	1	1	3	4	1	2	1	1	1	1	1	1	1	4	1	1	1	1	10
7 PROG DE SALUD RURAL	125	25	25	25	125	125	125	125	125	125	125	25	375	5	125	25	375	25	125
8 POLITICAMENTE FAVORABLE	6	6	3	6	6	15	15	45	45	15	3	3	6	6	3	3	3	3	15
9 INFRAESTRUCTURA (SALUD)	15	3	15	15	15	15	15	15	15	15	3	3	45	45	15	3	3	15	15
10 CRECIM DEMOGRAFICO	1.5	125	375	125	125	375	125	125	125	125	125	125	25	5	125	125	125	125	125
11 FACTORES DE EXITO	125	375	25	25	25	125	125	125	125	125	25	25	5	5	25	125	375	25	125
12 DENSIDAD DE POBLACION	5	375	25	5	5	25	25	25	375	375	25	25	25	25	125	125	125	125	125
13 NECESIDAD SALUD RURAL	6	5	6	6	6	45	45	45	45	45	45	45	6	6	45	45	45	45	15
PUNTAJE	2000	4250	4775	4275	4150	3350	3275	3550	3275	2075	3550	4075	3075	3075	3250	3125	3125	3275	
PRIORIDAD	10a	5a	3a	3a	6a	13a	15a	16a	14a	17a	12a	7a	2a	1a	5a	8a	9a	11a	

*OFICINA DE PLANIFICACION

AREAS POTENCIALES

CALIFICACION POR LA COMISION INTERMINISTERIAL-

CRITERIOS	1 LAGO	2 YUNGAS	3 VALLE COCHABBA	4 VALLE ALTO COCHABBA	5 MINAS	6 POTOSI CENTRAL	7 CHUQUISACA CENTRAL	8 TARIJA CENTRAL	9 POTOSI SUR	10 TARIJA CHUQUISACA	11 TARIJA BERMEJO	12 IZOZOG	13 MUTUM	14 SANTA CRUZ NORTE	15 BENI CENTRAL	16 BENI-PANDO	17 PANDO-COBIJA			VALOR RELATIVO
1 DENSIDAD	8	9	10	9	7	6	5	6	5	5	5	3	3	6	4	3	4			
2 CRECIM POBLACION	8	10	7	7	9	4	4	7	6	4	4	4	4	8	4	9	4			
3 REQUER DE SALUD	4	5	4	4	4	5	5	5	6	8	6	9	9	6	9	10	9			
4 ACCESIBILIDAD	10	8	9	8	5	8	8	9	8	8	7	7	7	8	6	5	7			
5 OTROS PROGRAMAS	5	5	5	5	5	5	10	5	5	10	10	5	5	5	5	5	5			
6 CRECIM ECONOMICO POLOS DE DESARROLLO	4	7	5	5	8	6	6	7	6	10	9	10	10	9	10	6	6			
7 COINCIDENCIA CON AREAS SANITARIAS																				
8 APOYO LOCAL	5	6	7	7	6	5	5	5	5	5	6	6	5	6	7	7	7			
PUNTAJE	44	50	47	45	48	39	43	45	41	50	47	44	43	43	45	45	42			
PRIORIDAD	5a	1a	2a	4a	2a	9a	6a	4a	8a	1a	3a	5a	6a	2a	4a	4a	7a			

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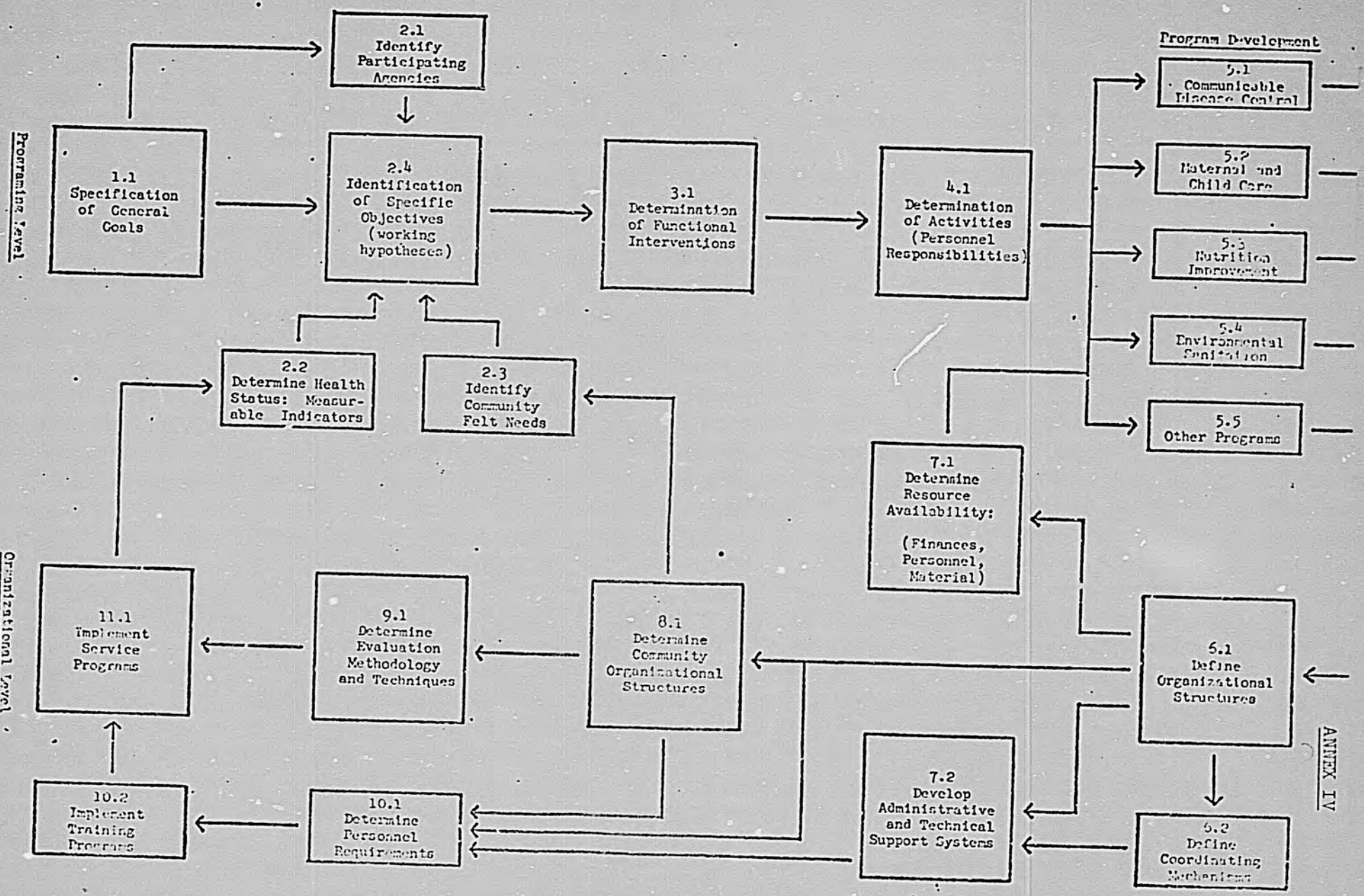
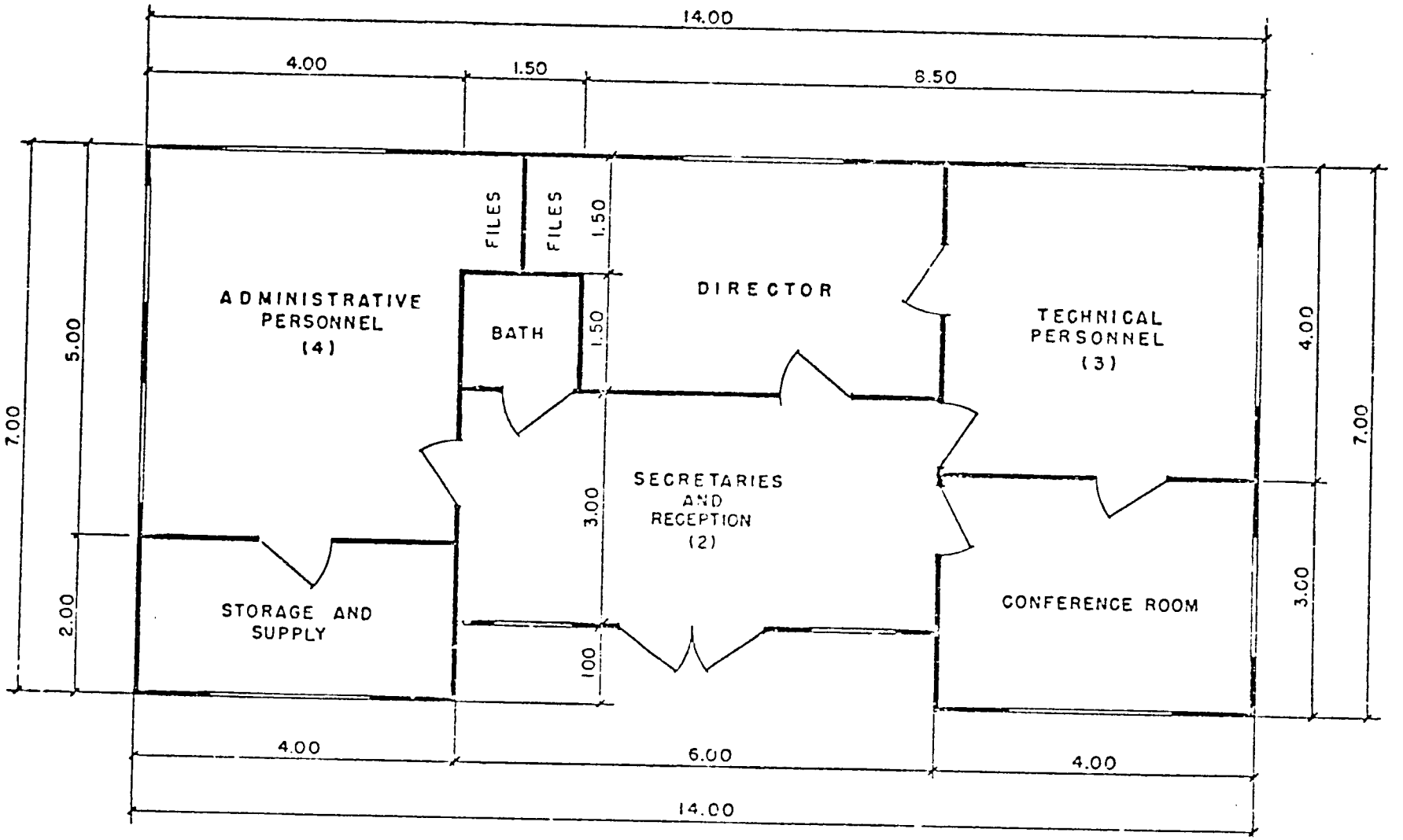
Annex IV - A Functional Approach to Health Program Development by Systems Analysis.



ANNEX IV



ADMINISTRATIVE WING AT DISTRICT LEVEL FOR RURAL HEALTH DELIVERY SYSTEM

ANNEX VI

BASIC STATISTICS - MONTERO DISTRICT

Estimated income: $300/family, of which approx. $6 (2%) is spent on health services (traditional and modern). ave. of 5-7 persons/family.

Estimated prevalence of major diseases:
Preschool (0-4) malnutrition = more than 60%
Parasitic infections = more than 90%
Tuberculosis = almost 5%
Measles, yellow fever, malaria also high.

Estimated mortality:
Infant (0-1) mortality = 300/1000 live births
Preschool (0-4) mortality = 50%
Crude mortality = 27/1000 inhabitants

Estimated birth and abortion rates:
Crude birth rate = 65/1000 inhabitants
Fertility = 8-10 pregnancies/female, 15-49
Abortions = at least 25% of all pregnancies

Age structure (population distribution):
Male/female ratio = 1.04 under 20 years.
0.82 over 50 years.
Population under 20 years = 52%
20-49 years = 37%
50 and over yrs. = 11%
Density = 7 inhabitants/km.^{2}
Communities over 2,000 inhabitants = less than 1/3 pop.
Clusters less than 200 and dispersed = more than 1/2 pop.

Status of women: 85% illiterate, more than twice that of men.

AID 1020-28 (7-71)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 1975 to FY
Total U.S. Funding $250
Date Prepared: May 30, -75)

Project Title & Number: Rural Health Delivery Systems/Accelerated Program Development

* Implementation

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPT
Program or Sector Goal: The broader objective to which this project contributes: To raise the standard of health of rural low income groups, particularly the young.	**Measures of Goal Achievement:** Increase in life expectancy at birth, by 3 years, with corresponding decreases in crude death (by 12%), infant mortality (by 25%), and crude birth (by 5%) rates in Bolivia by 1980.*	Standard health information systems, i.e. MOH records. Sample surveys and research.	**Assumptions for achieving goal targets:** The present project will be succeeded by rural health and sanitation loans, a support grant, and a comprehensive intersectorial nutriton loan in FY-77. The replication of this project in other regions of the country will depend on the financial capacity of the MOH and future AID and/or other donor assistance.

*These are highly tentative indicators which will be modified or refined as better and more information becomes available during the APD implementation process.

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AID 1020-28 (7-71)
SUPPLEMENT I

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 1975 to FY ___
Total U.S. Funding $252,0 (G)
Date Prepared: May 30, 1

Project Title & Number: Rural Health Delivery Systems/Accelerated Program Development

E2

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Purpose:	**Conditions that will indicate purpose has been achieved: End of project status.**		**Assumptions for achieving purpose:**
A. To initiate the development of a rural public health planning organizational and implementation capability within the GOB Ministry of Health (MOH) as a basis for the design and implementation of a comprehensive health delivery system (RHDS) in rural Bolivia.	A.1. The Montero District will have developed a rural health information system capable of: (a) on-going data collection, storage and retrieval for technical and administrative analysis, and (b) being corroborated with national data.	A.1. Data reports by project technicians of sufficient quality and submitted with enough time to be integrated into district plan and national survey; data availabilities meet requirements of analytical techniques of planning methodology.	1) That the MOH will further develop its capacity and decentralize certain administrative, technical and planning functions to the regional level.
	A.2. The rural health planning methodology developed by and in use in the Montero District will be adopted for national adaptation and use.	A.2. Ministerial Resolution; on-going planning/programming efforts at Montero District Center.	2) That the MOH will evaluate the Montero effort in terms of its replicability in other areas of rural Bolivia
	A.3. A comprehensive health plan providing basic health services for the project area (MOH Montero District) will be complete.	A.3. Ministerial Resolution adopting the plan; Min.Finance funding of planned program.	3) That there will be effective coordination with and support from other sectors (CONEPLAN, Ministries of Finance, Agriculture, Education and the NCDS.)
	A.4. There will be a core of personnel within key GOB ministries capable of developing and extending comprehensive RHDS's nationwide.	A.4. 35 persons in MOH trained and in responsible positions; review and approval by CONEPLAN and Min.Finance; USAID HAD observation.	
B. To initiate the implementation of a comprehensive health delivery system in a test area (Montero, Dept. of Santa Cruz) in order to gain basic experience for the development and implementation of the system on a wider scale.	A.5. There will be a series of recommendations to improve the administrative/management capacity of the MOH, particularly regarding its budgeting and programming process, personnel administration, evaluation, health planning and delivery system, etc.	B.1. Physical plan provides sufficient working space; MOH hires personnel involved in APD to supervise medical and public health outreach services of the plan; the frequency and substance of coordinating communications among three levels.	
	B.1. The Montero District planning and administrative center will be capable of implementing its plan in conjunction with regional and national levels.		

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AID 1020-28 (7-71)
SUPPLEMENT I

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 1975 to FY 1
Total U.S. Funding $250,000
Date Prepared: May 30, 1

Project Title & Number: Rural Health Delivery Systems/Accelerated Program Development

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Purpose:	**Conditions that will indicate purpose has been achieved: End of project status.** B.2. The Montero District will have initiated and gathered results from experimental medical and public health activities such as: a) 3,000 outreach visits; made from Montero District Center; types of services rendered, e.g. 25,000 children innoculated; and, b) health education , responsible parenthood practices, other health programs in effect and feedback on experimental activities from 15 Mothers' Clubs.	B.2. a) Reports of outreach workers; District Center records; and b) Reports from 15 Mothers' Clubs; observation of nutrition, sanitation, general health and family patterns.	**Assumptions for achieving purpose:**

24.

AID 1020-28 (7-71)
SUPPLEMENT I

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 1975 to FY [illegible]
Total U.S. Funding [illegible]
Date Prepared: [illegible]

Project Title & Number: Rural Health Delivery Systems/Accelerated Program Development

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Outputs:	**Magnitude of Outputs:**		**Assumptions for achieving outputs:**
1. Three new functional units in the planning office of MOH for: a) physical facilities; b) human resources; and c) applied research.	1. Re-organization plan adopted by MOH; staff hired or shifted from other positions in MOH.	1. Document; review of staffing pattern.	1) That the GOB and MOH will maintain their commitment to the project-financially and programmatically.
2. In-service training program complete for MOH personnel in health, planning and administration.	2. 15 seminars and 35 people trained: a) 15 for local implementation; b) 10 for regional support; and c) 10 for national replication and review.	2. Project documents; MOH personnel records; observation at site.	2) That the MOH and other personnel will be available for training and employment in the project.
3. Training program complete for: a) technical nurses; and b) outreach workers.	3. FY-76 / FY-77 / Total a) 10 / 15 / 25 b) 25 / 25 / 50	3.a) Number of graduates hired. b) Number of outreach workers hired; avg. number of contacts made per outreach worker; 3,000 outreach contacts total.	3) That in-service training is the best method to provide the required skills in planning and administration for MOH personnel.
4. *Support services provided to Mothers' Clubs, including general health education, MCH assistance and innoculations.	4. 5 / 10 / 15	4. Number of outreach worker contacts made; innoculations given.	
5.*Short-term research in three primary areas complete: a) Montero basic data, health status indicators and non-health status indicators (income, education); b) national corroboration of Montero data; and c) national nutrition.	5. Reports compiled; use in planning efforts.	5. Review reports and planning documents; coincidence of data requirements of planning tools and data availabilities.	
6. Long-term research schedule complete.	6. Schedule approved by MOH and CONEPLAN; initiation of some studies.	6. Review of schedule; initial funds for studies approved by MOH and Min-Finance.	
7. Manuals completed on: a) health administration; and b) health planning procedures	7. Two manuals complete by end of project, 1977.	7. Documents.	
8.*Innoculation of 25,000 children with following vaccines for: measles, diptheria, polio, tetanus, yellow fever, tuberculosis.	8. FY-76 / FY-77 / Total 10,000 / 15,000 / 25,000	8. Amount of vaccine used.	

AID 1020-23 (7-71)
SUPPLEMENT I

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 1975 to FY
Total U.S. Funding $252,000 (FY-75)
Date Prepared: MAY 31, 1975

Project Title & Number: Rural Health Delivery Systems/Accelerated Program Development

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Outputs:	**Magnitude of Outputs:**		**Assumptions for achieving outputs:**
9. Administrative Wing of Montero health center complete.	9. New office space ready by October, 1975.	9. Observation; project documents.	
* The specific questions to be answered by these studies and experimental services are listed on page 4 of the text.			

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D 1020-29 (7-71)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Rural Health Delivery Systems/Accelerated Program Development

Life of Project:
From FY 1975 to FY 1977*
Total U.S. Funding $252,000 (FY-75)
Date Prepared: May 30, [illegible]

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS			MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Inputs:	Implementation Target (Type and Quantity)				Assumptions for providing inputs:
	FY-75	FY-76	Total		
I. USAID					
A. Technical Assistance	252,000	-	252,000	Financial Reports.	1) That commodities will arrive on time.
1. Health Administration Adv. (12 m/m)	96,000	-	96,000	Project Agreement	
2. Public Health Admin. (18 m/m)	30,000	-	30,000	PIO/Ts	2) That AID and GOB will identify and approve operation procedures in a timely fashion.
3. Short-term Advisors (6 m/m)	46,000	-	46,000	PIO/Cs	3) That GOB, USAID and other resources will be available to the project as planned.
B. Commodities	20,000	-	20,000		4) That technicians will be available to carry out services planned in a timely fashion.
1. Medical Health and A/V equipment	31,000	-	31,000		
2. Office equipment	6,000	-	6,000		
3. Vehicles **	6,000	-	6,000		
4. Supplies	-	-			
5. Drugs	6,000	-	6,000		
6. Vaccines	3,000	-	3,000		
C. Other	10,000	-	10,000		
1. Logistic Support	125,000	-	125,000		
2. Ass't. Public Health Advisors (24 m/m)	41,500	-	41,500		
3. Secretarial help (12 m/m)	20,000	-	20,000		
4. Research	7,500	-	7,500		
5. Mother's Clubs	20,000	-	20,000		
6. Training	5,000	-	5,000		
7. Facility Improvement	10,000	-	10,000		
8. Travel and Per Diem	15,000	-	15,000		
	6,000	-	6,000		
II. GOB			115,400		
A. Technical assistance - HAA (12 m/m)	3,100	4,100	7,200		
B. Commodities - Vehicles	2,000	3,000*	5,000		
C. Other			103,200		
1. Training	-	2,100*	2,100		
2. Personnel	30,330	70,770*	101,100		

* These funds will require additional budget allocations of $42,540 for the MOH in CY'76.
** To be granted from USAID's excess stocks.

AID 1020-28 (7-71)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 1975 to FY 19[illegible]
Total U.S. Funding $256,00[illegible]
Date Prepared: May 30, [illegible]

Project Title & Number: Rural Health Delivery Systems/Accelerated Program Development

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS			MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Inputs:	Implementation Target (Type and Quantity)				Assumptions for providing inputs:
	FY-75	FY-76	Total		
III. Other			31,500		
Other			31,500		
1. Facility Improvement	20,000	-	20,000		
2. Personnel	4,500	7,000	11,500		
Summary of Inputs ($000)	Amount		% Participation		
USAID	252.0		63.0%		
GOB	135.0		34.0%		
Other	11.0		3.0%		
	398.0		100.0%		

28.