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UNCLASSIFIED

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

EL SALVADOR

PROJECT PAPER

PVO MATERNAL HEALTH/CHILD SURVIVAL

AID/LAC/P-618

PROJECT NUMBER: 519-0367

UNCLASSIFIED

PROJECT DATA SHEET

1. TRANSACTION CODE

A = Add
C = Change
D = Delete

Amendment Number

DOCUMENT CODE

3

COUNTRY/ENTITY

El Salvador

3. PROJECT NUMBER

519-0367

4. BUREAU/OFFICE

Latin America/Caribbean

05

2. PROJECT TITLE (maximum 40 characters)

PVO Maternal Health/Child Survival

6. PROJECT ASSISTANCE COMPLETION DATE (FACD)

MM DD YY
017 | 311 | 917

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

A. Initial FY 910 B. Quarter 4 C. Final FY 913

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
AD Appropriated Total (Grant)	(3,773)	()	()	(25,000)	()	(25,000)
(Loan)	()	()	()	()	()	()
Other U.S. 1.						
2.						
Host Country PVOs		571			8,333	8,333
Other Donors						
TOTALS	3,773			25,000	8,333	33,333

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)				-0-		3,658		25,000	
(2)									
(3)									
(4)									
TOTALS						3,658		25,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

440 | 510 | 350 | 920 | 540

11. SECONDARY PURPOSE CODE

510

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

A. Code	BRW	BUW	PVOU	PVON	PART	NUTR	EQTY
B. Amount	15,000	10,000	25,000	10,000	4,000	1,500	5,000

13. PROJECT PURPOSE (maximum 480 characters)

THE PROJECT PURPOSE IS TO EXPAND COMMUNITY BASED MATERNAL HEALTH/CHILD SURVIVAL (MHCS) SERVICES TO THOSE AREAS OF EL SALVADOR WHERE SUCH SERVICES HAVE BEEN WEAK OR NONEXISTENT. THE PROJECT WILL BE IMPLEMENTED BY PVOs CURRENTLY WORKING IN THE HEALTH SECTOR.

14. SCHEDULED EVALUATIONS

Interim MM YY | MM YY | Final MM YY
07 | 913 | | | 07 | 917

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000 941 Local Other (Specify)

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

Methods of implementation and financing are hereby concurred with.

Douglas L. Franklin
Douglas Franklin, CONT

17. APPROVED BY

Signature: *John L. Lovaas*
John L. Lovaas
Title: Mission Director, a.i.
USAID/El Salvador

Date Signed MM DD YY
10 | 21 | 910

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

MM DD YY
| | | | |

PROJECT AUTHORIZATION

Name of the Country: El Salvador

Name of Project: PVO Maternal Health Child Survival

Number of Project: 519-0367

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the PVO Maternal Health/Child Survival Project for El Salvador, encompassing a grant to a PVO or a for profit firm operating on a not-for-profit basis and involving planned obligations not to exceed Twenty Five Million United States Dollars (US\$25,000,000) in grant funds over a seven year period from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the Project. The planned life of the Project is approximately seven years from the date of obligation.

2. The Project consists of technical and financial assistance to expand community based maternal health/child survival services to those areas of El Salvador where such services have been weak or nonexistent.

3. The Project Agreement(s), which may be negotiated and executed by the officer 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 terms and conditions as A.I.D. may deem appropriate.

a. Source and Origin of Commodities and Nationality of Services

Commodities financed by A.I.D. under the Project shall have their source and origin in the United States or in member countries of the Central American Common Market, 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 member countries of the Central American Common Market 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, except as A.I.D. may otherwise agree in writing, shall be financed only on flag vessels of the United States.

b. Conditions Precedent to Disbursement

Prior to the disbursement of A.I.D. funds, or to the issuance of any documentation pursuant to which disbursement will be made, the Recipient shall, except as A.I.D. may otherwise agree in writing, establish separate bank accounts for the control of foreign exchange and local cost expenditures.

Henry H. Bassford
 Henry H. Bassford
 Director
 USAID/El Salvador

7/27/90
 Date

Clearances:
 HPN, RThornton *RT* Date 7/17/90
 /RAV/CONT, DFranklin _____ Date _____
 CO, LMcGhee *LM* Date 7/19/90
 DPP, TMcKee *TM* Date 7/28/90
 AMDO, JHeard *JH* Date 7/25/90
 DDIR, JLoVaas *JL* Date 7/27/90

Drafted: PRJ, DKennedy
 5304B

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ACRONYMS

ADS	Asociación Demografica Salvadoreña (Salvadoran Demographic Association)
AMSS	San Salvador Metropolitan Area
ANDA	Water and Aqueducts National Administration
APSISA	Health Systems Support Project
ARI	Acute Respiratory Infection
CDSS	Country Development Strategy Statement
CHP	Community Health Promoter
CHS	Community Health Specialist
CHT	Community Health Trainer
CISI	Committee for Child Survival
CIPHES	Coordinating Council for Private Institutions in Human Promotion in El Salvador
CODEPROSES	Corporation for Development and Social Promotion of El Salvador
CPA	Certified Public Accountant
CYP	Couple Years of Protection
DHS	Demographic and Health Survey
EEC	European Economic Community
EOP	End of Project
FMLN	National Liberation Front Farabundo Marti
IDB	Inter-American Development Bank
ISSS	Salvadoran Social Security Institute
IRR	Internal Rate of Return
IUD	Intra-Uterine Device
GAO	General Accounting Office
GDP	Gross Domestic Product
GNP	Gross National Product
GOES	Government of El Salvador
LAC	Latin America and the Caribbean Bureau (AID/W)
LOP	Life of Project
MCH	Maternal Child Health
MHCS	Maternal Health and Child Survival
MOH	Ministry of Health
OIC/MOH	Office of International Cooperation/Ministry of Health
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PAC	Project Advisory Committee
PACD	Project Activity Completion Date
PAHO	Pan American Health Organization
PID	Project Identification Document
PIO/C	Project Implementation Order for Commodities
PM	Person/Months
PSC	Personal Service Contract
PVO	Private Voluntary Organisation

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SA	Sub-Agreement
SDA	Special Development Activities
TA	Technical Assistance
TBA	Traditional Birth Attendant
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Education Fund
USAID	United States Agency for International Development
USFDA	United States Food and Drug Administration
USG	United States Government



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I. PROJECT SUMMARY AND RECOMMENDATIONS

A. Summary

The continuing internal conflict in El Salvador has placed a severe budgetary strain on the public sector. The constant need for the GOES to repair damages caused by the conflict has severely limited social services expansion in the country. Nevertheless, the Ministry of Health has been able to achieve some improvement in health indicators and, with assistance from other donors, is planning to expand community level health services to many areas of El Salvador. However, there are still large areas, primarily in the more remote parts of the country, where populations lack access to basic health care and which the MOH will not be able to reach in the next five to seven years. One consequence of this gap in basic services delivery can be noted in the health status of those populations most affected by the conflict, the more remote rural and marginal urban poor.

The Maternal Health/Child Survival Project (519-0367) has been designed to help address this gap. The Project will widen the scope and improve efficiency/effectiveness of health care programs of existing Salvadoran private voluntary organizations to help them reach some of the marginal urban and rural poor not now attended by public health programs. As such, this Project supports the Mission strategy, "to broaden the benefits of growth through the expansion of basic services, such as health care and education."

The Project goal is to improve the health status of the rural and marginal urban population by increasing the percentage of this population which has access to adequate basic health services. The Project will directly serve an estimated 350,000 of the poorest Salvadorans.

The Project purpose is to expand community based maternal health/child survival (MHCS) services to those areas of El Salvador where such services have been weak or nonexistent. This will be achieved by assisting up to 50 local PVOs now operating clinics and/or community based health programs to expand and extend their programs. Emphasis will be given to helping those PVOs which use an approach that leads to self-sustaining community health systems. The principal beneficiaries of the Project will be women of fertile age and children under the age of five living in some 350 rural and marginal urban communities. In addition, the Project will strengthen the ability of the indigenous PVOs to design and implement health care programs, including the establishment of cost recovery schemes, which will result in better management of private resources programmed by these organizations.

The Project is comprised of three major inter-related categories of activities. The first category is Maternal Health/Child Survival Service Delivery and will provide technical assistance, commodities, training, and some start up costs to experienced PVOs to establish a series of health care interventions at the community level. Community participation will be a prerequisite to the provision of Project support to these organizations. The second category is Institutional Strengthening of PVOs and will focus on improving the planning, administrative, and financial functions necessary for effective and efficient project development, monitoring, and evaluation. By improving PVO administrative and managerial skills, organizations will develop the capability to deepen and extend their health programs. The third category is Coordination, Policy Development, and Research and will give emphasis to information exchange among health sector PVOs, the MOH, and other donors, and provide a forum for policy dialogue with the GOES to address issues which inhibit the effective implementation of private sector health programs. The Project will support the collection, review, and dissemination of information through publications, including a periodic newsletter. Seminars, workshops, and conferences will be organized for coordination and training purposes and some operational research on relevant MCH issues will be funded.

By the end of the Project, a self-sustaining network of PVO projects will exist offering basic preventive and curative services for the most serious, life threatening conditions impacting on maternal health and child survival in 350 high risk communities. Direct beneficiaries are expected to be 350,000 rural and marginal urban Salvadorans and up to 50 PVOs which will receive institutional strengthening assistance. The improved access to critical health services among high risk populations resulting from this PVO network will decrease the incidence of undernutrition, illness, and death among women in fertile age and children under five. Increased access to birth spacing services is expected to decrease the birth rate in target communities, and as a result, lead to improvements in maternal and child health.

The Project will be managed by a Coordinating Organization selected through a competitive process following AID and FAR procedures. This Coordinating Organization will manage the Project with the substantial involvement of the USAID/ES Office of Health, Population, and Nutrition to ensure that Project activities conform to general GOES and AID health sector policy and strategy. The Coordinating Organization will act as the principal liaison with other health care providers and related projects; carry out Project procurement, planning, logistics, and financial reporting; and manage all Project inputs to participating PVOs, including technical assistance, training, and commodities. Delivery of health care services to the community will be provided by the PVOs that participate in the Project. With community participation, PVOs will expand and extend services among at risk populations in underserved geographic areas.

The proposed project budget by year is:

YEAR	USAID	PVOs
Year 1	\$ 2,497,807	\$ 571,218
Year 2	3,954,347	1,053,618
Year 3	4,414,445	1,566,618
Year 4	4,105,716	1,590,618
Year 5	3,566,916	1,494,618
Year 6	3,616,356	1,221,018
Year 7	2,844,413	835,625
	=====	=====
TOTALS	\$25,000,000	\$8,333,333

Project inputs will include technical assistance, commodities, training, and some limited financial support for short term start-up costs for promising PVO activities. PVO contributions will include commodities, personnel, program administration, and facilities.

B. Recommendation

The Project Design Committee recommends the authorization of the Maternal Health/Child Survival Project (519-0367) given its focus on efforts to increase MCH coverage of underserved rural and marginal urban populations through private voluntary organizations (PVOs). The recommended life of project is seven years, with a proposed USAID life and project budget of \$25,000,000.

II. PROJECT BACKGROUND, RATIONALE AND PROBLEM DESCRIPTION

A. Country Setting

Over the past decade, civil conflict, global recession, and a devastating earthquake have strained the economic and social fabric of El Salvador. The civil conflict that began in 1979 has caused extensive damage to infrastructure and disrupted production. On the economic front, the prosperous era of the 1970's, with its 5.4% annual average growth in GDP, was quickly brought to an end, and the country entered a prolonged economic slump. Real GDP fell by 22% between 1979 and 1983, and per capita GDP dropped by 29%.

Substantial foreign aid beginning in 1983 provided some relief, and the economy began a modest recovery posting annual average real growth rates of about 1.5% from 1983 to 1988. However, population growth, despite emigration, exceeded these rates and per capita GDP fell further. According to an IDB report, per capita GDP was the same in 1988 as in 1964. Upon assuming office in 1989, the new administration

recognized that sustainable, positive levels of growth will only be attainable if a series of structural imbalances (e.g., in fiscal policy, monetary policy etc.) are corrected. Thus, the country has embarked on a macro economic, structural adjustment program which, if followed through, will place the country in a position to attain much higher annual rates of growth.

Notwithstanding the economic decline, further exacerbated by the 1986 earthquake and a major offensive in the capital in November and December 1989, El Salvador has made some notable progress in recent years. Over 40,000 farmers have received titles to agricultural lands and efforts continue to enhance the impact of the Agrarian reform on the incomes of the poor rural population. Democratic processes have a strong foothold, with Salvadorans turning out in significant numbers to vote four times in the past five years; and in June, 1989, Salvadorans witnessed the first transition in power between two democratically elected Presidents. The newly elected government has expressed its firm commitment to bring an end to the decade of civil conflict and to restore economic and social stability to the country. As evidence of this commitment, it has initiated peace discussions with the insurgent forces and, as noted above, launched a structural reform and adjustment program accompanied by initiation of special assistance targeted to the poorest segments of the Salvadoran population.

B. Project Background and Setting

1. Major Health Care Problems

In spite of the country's internal trauma and continuing decline in the purchasing power of the MOH's budget, moderate improvements in the health status of the Salvadoran population have been achieved over the past ten years. With the assistance of international donors, the people of El Salvador have been able to receive a minimum level of health care. Nevertheless, in El Salvador there is a widening disparity between rural and urban access to health care. The consequences of this limited access to health care can be found in statistics on the health status of the rural and urban populations. A recent national survey placed infant mortality for the country as a whole at 50 per 1,000 live births, while the rural rate was higher at 56 per 1,000. The high rates of illness and death among rural populations are caused directly by complications of birth, diarrheal diseases, acute respiratory infections, undernutrition, and vaccine preventable diseases, reflecting the poverty, limited availability of health care services, and limited access to potable water in rural areas. These problems are discussed in more detail below.

High risk pregnancies, complications of birth and the neonatal period: Perinatal mortality is the first cause of death in El Salvador. The extremely high death rate among newborns is of serious concern.

Although its specific cause is not yet known, it is known that the high newborn death rate is related to maternal and fetal undernutrition, inadequate birth spacing and prenatal care, harmful birth practices, complications during birth, and inadequate care of the newborn.

Diarrheal disease and intestinal infections are the second most common cause of death in the country and the first cause of death in children after the first few months of life. Factors associated with severe childhood diarrhea include the family's economic status, household food insecurity, lack of access to clean water, and inadequate sanitation and hygiene. Of particular concern, given its relation to diarrheal disease, is that according to data obtained in 1988, only 21% of all rural communities have water systems. Potable water availability is lowest in the rural areas of the Department of San Salvador (2.2%), followed by the Paracentral and Eastern regions of the country where availability is under 3.5%. Rural sanitation coverage is estimated to be 38.6% nationwide.

Acute respiratory infections (ARI) vie with diarrheal disease as the second cause of childhood illness and death. Some 300 agents have been identified as causing respiratory infection in El Salvador. As with all other areas of child survival, respiratory illnesses interrelate with other causes of child morbidity and mortality, thus compounding the ill effects of these diseases. For example, while undernutrition or respiratory infection alone may not be fatal to a child - a malnourished child who falls prey to continuous bouts of respiratory infections is at mortal risk. Also, environmental conditions, including poor housing and overcrowding, increase ARI incidence.

Undernutrition is one of the most important underlying factors adversely affecting maternal and child health. Women who are undernourished during pregnancy give birth to underweight children at high risk of early death. Continued undernutrition during the early years of life also increases a child's susceptibility to infectious disease, and in a vicious cyclical manner, worsens the severity of undernutrition. The combination of low living standards and low educational levels creates a chain effect of household food insecurity, unequal patterns of intra-familial food distribution, and negative practices which restrict food intake of women during pregnancy and the weaning period. These in turn can lead to infectious disease and child morbidity and mortality.

Vaccine preventable diseases, such as measles, whooping cough, diphtheria, polio, tetanus, and tuberculosis also continue to be a danger to young children. These diseases interact with states of undernutrition and cause high mortality. Although vaccination coverage is currently estimated to be high-- a 1987 study found 63% of Salvadoran children to be fully immunized-- in recent years there have been serious regional outbreaks of some of these diseases.

2. Differential Access to Health Care Services

Women of fertile age living in communities not covered by adequate health services are a high risk group, especially those in union who suffer from maternal malnutrition and depletion due to young maternal age, inadequate diets, repeated lactation, and closely spaced pregnancies. Children under five-- particularly the youngest of these-- are also at high risk; deaths among children during the first month of life account for 45% of all infant deaths. Most of these deaths occur during the first seven days after birth.

Through national surveys, morbidity and mortality statistics prepared by the MOH, and interviews with experts and practitioners, the USAID was able to analyze and identify geographical risk areas that are in most need of maternal health/child survival assistance. As a starting point, the 1988 Demographic Health Survey (DHS) demonstrates that rural areas have lower medical service coverage than urban areas. One indicator, contraceptive coverage, for example, shows that rural areas in five departments (Ahuachapan, Sonsonate, La Libertad, Cabañas, and Usulután) have serious gaps in family planning service delivery. In addition, the nutrition survey carried out as part of the DHS indicated that the northern and western areas of the country have the highest percentage of rural malnourished children under five; these areas include the northern parts of Santa Ana, Ahuachapan, Chalatenango, Cabañas, San Miguel, and La Unión. Recent vaccination coverage data from the MOH indicates that problem areas exist in the northern portions of Santa Ana, Morazan and La Unión. These are areas which the MOH has been unable to penetrate with success, and it therefore looks to other agencies to assist in extending coverage.

Quantified information on current public sector coverage was also provided for this analysis by the APSISA Project Manager in USAID. This information confirms the reports on health care access. The highest percentages of health establishments closed because of the violence have been in two of the regions identified as high risk: the Central Region (23%, mainly in Chalatenango) and the Eastern Region (11.3%, mainly in San Miguel and Morazan). All of the establishments closed have been health posts, which is the lowest level MOH facility and located in rural areas. Because of the health need in these geographic areas, the MOH has recently increased its emphasis on community-level service delivery through the use of health promoters. Currently 522 MOH promoters are each serving an average of 10,000 people, with the highest concentration serving in the Eastern, Central and Paracentral Regions of the country. Coverage in these regions is approximately one promoter per 7,000 people, while in the high risk Western Region, coverage is approximately 1 promoter per 13,500 people -- both are very high ratios and inadequate for an effective primary health care system.

Interviews with practitioners and other knowledgeable informants provided information to supplement the findings of these studies and attempt to more accurately pinpoint pockets of low public sector coverage and high morbidity and mortality rates among target groups. Individuals interviewed included individuals who have traveled extensively throughout the country, representatives from projects serving the displaced, and key PVO personnel working in community development. These persons were given maps of El Salvador which showed the departments and urban areas within departments. They were asked to shade in areas which they considered to be high risk. Responses among informants were remarkably similar and coincided with epidemiological data provided through the DHS and the MOH.

The map at the end of this section graphically shows what we have determined to be the highest geographical risk areas of the country. It shows large areas of need in the Eastern region (northern Morazan; northern, central, and southern La Union; northern San Miguel; and central and southern Usulután), the Western region (northern Santa Ana, central Ahuachapán, and southern Sonsonate), and the Central region (particularly eastern and central Chalatenango and southern La Libertad). In the Paracentral region, only a section of northern Cabanas has been designated a high risk area.

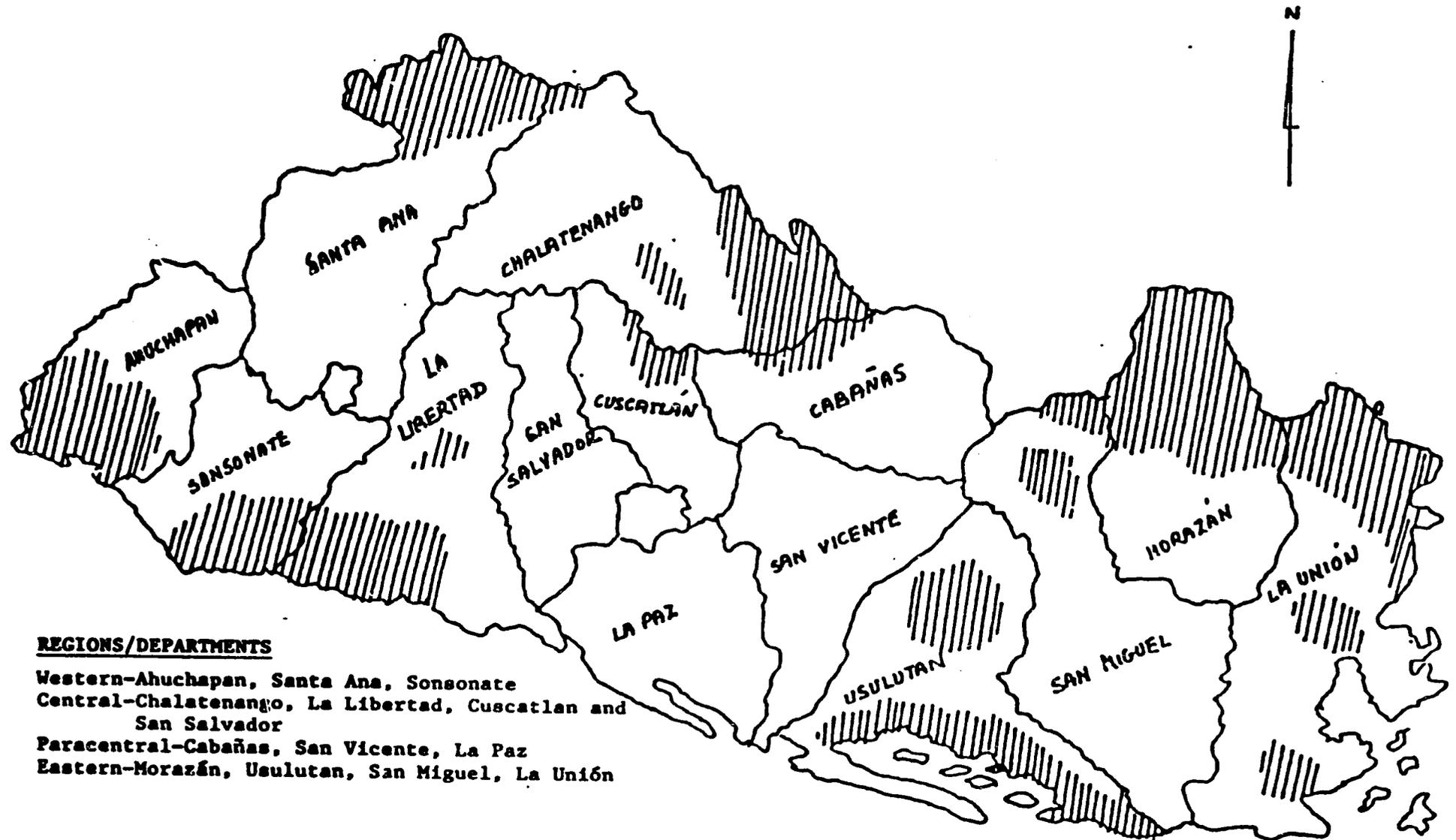
Although the map indicates the largest concentrations of high risk communities, it is clear from site visits with PVOs that there are also smaller pockets of high risk communities in departments generally considered to be low risk. For instance, one organization had no difficulty identifying a group of five high risk communities located in a rural section of the department of San Salvador. In another case, several rural communities in northern Ahuachapán were identified as high risk, even though these areas are not identified on the map.

3. Demand and Sustainability of Private Sector Services

A recent health sector demand study (REACH, 1990) found private sector health care services to be a well-accepted source of care in both urban and rural areas. Even though private sector services were on the average 12 times more expensive than those of the MOH, 58% of the services sought in metropolitan San Salvador (AMSS) were from private providers. In rural areas, the MOH provided a much higher proportion of total use (58%), but use of private sector services was still high at 43%. This difference between the AMSS and rural areas may be partially explained by the latter's reduced access to private sector facilities and lower per capita income.

The MOH's average cost associated with an episode of sickness represents about 2.3% of the average annual per capita income, while the private sector's cost is 11.7%, a very high percentage considering the fact that many individuals seek health care on multiple occasions over

**GEOGRAPHICAL RISK
EL SALVADOR**



REGIONS/DEPARTMENTS

Western-Ahuchapán, Santa Ana, Sonsonate
Central-Chalatenango, La Libertad, Cuscatlán and
San Salvador
Paracentral-Cabañas, San Vicente, La Paz
Eastern-Morazán, Usulután, San Miguel, La Unión

the period of one year. As one might expect, there is an inverse relationship between the price of the service provided and the probability that an individual will seek health care outside of the home and in a particular sub-sector. For the private sector, the elasticity of demand is 0.40, that is, for every 1% increase in private sector prices there is a 0.4% decline in the demand for services; for every 1% price decrease, there is a 0.4% increase in service demand. The REACH analysis also indicates that, when seeking health care, people at lower income levels are much more sensitive to prices than those with higher incomes. In general, however, this study found that reasonable cost recovery fees for services and pharmaceuticals charged by private sector providers are accepted in both urban and rural areas. These mechanisms may be a source of cost recovery and Project sustainability even for PVOs working among the poorest and highest risk populations.

4. PVO Role in the Health Care System.

Against a backdrop of uncertainty and uneven development progress, PVOs in El Salvador have generally been known as steady, constant sources of assistance to the poor, responding to the felt needs of the populace, despite significant resource limitations. In touch with the government and people at the village level, dedicated PVO staff have constructed intricate networks that reach and influence Salvadoran citizens and entire communities. PVOs usually answer immediate needs, and often possess technical and local management skills that parallel local financial sources.

There is a wealth of experience among the 75 or more health sector PVOs in El Salvador and documented in a recent PVO survey (MARCABLE, June 1990). Just over half have been working in El Salvador for more than ten years, and some of these have over twenty years of health experience. Another 35% have between five and ten years experience, and only 12% have been operational for less than five years. Legal status does not seem to be a problem for PVOs in El Salvador. Seventy four percent have acquired legal status, and another 21% are currently in the process of obtaining legal status or are affiliated with another organization which already has legal status.

There is a relatively large geographical spread of service delivery areas among health sector PVOs in El Salvador. PVOs work in all five health regions of the country: 78% are active in San Salvador, 58% in the Western Region (Ahuachapan, Santa Ana, Sonsonate), 56% in the Central Region (Chalatenango, La Libertad), 46% in the Paracentral Region (Cabanas, Cuscatlan, La Paz, San Vicente), and 48% in the Eastern Region (La Union, Morazan, San Miguel, Usulután). Moreover, as demonstrated in the Marcable survey, the majority of PVOs work in or near areas which we have identified as high risk. Given technical and financial assistance, many would be willing to enhance or expand their programs, and thereby

fill a pressing service delivery gap. Several case studies of ongoing PVO programs, as well as sketches of service enhancement/expansion which could be accomplished with support, are contained in Annex D.

PVOs in El Salvador, in general, have a record of providing low cost MCH services due in large part to their success in obtaining in-kind contributions, achieving active community participation, establishing service fees, and charging for drugs/supplies at cost. They have significant strengths in community development and organization. On the other hand, some have weak technical support for programs, only limited coordination with other agencies, and weak administrative and logistical systems which inhibit greater service coverage and effectiveness.

5. Efforts to Coordinate Private and Public Sector Health Care Programs

The MARCABLE survey identified two groups which serve as coordinating bodies for PVOs: the Inter-sectoral Committee for Child Survival (CISI) and the Coordinating Council for Private Institutions in Human Promotion in El Salvador (CIPHES). There is also at least one other PVO coordinating body, the Corporation for Development and Social Promotion of El Salvador (CODEPROSES). CISI has 39 members including representatives from the MOH, major PVOs, and four universities. It was formed by the MOH in March, 1988, in order to standardize norms, avoid duplication of services, and improve coverage. CIPHES has 23 members, some of which also belong to CISI. It was formed in June, 1985 in order to strengthen community self-determination through PVOs working in the human potential movement. CODEPROSES is smaller than the other two groups, but it is also involved in strengthening PVOs with programs which include community participation. The effectiveness of these coordination efforts is, however, limited due to their lack of financial resources and technical support for information dissemination, seminars, etc.

C. Project Rationale

The MOH Health Plan for 1985-1989 stressed primary health care, decentralization of management and delivery mechanisms, and increased community participation in health care programs. The plan emphasized the need to improve the health of the Salvadoran population by providing direction to the national health system, improving environmental conditions, and increasing basic health coverage. In order to meet the health needs of the entire population, policies in the plan included improving the structure of the primary health care delivery system to increase efficiency. Some progress toward these goals has been achieved: the Ministry was reorganized, regional offices were reviewed and recommendations were made for improving their efficiency, and renewed emphasis has been placed on the decentralization of decision-making in planning, budgeting, and programming. Efforts have also been directed to extending service coverage through the Community Health Program, which emphasizes community participation.

When the new government of El Salvador took office in June 1989, it reviewed the health situation and issued a Health Strategy in September of 1989. This strategy does not differ significantly from the 1985-1989 Plan. It also stresses the most prevalent and serious health problems of the most vulnerable groups, places preventive measures (especially child survival interventions and education) as a high priority, and reiterates the previous plan's intention to decentralize decision making to the extent possible, coupled with greater community involvement. It reaffirms an intention to equalize access to services for rural residents, that is, to reduce the disparity of access to health services available to the rural and marginal urban poor in contrast to those available to other groups.

The slow rate of economic growth combined with rising inflation, unemployment and under employment and continuing internal conflict diminish the possibility that the MOH alone will be able to achieve the stated key objectives of the Ministry's plan. Moreover, in the short term, vitally important structural economic adjustment measures being taken by the GOES are expected to have a negative impact on certain sectors of the population, particularly the unemployed or underemployed marginal urban and rural poor.

This Project is designed to complement the efforts of the public sector to expand service delivery to high risk areas. It will be implemented through the private nonprofit sector. This is in keeping with the September, 1989 MOH Strategy which emphasizes the need for the public sector to work in close collaboration with the private non-governmental sector. Private voluntary organizations are already working in maternal child health in rural and marginal urban areas, mobilizing private sector resources, and their decentralized decision making structure makes it possible for them to respond quickly to priorities consistent with their institutional objectives. They have also indicated readiness to extend and expand the range of their services, but lack the technical and financial assistance needed to do so.

As indicated in the findings of a national Health Care Demand Survey financed by USAID, the private sector plays a major role as a provider of health care services to all population groups, including the rich and poor, in both rural and urban areas. This is probably related to the perception of over 65% of respondents who stated they would choose private providers over the Social Security Institute (30%) or the MOH (3%). MOH facilities are perceived to be of poor quality, which private providers are perceived as providing the highest quality of care. Thus, despite the fact that private sector prices are 12 times as high as the MOH, the private sector provided more than 40% of all consultations in rural areas. This Project, therefore, responds to an already existing demand for private sector health care and will contribute to an increase in low-cost health care services through the expansion of PVO service programs, which are less costly than for-profit practitioners.

D. Problem Statement

In spite of improvement in overall health indicators for El Salvador over the past ten years, sociopolitical conflict and constrained economic growth have resulted in declining budgets in real terms for social programs, notably inhibiting MOH extension of adequate maternal-child health services to high risk populations. Death rates, morbidity rates and the nutritional status of rural and marginal urban families are worse than those of families in urban areas. Additionally, the economic situation of rural and marginal urban families has declined, and to add to the problems, the birth rate remains high leading to poor maternal health, high perinatal mortality, and malnutrition among children. Without additional service programs, infant and child mortality levels will not improve and may even increase above current levels. The outlook for increased budget allocations to public health in the near term, coupled with significant management and administrative problems in the Ministry, will result in continuing service gaps, particularly in rural areas for the next 5-10 years or more. Thus, alternatives must be developed to increase access of the poor, and particularly in rural areas, to health care.

Recent findings of a health care demand survey and a survey of private voluntary organizations indicate that an expansion of health service delivery programs of PVOs may be both an efficient way to increase access rapidly, while also responding to preferences of the population for private care which they consider of higher quality than public services. Thus, the challenge for this Project is to identify and support the expansion and enhancement of sustainable private sector programs which deliver key maternal health and child survival interventions among underserved poor populations and, thereby, achieve increased access to health care by the poor.

E. Constraints to Extending Private Sector MCH Services and Improving Health Status Among High Risk Populations

1. Institutional Constraints: Despite the many positive impacts of PVO health care programs described in Section II B above, weak technical support and the lack of discipline limit greater health impact, in particular through the lack of adequate regard regarding the sustainability of health care programs. These factors, which also constrain PVOs from implementing expanded programs, include:

Technical Support - PVOs may not always employ adequate technical support to maximize their investment and to assure project results. They are known to skimp on technical analyses in favor of delivery of services.

Management - Expansion of health service programs is constrained in many instances by the limited management capability of the PVO organizations themselves. This includes limitations in administration and logistics systems. Most of the staff of such organizations are volunteers or modestly compensated part-time officers and this inhibits the development of agile management arrangements. Many PVOs also are not accustomed to, or may not have the expertise to, design a project which includes the programming of diverse inputs to reach defined objectives. This results in wasted resources and ad hoc distribution of services.

Financial Capabilities - Although most PVOs have some rudimentary system of financial accountability, these systems often lack the flexibility and completeness to incorporate additional programmed activities.

Sustainability - PVOs are frequently reluctant to charge for services; thus, their projects depend on handouts of medicines or good will donations of time and resources.

Evaluation and Monitoring - PVOs lack strong and dependable evaluation and monitoring procedures essential to periodically assess program direction and ensure program effectiveness. As a result, many PVOs do not have evaluation or monitoring systems in place, and some do not consider them to be a priority. Systematization of successful programs is, therefore, often not documented and this leads to poor utilization of resources.

Coordination - For a myriad of reasons, PVOs lack coordination with other agencies and with other PVOs. This absence of information exchange impoverishes the service delivery of all involved, and often results in duplication of effort.

2. Infrastructure: As indicated by the high rates of diarrheal disease, access to safe water supplies, particularly in the rural areas, continues to be a major constraint to improving health status. Rural access to potable water has dropped from 30% in 1984 to 21% in 1988. The internal conflict, high population growth rates, and lack of maintenance for existing systems are major factors in this rapid drop in access. On the positive side, however, a series of A.I.D. and other donor programs (e.g., BID) are now in place to reverse this trend. The mere placement/installation of a water source is, however, insufficient to improve health status. These interventions must be accompanied by health education and improved sanitary practices.

3. Cultural-attitudinal: There are a host of cultural beliefs and practices which work against the delivery and acceptance of health interventions. For example, some practices (e.g., restricting food and liquid intake) exacerbate diarrhea-induced dehydration; there is a

cultural aversion to boiling drinking water; and certain cultural beliefs fix gender-specific food allocation protocols that lead to food restrictions for the mother during the prenatal and postpartum periods and which are harmful to the child. These beliefs represent significant barriers to improving maternal child health and can only be overcome through educational efforts involving mothers.

4. Educational: The formal educational level of caretakers and parents has been shown to be related directly to the health status of children. For instance, low levels of formal education of parents are associated with high rates of childhood undernutrition and low use of birth spacing methods. Proper sanitation management also diminishes with low levels of formal education among heads of household. However, these trends can be reversed if adequate health education is provided in the community.

5. Economic: Household purchasing power continues to remain low in the high risk population. Although actual wages have risen, when income is adjusted for inflation, the purchasing power of the average wage earner has fallen over the past five years. Nevertheless, 43% of rural families chose private health care over that offered by the public sector, despite the fact that private consultations may cost as much as 12 times that of a MOH consultation. Moreover, demand is very price sensitive; thus efforts to reduce the cost of private care, such as through PVO service expansion, could result in increased access and use.

6. Ecological: El Salvador is the most densely populated Latin American country. Although the fertility rate has dropped commendably to 2.5 percent, the country's population density will continue to exert great pressure on the land's carrying capacity. This means that ecological degradation will continue to occur. Clearing for agriculture, the demand for building material, and the quest for fuelwood has left only nine percent of the territory with primary forest growth. Continued deterioration of the natural resource system will lead to decreased productivity and income, further exacerbating problems of poverty and social concerns, including implications for the health status of the rural population.

7. Continuing conflict: In several regions of the country, in particular the northern and eastern sections, the conflict continues to restrain the outreach of health services delivery. For example, the Ministry of Health had to close 25 of the 100 health units and posts in the eastern region as well as numerous other health facilities in other parts of the country. Some of these facilities have been re-opened as the intensity and loci of the conflict has changed. Nevertheless, in some conflictive areas, health personnel continue to be in danger when delivering health services. Any form of social organization effort can be perceived as a threat by one side or the other, placing the security of health workers in danger.

F. Project Strategy

The Project strategy has three major dimensions: a phased progressive involvement of as many as 50 PVOs; high risk focus; and sustainability.

Many PVOs, as shown by the recent MARCABLE Survey, have institutional objectives and programs which are compatible with the goal and purpose of this Project. Several of these PVOs have shown strong interest in the Project and are prepared to design new sub-project proposals targeted to the delivery of maternal health/child survival services to high risk populations and to begin implementation activities promptly after the Project begins. Other less-ready PVOs have also expressed participatory interest and are amenable to training and other inputs that will prepare them to participate in the Project. The Project is based on a progressive involvement strategy; a phased-in approach, wherein an increasing number of PVOs are brought into the Project throughout the life of the project (LOP) which will yield by end of project (EOP) a universe of participating PVOs with sufficient capacity to reach the target communities and to have expanded service delivery among the high risk areas. To achieve this, the Project will, initially focus on those relatively stronger PVOs that can begin with comparatively little technical assistance. Gradually, other PVOs will be added using the Coordinating Organization as well as implementation-ready PVOs to assist less ready PVOs in upgrading their institutional capability in order to enhance their role in the Project.

The focus of this Project is on high risk geographical locations defined for purposes herein as rural or marginal urban area which has two characteristics. The first is inadequate health service coverage, which is essentially a function of large distances or other geographical barriers to access, weak or partial services, or access to expensive for-profit services only. The second is poor health and nutritional status among young children and women in fertile age. In selecting PVO proposals, care will be taken to assess the relative cost-effectiveness of a PVO program versus MOH service expansion, prior to deciding whether this Project is best positioned to fit the community's need or whether the community should be referred to the MOH for attention.

In selecting among PVO sub-project proposals that meet the high-risk focus, the Project will give emphasis to those which are likely to be self-sustaining. The intent is for PVOs to motivate community leaders and residents to collaborate in the sharing of the cost of the services provided. Project sustainability depends, in part, on the success of this collaborative cost-sharing. The Project's support for cooperation and policy development among PVOs and with the MOH will also enhance sustainability prospects. The PVOs will be expected to become a forceful network to assist in exerting pressure for necessary changes in GOES policies and legal constraints which inhibit the provision of health care services to the rural and marginal urban poor, (e.g., availability of lower priced genetic drugs).

In spite of the emphasis on the highest risk areas, the Project will not be able to address needs in all of the high risk areas of El Salvador. In fact, a disproportionate number of these areas are in the most conflictive zones where the MOH and other PVOs are generally not able to work. It is presently not the intent of the Project to attempt to work in these conflictive zones. As noted above, the Project will be implemented in phases -- the first focusing on those PVOs who are ready to absorb assistance, have well established controls, and can move quickly to meet unmet needs in areas of high risk but in relatively more peaceful locations. However, during the life of the Project, the Mission, the Coordinating Agency and the Project Advisory Committee will periodically review the level of conflict in priority zones now unaccessible with an eye to a phased expansion into these areas as soon as it is feasible.

Finally, the Project also recognizes the importance of medical neutrality. Hence, one of the criteria for approval of sub-grants will be an "apolitical" philosophy on the part of the sub-grantee. These criteria are described in fuller detail in subsequent sections of this Project Paper.

G. Consistency with AID/W, Mission and Host Country Strategies

The AID Child Survival Strategy "seeks to reduce significantly the number of child deaths in the lesser developed countries by the end of the decade." This strategy includes a comprehensive approach to reduce child mortality by focusing on interventions which comprise the maternal-child health framework. It has long been AID's policy to focus its health programs on the most vulnerable members of the developing world's population - infants and children under five, and pregnant and lactating women. The policy promotes key interventions for achieving improvements in health and nutrition which include, but are not limited to: immunization, oral rehydration, birth spacing, improved nutrition, and growth monitoring. These key MCH interventions and others should be delivered as an integrated set of actions in a comprehensive maternal health/child survival approach. The AID Strategy emphasizes involvement of the private sector in health service delivery. This Project focuses on expanding access to MCH interventions through the private, nonprofit sector. Thus, the PVO Maternal Health/Child Survival Project is consistent with the Agency's goal for the health, population, and nutrition sector.

The specific Mission CDSS objective in the Health Sector is to "increase access to family planning, reduce infant and child mortality, and improve health services." The thrust of the Strategy, articulated therein, is to seek these objectives by addressing three target groups: women of fertile age and children under five living in some 2,000 of the poorest, smallest and most rural communities; women of fertile age and

children less than five years of age living in some 100 of the country's towns; and the disadvantaged general population living in marginal urban areas. Recognizing the constraints which limit MOH possibilities for reaching these underserved target groups, the CDSS stresses the need to support health delivery outreach through PVOs. This Project is therefore consistent with the CDSS and Action Plan initiatives, given its rural emphasis and reliance on PVOs. The Mission's Health, Nutrition and Child Survival Strategies make more specific the general goals expressed in the CDSS. In all sectoral strategy and policy documents, resources are directed to the extension of those services that have the greatest potential for impact on the highest risk populations, and the involvement of the private sector is considered a critical agent for program implementation.

As noted earlier, the government that entered office in June, 1989, reviewed the general health situation and published its health strategy in September, 1989. The priorities that were identified included: emphasis on the most prevalent and serious health problems of the most vulnerable groups, emphasis on prevention especially child survival interventions and education, and the decentralization of decision making directed specifically towards the community level. Most notably, the Ministry stated its intent to carry out these strategies with private non-governmental sector participation. This Project is consistent with all of these 1989 MOH strategy statements.

H. Relationship with Other USAID Projects and Donor Assistance

There is a fortuitous coincidence of timing that promises a period of close, productive interaction between this Project and other USAID projects soon to be implemented or amended and extended. In addition to activities supported through this Project, the new Family Health Services (519-0363) and Public Services Improvement Projects (519-0320) and the ongoing Health Systems Support Project (519-0308) include activities which, with appropriate coordination, will enable the country to achieve sustainable decreases in child and maternal mortality and morbidity. The Family Health Services Project, funded for five years beginning in FY 1990, will improve and expand family planning and health services in rural and marginal areas through the Salvadoran Demographic Association. These interventions will impact on child mortality and malnutrition, which in El Salvador is very much related to inadequate birth spacing. The water and sanitation component of the Public Services Improvement Project, just beginning, will provide safe drinking water for low income rural and urban areas. Although the Project will benefit all family members of the target group by providing a safe water supply and latrines, children will especially benefit since their incidence of diarrheal disease is highest.

The Health Systems Support Project (519-0308) has compiled over four years of experience supporting and extending the basic health care services of the MOH, including preventive primary care services important to the MOH child survival program, and has accumulated data and information which is relevant to the planning and implementation of this Project. An FY 1991 planned amendment will support the extension and strengthening of MOH rural health services. This PVO Project will finance similar services, but in areas where the MOH cannot reach cost effectively within the next seven years. Involvement of the project managers for the Health Systems Support Project, as well as the other two USAID funded projects in the health sector, in the Project Advisory Committee for this Project will facilitate the coordination of these mutually reinforcing efforts and result in benefits much greater than if these activities were implemented in isolation.

Several international donors are also active in maternal health and child survival. These include UNICEF, UNFPA, the Inter-American Development Bank, the World Food Program, PAHO, and donor countries such as Italy and the members of EEC. The Project will coordinate its activities with those of other donors through its involvement with the three inter-agency coordinating groups discussed in more detail under Category Three of this paper. That category of the PVO Maternal Health/Child Survival Project calls for the sharing of information related to MCH topics and coordination of service delivery. Inter-agency and inter-donor communication and coordination will be essential to this effort.

III. DETAILED PROJECT DESCRIPTION

A. Project Goal and Purpose

The goal of the Maternal Health/Child Survival Project is to improve the health status of the rural and marginal urban population by increasing the percentage of this population which has access to adequate basic health services. Specifically, this Project will contribute to a reduction in child morbidity and mortality, maternal morbidity and mortality and a reduction of fertility rates in target communities.

The Project purpose is to expand community based maternal health/child survival (MHCS) services to those areas of El Salvador where such services have been weak or nonexistent. The Project will be implemented by PVOs currently working in the health sector.

By the end of the Project, an estimated 350,000 individuals living in 350 of the country's poorest high-health-risk rural and marginal urban communities will have access to quality maternal health-child survival services, including, but not limited to immunization, prenatal care, family planning and basic curative care for common illnesses, such as ORS

for diarrheal disease. These services will be provided by a network of 35 to 50 PVOs and partially or entirely supported by the communities served through cost sharing arrangements. As a result, these communities will have reduced births and reduced incidence of undernutrition, illness and death among women in fertile age and children under five.

B. Project participants/beneficiaries

The MHCS Project has two levels of participation and two groups of beneficiaries. The first is the community-level participant/beneficiary, and the second is the institutional-level PVO through which the Project is implemented.

1. Community-level Participants/Beneficiaries:

The Project has a high risk focus in a double sense. Its participants will be those who are personally at risk, largely low-income women in fertile ages and children under five years of age, and who also live in communities located in high health risk areas, largely rural and marginal urban areas with inadequate health service coverage and poor health and nutritional status indices. Project activities will not be limited to these areas, however, as high risk communities are also located within departments generally considered as a whole to be of lower risk.

Many Project activities will also directly and indirectly benefit most members of the community. Examples of direct benefits include the diffusion of basic community health education, improved access and use of water, improve sanitary practices, and improved access to basic preventive and curative health services. Indirect spread effects will occur on a wide basis due to the participatory nature of the Project. Because community organizations will be stressed, communities may also become more self reliant in other areas of development as they learn skills related to working in groups.

2. Institutional Participants/Beneficiaries:

By the end of the Project, from 35 to 50 PVOs will have participated and as a result, have stronger technical and administrative capabilities. Moreover, they will have expanded their base of financial and in-kind support, and thus, the sustainability of their programs. These will be chosen from the universe of at least 75 PVOs already providing maternal-child health services in El Salvador.

C. Project Categories and Their Interrelationship

For planning and presentation purposes, the Project is divided into three major categories of activities. It is important to keep in mind that these three categories are in reality, closely inter-related. The first category (Maternal Health/Child Survival Services Delivery at

the community level) involves the provision of material and financial support for MHCS preventive and curative care delivery by the PVOs in target communities. These activities include efforts to increase community participation in service delivery and develop sustainability mechanisms in the community. The criteria that will be used to approve PVO eligibility for support under the Project and the criteria used to guide approval of PVO proposals are also described in the section that follows. The second category (Institutional Development of PVOs) includes, inter alia, technical assistance and training for PVOs to strengthen, institutionalize, and expand their ability to deliver community services. The third category (Coordination, Policy Development, and Research) focuses on efforts to coordinate PVO activities with the MOH, other related USAID projects, other donors, and among the PVOs themselves; enhance policy development; and carry out limited operational research to, inter alia, improve PVO service delivery and policy development.

PROJECT CATEGORY I: Maternal Health/Child Survival Services

The Project will support PVOs in the provision of a range of preventive and curative services in MHCS which are designed to impact directly and indirectly upon morbidity and mortality among at risk populations. Given the differences in capacities and operational philosophies among PVOs, some may provide all of these services while others may provide a limited number of services (preventive only, for example). The range of health interventions by the Project will include those described below:

Preventive:

Community Health Education. Although many beliefs and practices in high risk communities are beneficial, some of the proximate causes of maternal and child undernutrition, illness, and death are cultural beliefs and practices which are harmful. These include beliefs and practices about contraception, pregnancy, birth, care of the newborn, lactation and weaning, diet, hygiene, infectious disease, and the inability to recognize serious complications related to pregnancy and birth, infectious disease and undernutrition. The Project will assist PVOs in providing community education on these topics and others to both women and men in target communities. Simple growth monitoring of children (weight for age) will be used as an educational tool.

Traditional Birth Attendants. Much of the health care during pregnancy and birth in high risk groups is provided by traditional birth attendants (TBAs). Lack of information and harmful beliefs and practices among these practitioners are related to maternal mortality and neonatal deaths. These include inappropriate treatment of complications during pregnancy, use of pharmaceuticals during birth causing fetal stress,

practices contributing to neonatal tetanus, and inadequate treatment of postpartum complications and high risk neonates. The Project will assist PVOs in providing training to TBAs to improve their practices, and enable them to recognize risk and use referral where appropriate. It is expected that much of the training will be done cooperatively with the MOH, since it has considerable experience in this area.

Water and Sanitation. When access to potable water is limited, families must conserve the little water they have; only small amounts are available for personal hygiene on a daily basis. This increases the risk of contracting and transmitting serious infectious diseases, particularly those causing diarrhea, vomiting and dehydration. The Project will improve access to potable water by assisting PVOs and participating communities with the equipment and technical assistance for the construction of ecologically sound water systems. Construction of systems will be accompanied by community education related to water. The Project will liaison with the Public Services Improvement Project for collaboration in the construction of water systems.

Inadequate disposal of human waste is also a source of diarrheal infection. During the rainy season waste deposited in open areas is washed into the water, increasing the incidence of diarrheal disease throughout the country. Waste disposal is especially a problem in crowded marginal urban areas. This Project will assist PVOs with the equipment and technical assistance necessary for the construction of sanitation facilities. Construction of these systems will also be coordinated with the Public Services Improvement Project and accompanied by community education related to sanitation.

Medical-technical Interventions. Both preventive and curative interventions will be supported by the Project. The Project will provide medical-technical interventions which prevent maternal and child morbidity and mortality through the expansion of clinic services, community education groups, and by development within the PVOs of a cadre of specially trained health promoters. Preventive interventions include vaccinations against serious infectious diseases (measles, diphtheria, whooping cough, tetanus, polio and tuberculosis), oral rehydration therapy, Vitamin A capsules, and birth spacing methods (condoms and pills).

Curative:

Lack of access to adequate, comprehensive curative care is also an important cause of maternal and child morbidity and mortality. Access may be restricted by geographical factors, income-level, or weaknesses in delivery of services. Although the Project emphasis is primarily on prevention, the Project will assist PVOs in extending curative services to communities where access is a problem. Curative services which will

be provided include but are not limited to prenatal care, delivery of normal pregnancies, postpartum care, neonatal care, treatment of life-threatening infectious diseases especially diarrheal disease and respiratory infections, and treatment and referral of complications during pregnancy and the postpartum period.

Community participation in the design, implementation, and maintenance of health services will be a sine qua non for Project support and is essential for sustainability. The Project will facilitate such participation through efforts to organize committees and use of community volunteers. The community health committee will select and serve as an advisory body to the female health promoter, linking the promoter to the wider community. A special water committee, may also be formed to select a water promoter, typically a man, and serve the same function for this promoter. The use of a male-female promoter team has many advantages in lowering cultural constraints to service delivery. The promoters provide their community with education, access to preventive and some curative care, and referral.

Cost Recovery: Communities that want water systems commonly share in the cost of the system by providing labor and some materials and assume responsibility for maintaining the system once it is in place. Communities that want improved access to preventive or curative services must also assume a reasonable fee-for-service charge. Similarly, many PVOs already working in community health have a clearly defined method for figuring the cost of medicines and consultations among low income populations and charging for these services. This Project will provide technical support to PVOs to improve such systems, or where non-existent, to establish cost-recovery schemes.

Most support to PVOs will be in the form of technical assistance, training, and commodities. In some instances, however, short-term financial support for the PVOs operational costs may also be provided. For example, some of the smaller PVOs will find service expansion difficult due to lack of personnel or office space. In these instances, the Project will support additional personnel for a limited period or assist in building rental until the PVO's own resources can support the additional personnel and space. The Project will also support one-time financial expenditures such as the costs of research, per diem during training sessions, and select local costs including some commodities. The Coordinating Organization will ensure that all PVOs receiving financial assistance from the Project have adequate financial controls in place to properly account for Project funds.

Following is an illustrative list of the kinds of commodities which will be procured and distributed to PVOs over the life of the Project to support PVO program activities on the community level:

- * Jeeps/Automobiles
- * Motorcycles
- * Pharmaceuticals
- * Contraceptives
 - Condoms
 - Pills
- * Biomedical Equipment
 - Microscopes
 - Autoclaves
 - Centrifuges
 - Blood Pressure Cuffs
 - Thermometers
 - Salter Scales
 - Clinic Scales
 - First Aid Kits
- * Medical Supplies
- * Water/San. Equipment
- * Audio-visual Equipment
- * Educational Materials
- * Building Materials (for clinic/office renovation)

Commodity procurements will be carried out by the Coordinating Organization, in accordance with the standard provisions of the Cooperative Agreement governing the procurement and shipment of goods. Only items which require USFDA quality assurance and must be purchased through AID/W (pharmaceuticals, contraceptives, and oral rehydration salts) will be procured through Mission PIO/Cs and purchase orders. Purchases by PVOs will be limited to local shelf items such as office supplies, educational materials and supplies, and limited medical supplies and equipment. The Provision of specialized technical support will also be provided to enhance PVO impact in fields such as community participation, water and sanitation and MCH activities. This kind of support is described under Institutional Development.

PROJECT CATEGORY II: Institutional Development of PVOs

This component is designed to assist the PVOs in achieving Project objectives efficiently. However, it will also contribute to improving overall PVO functioning and capabilities through provision of training and technical assistance on a very limited basis (e.g., depending on space availability in workshops, etc.) to PVOs that are already delivering health services, but in geographical areas not targeted by this Project with the expectation that the limited Project assistance for PVOs operating outside of specifically targeted areas will enable the PVOs to expand their services, possibly into areas targeted by the Project.

In order for PVOs to effectively serve community needs and to become a sustainable part of the health care system, they must:

- * develop a clear mission;
- * carefully select and place staff - paid as well as volunteer;
- * offer appropriate training for staff;
- * create a disciplined management structure and standards for performance; and
- * develop and operate by policies and procedures that encourage accountability for performance and results.

Each of the 75 PVOs which make up the universe of potential participants in this Project are unique. Their needs for technical assistance, training and organizational and other assistance vary. The Institutional Analysis (Annex G) shows that most PVOs will need initial management training as a prerequisite to their implementation of Project activities, and ongoing training as their programs expand. Therefore, the Coordinating Organization will work with each PVO during its project proposal preparation to assess and define specific needs. While it is difficult to prescribe the training packages for the PVOs in detail at this point, it is expected that the training areas will include: project preparation, financial management, cost recovery, supply management (procurement, warehousing, distribution, inventory), monitoring, evaluation, and training of community health personnel. More individualized technical assistance will be needed in community participation, water and sanitation and financial management.

The purpose of the assistance provided to PVOs is to foster the institutional development of the PVOs themselves and to strengthen, expand, and diversify their maternal health and child survival services. Eligible PVOs will receive assessments of their management systems and capabilities, their training needs on all levels, specific requirements, and short-term needs for financial assistance. In addition to providing traditional management assistance, the Coordinating Organization may also serve as a catalyst for establishing cooperation and support by PVO and nonprofit organizations in the United States.

Various training methodologies will be employed by the Project to meet PVO needs. In some instances (project preparation), this will be done by Project staff. In other instances (financial, logistical, monitoring, evaluation, community health specialists), training will be contracted using in-country expertise. Other training needs (cost-recovery, community health trainers) will be filled through

national conferences and short seminars for information exchange. A short educational visit to a third country is also anticipated for the Community Health Trainers and Community Health Specialists. Training of health promoters and community education will be conducted by PVO staff.

Eligible PVOs interested in the Project will develop their own sub-project proposals with the assistance of the Project Coordinating Organization. Actual community site selection and proposed activities will be made by the PVO according to its needs and capacities for expansion and potential sustainability. The sites and activities proposed, however, must be guided by the risk emphasis of the Project. PVO requests which may be considered for assistance will be those which meet the following criteria:

- * involve non-sectarian and apolitical extension of services to high risk rural and marginal urban areas or the enhancement of services already being provided;
- * demonstrate an understanding of the maternal health and child survival needs of target populations, especially those which address the most prevalent and serious health problems of the most vulnerable groups;
- * stress those activities which fall within the range of maternal health and child survival interventions outlined in Category One above;
- * focus on issues of severity (severe and/or compelling needs), magnitude (how many Salvadorans will benefit), and impact (the degree to which a need will be met);
- * include mechanisms which maximize community engagement in the planning, implementation, and evaluation of program activities; and
- * include provisions supporting partial or total program sustainability.

Most support to the institutional development of PVOs will be in the form of technical assistance and training. However, the Project will provide select commodities, such as office equipment and computers, to assist the PVOs in carrying out their community level service delivery activities discussed under Category I. The Project may also provide some training for strengthening the management of PVO core staff.

PROJECT CATEGORY III: Coordination, Policy Development & Research

This category provides support to enhance inter-agency coordination and policy development; it also includes support for operational research to, inter alia, identify and replicate promising new approaches to service delivery.

1. Inter-agency Coordination and Information Exchange

PVO Coordinating Committees: The Project will work with all three PVO coordinating committees: the Inter-sectoral Committee for Child Survival (CISI), the Coordinating Council for Private Institutions in Human Promotion in El Salvador (CIPHES), and the Corporation for Development and Social Promotion of El Salvador (CODEPROSES). However, coordination of Project activities with participating and nonparticipating PVOs is expected to be carried out primarily through CISI, because it's membership includes the MOH and is focused on maternal-child health. PVOs that are not presently CISI members will be invited to join. Other PVO coordinating bodies will be asked to send a representative to CISI meetings.

CISI will play an important role in the Project in several ways. It will be strengthened with the necessary office equipment, supplies, and a vehicle to act as a national and regional networking and information point for health sector PVOs in El Salvador. It will facilitate inter-agency networking and sharing of information, training, educational materials, and service delivery methods. For instance, PVOs which are not interested in implementing community outreach will be encouraged to extend their clinical base by coordinating their activities with PVOs experienced in community development; thus community involvement for clinically oriented PVOs will be promoted.

CISI will also encourage communication and inter-sectoral relationships on the regional and local levels through the formation of regional and local working groups made up of a representative of each implementing PVO, a representative of the nearest MOH facility, other PVOs in the area (which may or may not be involved in health), and representatives from other local organizations which might be appropriate (the municipality, schools, and churches). CISI will also be responsible for collecting, analyzing, and disseminating key programming information through the publication of a PVO newsletter, and the organization of annual national and regional conferences. The newsletter will invite active PVO contribution and provide a forum for PVO discussion. It will keep PVOs informed about each other's activities by presenting examples of training and education materials which have been developed, disseminating the results of research, and providing examples of innovative methods of implementation. A CISI representative will sit on the Project Advisory Committee; thus, CISI is expected to have a prominent role in advising on Project implementation.

The Office of International Cooperation of the Ministry of Health (OIC/MOH): The OIC in the MOH is the principal office for MOH coordination with this Project. It will play an important role as a PVO advocate and coordinating body within the public sector. A representative of this office will be a member of the Project Advisory

Committee and also CISI. As such, the OIC will act to promote MOH coordination with the PVOs. Examples of the types of coordination possible between PVOs and the MOH include the accessing of Ministry training and educational materials by PVOs; joint training of personnel (especially health promoters and TBAs); PVO assistance with MOH services, including vaccination campaigns, malaria activities, and the reporting of epidemiological data; the possibility of coordination of pharmaceutical purchases; and coordination of all services and referrals at the local level. The Project will provide the OIC with the necessary office equipment, supplies, and vehicles to assist with its important coordination responsibilities.

In addition, some training will also be provided to the MOH and PVO coordinating committees. The Director of the Office of International Cooperation (OIC) of the MOH will visit selected countries known to have a successful OIC, and OIC personnel will receive training in information collection and dissemination.

2. Policy Dialogue

CISI, with technical support from the Coordinating Organization, will help PVOs identify important areas for policy dialogue on issues related to private and public sector provision of health services to high risk populations, and raise these issues for discussion at appropriate levels of the government. Information for this task will be available from the results of operations research and Project implementation. Issues which may be explored include reducing duties on pharmaceuticals, the availability of generic drugs, formation of a national committee to collect and distribute appropriate pharmaceutical donations, etc. Project resources will be used to finance seminars and meetings to develop these issues and facilitate public discussion and resolution.

3. Research

All PVO activities supported by the Project will focus on maternal-child health. However, the Project will allow PVOs to develop their own service delivery methods. This flexibility will create the opportunity to compare and test the viability and effectiveness of various delivery methodologies. For this reason, the Project will support a limited number of research activities. These activities are expected to be primarily operational research studies which will compare PVO efforts in areas such as cost-recovery at the community level and the use of health promoters in service delivery. Some case studies may also be conducted in order to learn more about the causes of perinatal mortality in target populations.

IV. PROJECT FINANCIAL PLAN AND COST ESTIMATES

A. Project Budget

The total cost of the Maternal Health and Child Survival Project is \$33,333,333, of which A.I.D. will finance \$25,000,000 (75%) and participating private voluntary organizations will contribute \$8,333,333 (25%) from in-kind contributions and the proceeds of cost-recovery mechanisms. A.I.D. resources will be used to finance training (\$1.64 million), technical assistance (\$5.12 million), commodity purchases (\$8.38 million), personnel (\$1.00 million), program administration (\$3.83 million), evaluations (\$200 thousand) and audits (\$660 thousand), and provide for inflation and contingencies (\$4.17 million). PVO contributions (\$8,333,333) will be used to support Project Category I activities, Maternal Health and Child Survival Services. Counterpart contributions will be comprised primarily of PVO in-kind contributions, such as staff time, office space, land, labor and supplies donated by participating communities, and the proceeds of cost-recovery mechanisms.

Five tables containing illustrative financial information are included at the end of this section. Table I contains a summary cost estimate and financial plan, including a breakdown of the foreign exchange (72%) and local currency (28%) requirements under the Project. Table II provides a summary cost estimate by category and line item. Table III shows a projection of Project expenditures by year and line item. Table IV contains a payment verification matrix which outlines the proposed method of implementation and financing for each major input. Table V includes an estimate of recurrent costs.

Tables XIII through XVI provide an illustrative itemization of Project costs by category and can be found in Annex J, Financial Analysis. All financial tables have incorporated a 20% inflation and contingencies factor.

B. Recurrent Cost Analysis

Table V provides an estimate of annual recurrent costs associated with the Project activities described in this document. Per these tables, the annual recurrent cost per PVO to serve 10,000 people is \$57,000 per year or \$5.70 per person per year. This figure compares favorably with data collected on costs of family expenditures for health care. According to the results of the 1988 Health Care Demand Study financed by AID, families currently spend approximately \$2.70 per visit to the Ministry of Health. Thus, the annual cost of PVO service under this project would be equal to just slightly over the cost of two visits to the MOH clinic.

The Coordinating Organization will work closely with PVOs on the vital issues of cost recovery and the identification of additional sources of funding. Cost recovery and sustainability mechanisms are expected to include in-kind contributions, the generation of active community participation, establishing user fees for services, and charging for drugs and medical supplies at cost, including the creation of revolving funds for sustained pharmaceutical procurement.

TABLE I (ILLUSTRATIVE)
 SUMMARY LOP COST ESTIMATE AND FINANCIAL PLAN
 MATERNAL HEALTH/CHILD SURVIVAL PROJECT
 Project No. 519-0367
 (US Dollars)

CATEGORIES	AID		TOTAL	PERCENTAGE
	FX	LC		
ii. Maternal/Child Survival Health Service Delivery	8,921,381	3,491,174	12,412,555	49.3%
iii. Institutional Development of FVO's	4,441,441	1,738,054	6,179,495	24.0%
iiii. Coordination and Collaboration	1,610,897	630,386	2,241,283	9.0%
SUBTOTAL	14,973,719	5,859,614	20,833,333	
Inflation and Contingencies	2,794,744	1,171,723	4,166,667	16.3%
GRAND TOTAL	17,768,463	7,031,537	25,000,000	100.0%

TABLE II (ILLUSTRATIVE)
 SUMMARY COST ESTIMATE BY LINE ITEM AND CATEGORY
 MATERNAL HEALTH/CHILD SURVIVAL PROJECT
 Project No. 519-0367
 (US Dollars)

Line Items	CATEGORY I Maternal/Child Survival Health Service Delivery	CATEGORY II Institutional Development of PVO's	CATEGORY III Coordination Policy Develop. & Research	TOTAL	PERCENTAGE
1. TRAINING	743,036	817,565	81,004	1,641,605	6.6%
2. TECHNICAL ASSISTANCE	2,429,609	1,833,944	858,165	5,121,718	20.5%
3. COMMODITIES	6,360,004	1,832,580	181,004	8,373,588	33.5%
4. PERSONNEL	533,439	287,525	182,525	1,003,489	4.0%
5. PROGRAM ADMINISTRATION	1,916,467	1,149,883	766,584	3,832,934	15.3%
6. EVALUATIONS AND AUDITS	430,000	258,000	172,000	860,000	3.4%
TOTAL	12,412,555	6,179,497	2,241,282	20,833,334	83.3%
7. INFLATION AND CONTINGENCIES	2,482,509	1,235,899	448,258	4,166,666	16.7%
GRAND TOTAL	14,895,064	7,415,396	2,689,540	25,000,000	100.0%

TABLE III (ILLUSTRATIVE)
 SUMMARY OF PROJECTED EXPENDITURES BY SOURCE AND YEAR
 MATERNAL HEALTH/CHILD SURVIVAL PROJECT
 Project No. 519-0367
 (US Dollars)

Category	Year 1		Year 2		Year 3		Year 4	
	AID	PVO's	AID	PVO's	AID	PVO's	AID	PVO's
I. Maternal/Child Survival Health Service Delivery								
1. TRAINING	106,148		106,148		106,148		106,148	
2. TECHNICAL ASSISTANCE	347,087		347,087		347,087		347,087	
3. COMMODITIES	131,000	120,721	1,218,000	283,321	1,398,000	411,571	1,553,501	431,571
4. PERSONNEL	26,075	355,294	53,075	594,694	80,075	893,944	116,075	893,944
5. PROGRAM ADMIN.	273,781		273,781		273,781		273,781	
6. EVALUATIONS & AUDITS			55,000		105,000		55,000	
SUBTOTAL	884,091	476,015	2,053,091	878,015	2,310,091	1,305,515	2,451,592	1,325,515
II. Institutional Development of PVO's								
1. TRAINING	116,795		116,795		116,795		116,795	
2. TECHNICAL ASSISTANCE	261,992		261,992		261,992		261,992	
3. COMMODITIES	264,730		330,979		398,394		49,619	
4. PERSONNEL	30,875		38,075		47,075		47,075	
5. PROGRAM ADMIN.	164,269		164,269		164,269		164,269	
6. EVALUATIONS & AUDITS			33,000		63,000		33,000	
SUBTOTAL	838,661		945,110		1,051,525		672,750	
III. Coordination Policy Develop. & Research								
1. TRAINING	11,572		11,572		11,572		11,572	
2. TECHNICAL ASSISTANCE	122,595		122,595		122,595		122,595	
3. COMMODITIES	89,000		5,334		5,334		5,334	
4. PERSONNEL	26,075		26,075		26,075		26,075	
5. PROGRAM ADMIN.	109,512		109,512		109,512		109,512	
6. EVALUATIONS & AUDITS			22,000		42,000		22,000	
SUBTOTAL	358,754		297,088		317,088		297,088	
TOTAL	2,081,506	476,015	3,295,289	878,015	3,678,704	1,305,515	3,421,430	1,325,515
Inflation and Contingencies	416,301	75,203	659,058	175,603	735,741	261,103	684,286	265,103
GRAND TOTAL	2,497,807	571,218	3,954,347	1,053,618	4,414,445	1,566,618	4,105,716	1,590,618

TABLE III (Cont.)
 SUMMARY OF PROJECTED EXPENDITURES BY SOURCE AND YEAR
 MATERNAL HEALTH/CHILD SURVIVAL PROJECT
 Project No. 519-0367
 (US Dollars)

Category	Year 5		Year 6		Year 7		TOTAL	
	AID	PVO's	AID	PVO's	AID	PVO's	AID	PVO's
	I. Maternal/Child Survival Health Service Delivery 1. TRAINING 2. TECHNICAL ASSISTANCE 3. COMMODITIES 4. PERSONNEL 5. PROGRAM ADMIN. 6. EVALUATIONS & AUDITS SUBTOTAL	: : : 106,148 : : 347,087 : : 973,501 : 351,571 : : 107,075 : 893,944 : : 273,781 : : 55,000 : : : 1,862,592 : 1,245,515 :	: : : 106,148 : : 347,087 : : 897,501 : 283,171 : : 89,075 : 734,344 : : 273,781 : : 55,000 : : : 1,768,592 : 1,017,515 :	: : : : : 188,501 : 201,407 : : 61,989 : 494,947 : : 273,781 : : 105,000 : : : 1,082,506 : 696,354 :	: : : 743,036 : : 2,429,609 : : 6,360,004 : 2,083,333 : : 533,439 : 4,861,111 : : 1,916,467 : : 430,000 : : : 12,412,555 : 6,944,444 :			
II. Institutional Development of PVO's 1. TRAINING 2. TECHNICAL ASSISTANCE 3. COMMODITIES 4. PERSONNEL 5. PROGRAM ADMIN. 6. EVALUATIONS & AUDITS SUBTOTAL	: : : 116,795 : : 261,992 : : 189,619 : : 47,075 : : 164,269 : : 33,000 : : : 812,750 :	: : : 116,795 : : 261,992 : : 269,619 : : 42,275 : : 164,269 : : 33,000 : : : 887,950 :	: : : : 116,795 : : 329,620 : : 35,075 : : 164,269 : : 63,000 : : : 970,751 :	: : : 817,565 : : 1,833,944 : : 1,832,580 : : 287,525 : : 1,149,883 : : 258,000 : : : 6,179,497 :				
III. Coordination Policy Develop. & Research 1. TRAINING 2. TECHNICAL ASSISTANCE 3. COMMODITIES 4. PERSONNEL 5. PROGRAM ADMIN. 6. EVALUATIONS & AUDITS SUBTOTAL	: : : 11,572 : : 122,595 : : 5,334 : : 26,075 : : 109,512 : : 22,000 : : : 297,088 :	: : : 11,572 : : 122,595 : : 65,334 : : 26,075 : : 109,512 : : 22,000 : : : 357,088 :	: : : 11,572 : : 122,595 : : 5,334 : : 26,075 : : 109,512 : : 42,000 : : : 317,088 :	: : : 81,004 : : 858,165 : : 181,004 : : 182,525 : : 766,584 : : 172,000 : : : 2,241,282 :				
TOTAL	: 2,972,430 : 1,245,515 :	: 3,013,630 : 1,017,515 :	: 2,370,345 : 696,354 :	: 20,833,334 : 6,944,444 :				
Inflation and Contingencies	: 594,486 : 249,103 :	: 602,726 : 203,503 :	: 474,068 : 139,271 :	: 4,166,666 : 1,388,889 :				
	: 3,566,916 : 1,494,618 :	: 3,616,356 : 1,221,018 :	: 2,844,413 : 835,625 :	: 25,000,000 : 8,333,333 :				

TABLE IV
 PAYMENT VERIFICATION MATRIX
 MATERNAL HEALTH/CHILD SURVIVAL PROJECT
 Project No. 519-0367
 (000's of US Dollars)

METHOD OF IMPLEMENTATION	METHOD OF FINANCING	APPROXIMATE AMOUNT AID	TOTAL
1. Coop. Agreement with U.S. Contractor	Direct Reimb.		
A. Training		1,642	1,642
B. T.A.		5,122	5,122
C. Commodities		8,374	8,374
D. Program Adm'n. & Personnel	Direct Payment	4,836	4,836
2. Profit-making Contractor	Direct Payment	860	860
A. Audit			
B. Evaluation			
3. Contingencies & Inflation	To be determined	4,166	4,166

TABLE V
PROJECTED RECURRENT COSTS
MATERNAL HEALTH/CHILD SURVIVAL PROJECT
Project No. 519-0367
(US Dollars)

Cost Center	Total Annual Amount	Total Annual Amount Per PVD
1. Salaries	246,375	2,468
2. Commodities		
A. Medicines	718,430	47,895
B. Supplies	70,000	2,000
C. Educational Materials	7,000	200
3. Maintenance	140,000	4,000
4. Miscellaneous	18,195	520
TOTAL	1,200,000	57,083

V. PROJECT IMPLEMENTATION AND MANAGEMENT

A. Management Summary

The Project will be managed by a competitively selected organization, designated the Coordinating Organization, who will work with the general supervision of the USAID's Health and Population Office and obtain programmatic guidance from the Project Advisory Committee described earlier. The Coordinating Organization will provide technical assistance, training, commodities, and limited support costs to private voluntary organizations (PVOs) through Sub-agreements. PVOs will be the pillar of the Project. It is the PVOs who will conceive, design, and implement maternal health and child survival services and activities. They will also have the important responsibility of involving target communities as much as possible in proposal planning and implementation, and sharing the costs of services.

The Coordinating Organization will serve as a development resource unit for private voluntary organizations. It will be a place where PVOs can bring their program ideas and obtain assistance in translating them into sound proposals suitable for funding.

In order to receive assistance from the Maternal Health and Child Survival Project, PVOs must meet the following minimum selection criteria:

- * be willing to include in their concept of service delivery either/both preventive and curative services in MHCS to rural or marginal urban populations;
- * be non-sectarian and apolitical in the provision of maternal health and child survival services;
- * meet the financial management requirements outlined in Annex J, including a history of acceptable financial accountability in their operations, or, if problems of funds accountability, have been experienced in the past, be able to demonstrate that these problems have been rectified;
- * have two years of health experience in El Salvador, or, lacking this experience, demonstrate adequate organizational capability to effectively and efficiently utilize Project assistance; and
- * be willing to test methods for sustaining the planned programmatic or geographic expansion of the Project.

The highest priority for immediate Project assistance will be given to PVOs that are already trained and ready to begin Project implementation and want to expand or extend services among high risk

regions. Second priority for funding will be PVOs that need more training and TA but are also willing to extend or expand services among high risk populations including high risk areas located in relatively low risk departments. The third priority will be those PVOs in well served areas whose proposal includes promising delivery strategies or innovative interventions. This last group will be extremely limited. The Project will not provide start-up costs to new PVOs interested in working in El Salvador. It will, however, consider their proposals for inclusion in the Project after the PVO has been functioning in the country for one year. Financial assistance to for such programs would be on terms similar to PVOs having already established programs in El Salvador.

A Project Advisory Committee will be formed in order to facilitate coordination and collaboration among the Project, PVOs, other key USAID Projects, and the MOH. This Committee will consist of the USAID Project Manager for this Project, a representative of the Coordinating Agency, a representative from the MOH's Office of International Coordination, the Project Managers of each of the three other USAID health projects, and a CISI representative (and the other two PVO coordinating committees if appropriate). The principal task of this Committee will be to advise the Coordinating Organization on Project implementation, and to review proposals for sub-grants and make recommendations for final approval. In the event that the recommendation by the PAC is not unanimous, final approval will be required by the AID Director or his designee.

After approval of PVO proposals, Sub-agreements (SAs) will be developed with individual PVOs by the Coordinating Organization. These Agreements will specify the technical assistance, training, support costs, pharmaceuticals, medical supplies and equipment, vehicles, and other commodities to be provided. PVO Sub-agreements will have a minimum duration of one year and a maximum of five years. Although Sub-agreements will allow for multi-year support (up to the five-year limit), Project resources will be approved by year and will be contingent upon the receipt and approval of annual PVO implementation plans and budgets. Disbursements will be made periodically based on Project resource liquidation reports. Coordinating Organization personnel will aid PVO staff as required in the preparation of annual plans and budgets.

As the conduit of financial support and commodity aid to PVOs, the Coordinating Organization will have legal and operational responsibility for all assistance provided. Prior to disbursement the Coordinating Organization will certify that the sub-grantee has an adequate system to control funds, as well as a system to produce any required reports. Financial forms and systems of the Coordinating Organization's U.S. headquarters will be used and adapted as needed for the financial management and control of its in-country operations. Standard USAID accounting and fiscal management procedures will be followed to ensure

compliance with all applicable USAID regulations. The Coordinating Organization will request periodic advances from the Mission, and will, in turn, provide technical assistance, training, commodities and limited operational funds to PVOs in strict accordance with the terms of signed Sub-agreements.

The USAID Mission will oversee all Project activities through close communication with the Coordinating Organization and the Project Advisory Committee (PAC). Primary USAID responsibility for Project management will rest with the USAID/ES Project Manager. The Project Manager will report to the Chief of the Health, Population, and Nutrition Office (HPN), or his designate. The USAID/ES Procurements Specialist in HPN will assist with commodity procurements. The USAID Mission, through close coordination with the Project Advisory Committee (PAC) and regular contact with the Coordinating Organization, will provide guidance and direction in such areas as the approval of PVO proposals and the geographical distribution, philosophical and service focus and technical capabilities mix of PVO services supported by the Project.

B. Implementation Plan

Table VI provides an overview of the Project time line and is included at the end of this section. Because of the time involved in setting up an office, hiring staff, developing monitoring forms, and identifying sources of training and training materials, the first six months of the Project will be largely dedicated to the start-up of the Coordinating Organization's in country office. The first group of PVOs (estimated to be at least eight of those most ready to begin implementation) will begin participation in the middle of the first Project year. Each group of implementing PVOs will be in the Project for an estimated five years. This five-year period is designed in the following manner: the first year will be used for training and strengthening of PVOs as well as initiation of service delivery, and the remaining years will be dedicated to service implementation, with follow-up technical assistance and training as required. The final year will be a phasing-out period during which time donor funding will diminish gradually and program sustainability will be tested.

The Project will gradually incorporate additional PVOs as time goes on, reaching maximum participation in the third Project year. This time line is based on a phasing-in of PVOs which will bring in eight PVOs the first year, twelve the second year, and fifteen the third year. As discussed elsewhere in this paper, the total number of 35 was chosen based on the results of the MARCABLE study and interviews conducted during Project design. More PVOs (up to 50) will be incorporated if available and if they meet established Project criteria.

Details concerning the first six months of Project start-up are presented in Table VII. Coordinating Organization activities during this period will include locating and setting up an office, hiring personnel, establishing a warehouse and inventory systems, starting procurements, developing monitoring and proposal formats, and establishing working relationships with USAID and PVO coordinating committees. Once these activities are completed, the Coordinating Organization will begin to receive and/or develop proposals with PVOs.

Table VIII is an illustrative description of the first year of activities for each implementing PVO. Activities which will take place during that year include proposal development, certification and/or strengthening of PVO financial control systems, approval of the proposal, hiring of short-term personnel, strengthening of management and logistics systems, initiating procurements, community organization and selection of promoters and community groups, household data collection and analysis, initiation of clinical and preventive services where possible, and start-up and ongoing training in MHCS, management, and baseline data collection. Given the variety of capabilities already in place in PVOs, the actual list of start-up activities will vary depending on the unique characteristics of each PVO.

C. PVO Sub-agreements

Agreements between the Coordinating Organization and PVO governing the provision of commodities, training, technical assistance or financial support for a PVO sub-project will be formalized through the signature of sub-agreements modeled after A.I.D.'s Special Development Activities (SDA) Grants. Procedures developed by A.I.D. for this grant program were designed to enable USAID missions to quickly, and with a minimum of red tape, respond to requests for financial assistance from poor rural and marginal urban populations. The mechanism is devised to assist small community groups with little or no formal organizational structure to request, receive and properly account for financial assistance from A.I.D.

Based on the SDA procedures, the Coordinating Organization will establish guidelines and standardized formats, and provide technical assistance to assist PVOs in developing acceptable sub-project proposals. These proposal/requests for assistance will contain sufficient detail to be incorporated into the sub-project agreement and

TABLE VI
IMPLEMENTATION TIME LINE

PROJECT YEARS

	1990 - 91	91 - 92	92 - 93	93 - 94	94 - 95	95 - 96	96 - 97							
Coord. Agy. Start up	-----													
1st Group of 8 FVOs Start up	-----													
Impl.	-----													
Phase down					-----									
2nd Group FVOs (12) Start up			-----											
Impl.				-----										
Phase down						-----								
3rd Group FVOs (15) Start up			-----											
Impl.				-----										
Phase down	-----													
Total FVOs	0	8	8	20	20	35	35	35	35	35	35	27	27	15

TABLE VII
COORDINATING AGENCY START UP

	(----- MONTHS -----)					
	1	2	3	4	5	6
1. Office found, opened operating	=====					
2. Hiring of personnel				=====		
3. Warehouse found and set up	=====					
4. Procurements started and continued		=====				
5. Develop: - MOU instrument - proposal format - monitoring forms, log, etc.			=====			
6. Establish working relat. with AID. - Project Officer - Set up Project Adv. Committee.	=====					

form the criteria for implementation. The proposal will define actions the PVO plans to take to obtain in-kind contributions, achieve active community participation, establish service fees, and charge for pharmaceuticals. The PVO proposal will include: 1) a background statement providing information about the PVO such as its philosophical and service delivery focus, legal status, year founded, institutional objectives, etc.; 2) a sub-project description which will include a goal and objective statement, number of beneficiaries, and location of project activities; 3) an illustrative resource requirements plan, i.e. training, technical assistance, vehicles and other commodities, as well as financial needs; 4) estimated length of time required to carry out sub-project activities; and 5) the estimated level of counterpart contribution.

When a PVO's proposal is approved and following a certification by the Coordinating Organization that the PVO has adequate financial controls in place to ensure proper accountability and use of Project funds, a sub-agreement (SA) will be drafted between the Coordinating Organization (sub-grantor) and the participating PVO (sub-grantee) clearly defining the roles and responsibilities of each. In addition to containing sections of the formal proposal mentioned above the sub-agreement will include, as applicable: portions of the Standard Provision annex contained in the Grant Agreement between A.I.D. and the Coordinating Organization; language requiring that the participating PVO submit annual action plans, status and Project resource liquidation reports on a regular basis; any conditions precedent to initial and subsequent disbursements of Project resources, which the Coordinating Organization feels may be necessary; a schedule for the provision of AID funded inputs (i.e., technical assistance, training and commodities); and a sub-project assistance completion date. The completion date is important because it lets the participating PVO know from the start that Project assistance is temporary.

Sub-agreements between the Coordinating Organization and those PVOs having no previous track record for administering financial assistance will stress specific short-term goals. Disbursement of Project resources will follow the terms of the schedule of the sub-agreement and be based on certain conditions precedent. For example, the transfer of commodity resources will be contingent on approval of the PVO's first action plan. Transfer of a vehicle may require proof that the PVO is capable of purchasing fuel, maintaining the vehicle in good running order, and that the driver has undergone training in safe driving techniques. Should it be decided that financial support for salaries or other short-term recurrent costs is appropriate, conditions precedent to disbursement may include: proof that the PVO has opened a separate bank account into which Project funds will be deposited and maintained; specimen signatures of two PVO representatives authorized to co-sign checks; and submission of either proforma invoices or an approved payroll

roster. Funds transfers might also be made on the basis of proforma invoices, or three written bids in the case of construction activities. Subsequent transfer of resources will be based on liquidation of previous transfers: paid receipts matching the proforma invoices, countersigned receipts for salaries, etc. For larger financial resource transfers, more sophisticated accounting procedures may be required. Shortly after the Coordinating Organization has established a Project office and staff in San Salvador, it will develop and submit for A.I.D. approval specific procedures for the review and certification of accounting and financial control systems of PVOs prior to award of a grant. The Cooperating Organization will consult with the USAID Controller on the development and application of these procedures and standards, and language to be included in the Sub-Agreements concerning specific requirements for accountability and financial controls, and provide technical assistance and training to recipient PVOs as needed to meet A.I.D. requirements. In the case of smaller PVOs with no formal accounting systems, the Coordinating Organization will collaborate with the USAID Controller to establish acceptable minimum criteria which will enable these PVOs to receive Project funds and comply with A.I.D. financial accountability and reporting requirements.

The Coordinating Organization will develop special procedures for liquidation of "consumable" Project resources, such as salaries, medicines, contraceptives etc. For example, in the case of salaries for community health promoters, the sub-agreement may require that the receipt of payment be signed by three persons: the payee (proof of receipt), a representative of the community health committee (validation of the services provided), and a representative of the participating PVO (certification of payment). Reconciliation of medicines, contraceptives etc., may be carried out by the PVO on a regular basis by comparing the physical inventory on hand to patient records (medicines dispensed) and cash earned as part of the PVO's cost recovery scheme from the sale of medicines. This reconciliation will be included in the PVO's sub-project status report and considered proper liquidation of Project resources.

Simple reporting criteria with standardized outlines will be designed by the Coordinating Organization to facilitate proper reporting by the participant PVOs. The reporting formats will include identification of sub-project outputs and accomplishments and will contain a problems section to encourage the PVOs to identify problems and seek collaboration of the Coordinating Organization to resolve them in a timely manner. Use of standard proposal, sub-agreement and reporting formats will also provide documentation for monitoring and reporting as well as for Project evaluation and audit, and enable the Coordinating Organization to better handle the anticipated number of requests for assistance. In the case of the PVOs, establishment of strict uniform procedures will compel them to organize and follow systems which improve their administrative and organizational structure.

D. Monitoring Plan

1. Monitoring of PVO Activities

The Coordinating Organization will monitor two broadly defined aspects of the Project: inputs and outputs. Project inputs will consist of:

- * technical assistance and training (in-country, U.S. and third country),
- * commodities (vehicles, pharmaceuticals, contraceptives, biomedical equipment, medical supplies, water and sanitation equipment, audio-visual equipment, computers, and educational materials),
- * some office/clinic construction or renovations, and
- * limited financial assistance.

Examples of project outputs include:

- * development of cadres of Community Health Promoters,
- * task-oriented community-level Health and Water Committees,
- * PVO Community Health Trainers,
- * development or improvement of training materials,
- * a training curriculum and educational materials for CHTs and community health workers,
- * new water systems installed,
- * latrines constructed, and
- * communities receiving new or improved maternal health/child survival services.

The Coordinating Organization staff will conduct monitoring visits to PVOs on a quarterly basis for the duration of each organization's participation. The purpose of monitoring visits will be twofold: both to monitor and to support PVOs. These visits will be conducted in a spirit of collaboration, support, and coordination, seeking to determine not only areas for PVO improvement, but also what the PVO is doing well and how the Coordinating Organization can be of assistance. Monitoring visits will also be utilized, to the maximum extent possible, to ensure the appropriateness, efficiency, and effectiveness of the use of Project resources.

Three main areas of activity will be examined during monitoring visits: management and administration, finance, and programming. A detailed monitoring instrument will be developed by the Coordinating Organization during the first six weeks of the Project. This instrument will be refined over time.

Each PVO receiving financial assistance from the Project will submit quarterly financial reports which will be carefully reviewed by the Coordinating Organization and will be subject to a financial audit every year. Regular review by the Coordinating Organization of the PVO's quarterly statistical reports will facilitate programmatic monitoring.

2. USAID Monitoring

USAID will monitor all activities of the Coordinating Organization. Primary USAID monitoring responsibility will rest with the USAID Project Manager. The Project Manager will report to the Chief of the Health, Population, and Nutrition Office or his designate. The Project Officer will be assisted by the US/PSC Logistics Specialist, who will advise on commodity procurement requirements and procedures for the Project. The Project Advisory Committee will regularly review Project status.

VI. EVALUATION ARRANGEMENTS

A. Schedule

The Maternal Health/Child Survival Project will begin in June, 1990, and end in June, 1997. Two Project evaluations will be conducted. The first will be a mid-term evaluation which will take place in 1993, three years after Project start-up. The final evaluation will take place at the end of the Project in 1997, approximately in the last two months of the Project. Other Project assessments may also be conducted at more frequent intervals to provide important information for course correction during Project implementation. A total of \$200,000 in Project funds will be allocated for evaluations.

B. Tier Design

Project evaluations will follow the tier model developed by the LAC Bureau in AID/W. In this model, levels of evaluation are labeled as follows:

TIER I

Input - Output

TIER II

Effectiveness

TIER III

Impact

The first evaluation will focus primarily on Tiers I and II (inputs, outputs, and effectiveness). The final evaluation will take Tier I into account but will focus primarily on Tiers II and III (effectiveness, impact) and sustainability. The Project monitoring and supervision plan will also follow the tier model.

The input level of evaluation includes consideration of the adequacy and movement of all Project inputs. Major input categories are logistics (equipment and supplies), technical assistance and training. Information for the input level will be available from the Coordinating Organization, implementing PVOs, and USAID Project management.

The output level involves measurement of Project services and activities. Key outputs for the Project include expansion and extension of preventive and curative MHCS services among high risk communities, and strengthening PVO capabilities. Information for the output level will also be available from the Coordinating Organization, implementing PVOs, and USAID Project management.

The effectiveness level of evaluation is generally less easily measured as it involves the effectiveness of service delivery. For instance, this level measures how well the community health workers understand their training and are able to teach the community about MHCS topics or the mixing of ORS. Information for this level of evaluation is generally not available from Project management reports. Rather, data is taken from special pre- and post-training studies during Project implementation.

The impact level of evaluation measures the impact of the Project in its broadest sense. It asks what changes have occurred in maternal health and infant mortality in participating communities over the period of the Project. Since health indicators change very slowly (a decade is usually considered an appropriate interval to measure change) and since health status is dependent on a myriad of variables beyond the scope of this Project, no systematic attempt will be made to routinely measure changes in maternal/infant mortality. However, a small number of Project communities may be targeted for attempts to measure change in these and other health indicators. Moreover, a national Demographic and Health Survey (DHS) is planned for 1993. It is expected that several Project communities will be part of the DHS study.

VII. FINANCIAL MONITORING, ACCOUNTABILITY AND AUDIT

Financial monitoring of Project expenditures will be done periodically through a series of reports which will be developed jointly by the Coordinating Organization and the USAID Project Officer. Standard AID disbursement procedures will be followed by the Coordinating Organization.

On a yearly basis, a complete financial audit will be conducted by external auditors. The audit will be contracted at the beginning or prior to the start of the fiscal year being audited, thereby allowing the auditors to perform such specified procedures as petty cash counts, observe physical inventory counts, monitor payroll distributions, assess internal controls and accounting procedures, review accounting ledgers and documents for adequacy, and perform other tests deemed necessary. USAID will approve the statement of work before the Coordinating Organization contracts the external auditors and USAID, at its discretion, may supervise the audit and review draft reports. The contracted auditors will be affiliated with US CPA firms and will follow GAO standards.

At its discretion, USAID/El Salvador will contract additional financial management services, including the financial monitoring of Coordinating Organization transactions. Project funds in the amount of \$660,000. will be used for conducting the annual and final financial audits. At the end of the Project, a complete financial audit will be conducted. All audits will be conducted in accordance with US CPA and GAO standards.

VIII. SUMMARIES OF ANALYSES

A. Technical Analysis

All of the maternal health/child survival interventions to be used in this Project are tested, well-known, and feasible responses to the leading causes of mortality and morbidity among at risk populations. Moreover experience in El Salvador, through the MOH program, and that of other countries, has demonstrated that the type of interventions proposed herein (i.e., vaccination, improved health practices, pre-natal care programs, etc.) for reducing mortality and morbidity among women and children can be delivered through PVOs when a program is in place that includes participation of beneficiaries in the service delivery and a systematic, well managed structure for delivering the interventions. The Project is based on the type of community participation required.

Specifically, current public and private programs in El Salvador have demonstrated the viability of improving health status through interventions which minimize the impact of the major MHCS risks to be attacked through this Project -- undernutrition, high risk pregnancies, complications of childbirth and the neonatal period, diarrheal disease, acute respiratory infections and vaccine preventable diseases. ORT, birth spacing through contraception, improved nutritional status, community education, potable water supply, improved sanitation, and the availability of curative services are tested interventions which improve health status.

An integrated system of known interventions and the proven capability of PVOs as vehicles for health care delivery, combined with the level of technical and in-kind support to be provided to enhance the operational effectiveness and impact of PVO programs will assure a technically feasible Project.

Conclusion. The technical aspects of the health services to be provided by this Project are well known and they are already being utilized with positive results in El Salvador. With the provision of additional inputs of technical assistance, training, community education and commodities through participating PVOs, the Project is technically sound and capable of reaching its targets.

B. Institutional Analysis

Private voluntary organizations in El Salvador have a proven record of providing maternal health and child survival services which are less expensive than for profit firms and have the potential for financial sustainability once outside funding ends. When financial sustainability is achieved, it is typically due to PVO success in obtaining in-kind contributions, achieving active community participation, establishing user fees for services, and for drugs and medical supplies. Two-thirds of PVOs included in the MARCABLE study were characterized as having a high level of cost-effectiveness as determined by population coverage with available financial resources.

There are estimated to be as many as 90 health sector PVOs currently working in El Salvador. They vary widely in size, organizational focus, organizational structure, geographic service area, years of health experience, and management capabilities, but generally they have shown great resourcefulness and creativity in delivering curative and preventive services with limited resources, largely through the mobilization of community effort and contributions. However, they demonstrate weaknesses in technical support for programs and coordination with other agencies. Such weaknesses limits program effectiveness and in some cases to a costly duplication of services.

PVO administrative and logistical systems are weak; financial management practices are better established, but areas for improvement are evident. According to the June, 1990, MARCABLE study, three-quarters of all PVOs use some kind of accounting system, although only 34% have a complete financial system, including a formal accounting system, budget, and internal and/or external audits. Only 18% report formal monitoring and evaluation systems, and these systems in most organizations are weak or nonexistent. The impact of such system weaknesses is not significant in most cases, given the relatively limited scope of most PVO programs. However, as service coverage is expanded, such as will be required to

achieve the Project's purpose, technical assistance such as that programmed under the Institutional Development Category of this Project will be required to ensure program effectiveness.

In sum, despite the weaknesses noted above, overall private voluntary organizations in El Salvador have great potential for program strengthening and expansion in maternal-child health. PVOs are a viable means to achieve the Project goal and purpose, as is demonstrated by the fact that they are already providing a wide range of curative and preventive health services in a cost effective manner in all health regions of the country. With institutional strengthening made possible by Project technical assistance, training, commodity support, and limited financial assistance, PVOs will be able to further extend community based maternal-child health services in El Salvador.

C. Social Analysis

El Salvador is gripped in a stalemated, low intensity war. The climate of uncertainty that prevails in all sectors of life still remains high. However, there are indications that the outlook for the future will improve based on events in the Central American region and worldwide. Against the backdrop of cautious optimism, the sociocultural feasibility of the Project promises a reasonable degree of success.

Sociocultural Feasibility. The Project considers both community members and PVO institutions as beneficiaries. The Project will channel resources through implementing PVOs to high risk areas. In so doing, it will catalyze significant decision making and participation at the community level. This will increase the Project chances for achieving success. The Project will also rely on health promoters selected by their community who will be trained and supervised by the PVOs. The use of traditional birth attendants as health promoters when feasible should further ensure community acceptability. The delivery model using health promoters has been successfully tested in various regions of the world. Precedents for health promoter use in El Salvador include a malaria control project, an ongoing health promoter project in the MOH, and current PVO projects.

Spread Effects. The Project will have a spread effect among individuals and communities not directly involved in the Project. Although women in fertile age and children under five are the principal beneficiaries of the Project, water and sanitation systems, and both preventive and curative care will impact on the community in general. Diffusion of educational messages can also be expected to occur within the community and to neighboring areas. Because many PVOs have projects in other communities, it is also expected that service delivery methods and technologies tested by the Project will be adopted in other projects and other communities.

Social Consequences and Benefit Incidences. In addition to health care delivery, community organization and self-determination are principal areas that are stressed in this Project. A positive experience with participation and organization can be expected to affect other areas of people's lives, including agriculture, education, and micro-enterprise development.

D. Economic Analysis

This Project is designed to expand and improve the health delivery systems operated by private voluntary organizations in coordination with communities in rural and marginal areas, and thereby achieve improvements in maternal and child health. Thus, from an economic perspective, the principal objective of the Project is to improve human capital through the provision of services. While each of the Project supported interventions (e.g., immunization, ORT, etc.) has distinguishable and measurable effects on human resources and the economy, these benefits are not easily measurable in El Salvador due to the paucity of reliable statistical data on cost per treatment and episodes of each disease. Moreover, the indirect benefits, such as the value of lives saved, the pure utility values of reduced morbidity and mortality, and the value of improved performance in school or on the job are very difficult to estimate and even harder to measure. Thus, it is not possible to carry out a full-blown benefit cost analysis for this Project which would compare the streams of adjusted project costs and benefits over time to determine the internal rate of return.

Therefore, the Mission has performed a limited analysis of benefits so that we could weigh both the quantitative and qualitative benefits against costs. Again, due to the lack of reliable data, much of this analysis is based on experience and economic analyses performed for similar projects in other countries where the benefits of various MCH interventions were evaluated.

This Project will facilitate the delivery of a number of maternal child health interventions which will directly reduce mortality, morbidity, and debility in 350 communities, directly affecting 350,000 Salvadorans. In addition, we expect additional indirect benefits to derive from the technical strengthening of PVOs that will impact on ongoing health programs which they operate with non-Project funds; unfortunately, it is not possible to estimate the size of this population indirectly benefited. Priority interventions include diarrheal disease control, through ORT and improved health and sanitation practices, immunizations, and family planning to improve birth spacing and reduce the total fertility rate. An analysis performed by USAID/Peru to determine projected benefits of a \$1.0 million diarrheal disease control program (Project 527-0285, Child Survival Action) estimated that based on the investment, a savings of over \$2.8 million in MOH expenditures plus

\$43.4 million in family medical outlays would accrue. This estimate is based on averted treatment costs of severe dehydration, including Ministry of Health treatment costs (\$3.50 per visit) plus family expenditures per clinical visit (in Peru estimated at \$7.00 per episode). While the the average cost of visiting a MOH clinic in El Salvador is considerably less (about \$3.00 per visit per the 1988 Health Care Demand Survey), and therefore the total estimated savings less, the conclusion is clear -- the financial benefits of diarrheal disease control efforts are substantial.

Another intervention that will be supported will be immunizations. El Salvador enjoys relatively high levels of vaccination coverage, due to a concerted public and private sector effort. This has been achieved largely through a twice a year campaign strategy, rather than through the normal MOH and PVO health delivery system. USAID has encouraged the Government to reorient its immunization program from the more costly twice a year campaign strategy, to channelling through the regular MOH and private sector health care delivery system. This is essential for El Salvador achieving higher levels of coverage, as well as to improve the cost-effectiveness of this service. As demonstrated in an analysis of the comparative costs of these two strategies in Guatemala, the "channeling " strategy results in an average savings of 30% per dose of vaccine. Besides greater cost-effectiveness, the expanded coverage afforded through channeling also results in a reduced chance of disease outbreak. This additional benefit translates into lower medical expenses and greater productivity for the target population (pregnant women and children) as well as the community as a whole.

Efforts to collect new data and refine that which is currently available to sharpen conclusions about the economic and financial benefits of this Project would be both costly and time consuming, with the conclusions, at best, still subject to large margins of reliability. Nonetheless, the financial savings identified for two of the series of MCH interventions based on data from similar programs, while merely illustrative, demonstrative the substantial probable benefits of this Project. The proposed interventions are cost effective, will result in lower maternal and infant mortality and morbidity rates, and in turn reduce expenditures by health providers as well as families on treatment and more expansive in-patient care. Non-quantifiable gains in both utility and productivity, including improvements in children's school performance, reductions in the time caretakers spend tending sick children, and concomitant increases in productive activities should also accrue. In sum, the Project will produce a stream of benefits, both quantifiable and non-quantifiable, that will exceed the investment required.

ANNEX A
LOGICAL FRAMEWORK

NARRATIVE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
<u>Goal</u>			
To improve the health of the rural and marginal urban population by increasing the percentage of this population which has access to adequate basic health services.	<ul style="list-style-type: none"> - Decreased child morbidity/mortality. - Decreased maternal morbidity/mortality. - Reduced fertility rate. 	<ul style="list-style-type: none"> - FESAC surveys - PVO data - DHS 	<ul style="list-style-type: none"> - Political and economic situation does not worsen. - No natural disasters occur
<u>Purpose</u>			
To expand community based MHCS services to those areas of El Salvador where such services have been weak or nonexistent.	<ul style="list-style-type: none"> - 350,000 high risk beneficiaries receiving at least immunizations, prenatal care, family planning, and basic curative care. 	<ul style="list-style-type: none"> - PVO data - Coordinating Organization data 	<ul style="list-style-type: none"> - PVOs continue to work in health and in high risk areas.
<u>Outputs</u>			
1) MCH services extended and expanded in high risk communities.	<ul style="list-style-type: none"> - 350 communities receiving improved or new MHCS preventive/curative Services. - Health promoters providing services. - Community committees formed and functioning. - 25 new water systems in place and being maintained by the communities. 	<ul style="list-style-type: none"> - PVO data - Project data - Evaluations 	<ul style="list-style-type: none"> - Communities agree to participate and assume some of the cost
2) A network of strengthened PVOs providing MHCS services.	<ul style="list-style-type: none"> - At least 35 PVOs with improved/expanded MHCS services. - 10 new clinics installed or abandoned MOH facilities reopened with PVO/community/MOH collaboration. - Personnel trained where necessary. 	<ul style="list-style-type: none"> - Project data - Evaluations - PVO data 	<ul style="list-style-type: none"> - PVOs assume the recurrent costs for maintaining project activities.

NARRATIVE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
3) Enhanced inter-agency coordination, information dissemination	<ul style="list-style-type: none"> - Project Advisory Committee functioning. - PVO Coordinating body strengthened. - OIC/MOH strengthened. - Newsletter disseminated. - National conferences conducted. 	<ul style="list-style-type: none"> - Project Status Reports. - Record of meetings. - Evaluations, SARs. - PVO reports. - Participant reports and feedback. 	

Inputs

USAID

(US Dollars)

Training	1,641,605
Technical Assistance	5,121,718
Commodities	8,373,587
Personnel	1,003,489
Program Administration	3,832,934
Evaluation/Audit	860,000
Inflation/Contingencies	4,166,667
Total A.I.D.	<u>25,000,000</u>
Counterpart from PVOs	8,333,333
Project Total	<u>33,333,333</u>

5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to: (A) FAA funds generally; (B)(1) Development Assistance funds only; or (B)(2) the Economic Support Fund only.

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

- | | |
|--|-----|
| <p>1. <u>FY 1990 Appropriations Act Sec. 569(b)</u>. Has the President certified to the Congress that the government of the recipient country is failing to take adequate measures to prevent narcotic drugs or other controlled substances which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully?</p> | No. |
| <p>2. <u>FAA Sec. 481(h); FY 1990 Appropriations Act Sec. 569(b)</u>. (These provisions apply to assistance of any kind provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance from the Child Survival Fund or relating to international narcotics control, disaster and refugee relief, narcotics education and awareness, or the provision of food or medicine.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs</p> | N/A |

Congress listing such country as one: (a) which, as a matter of government policy, encourages or facilitates the production or distribution of illicit drugs; (b) in which any senior official of the government engages in, encourages, or facilitates the production or distribution of illegal drugs; (c) in which any member of a U.S. Government agency has suffered or been threatened with violence inflicted by or with the complicity of any government officer; or (d) which fails to provide reasonable cooperation to lawful activities of U.S. drug enforcement agents, unless the President has provided the required certification to Congress pertaining to U.S. national interests and the drug control and criminal prosecution efforts of that country?

4. FAA Sec. 620(c). If assistance is to a government, is the government indebted to any U.S. citizen for goods or services furnished or ordered where: (a) such citizen has exhausted available legal remedies, (b) the debt is not denied or contested by such government, or (c) the indebtedness arises under an unconditional guaranty of payment given by such government or controlled entity? No.
5. FAA Sec. 620(e)(1). If assistance is to a government, has it (including any government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities? No. (The GOES has made demonstrable progress toward compensation in the CAESS case.)

6. FAA Secs. 620(a), 620(f), 620D; FY 1990 Appropriations Act Secs. 512, 548. Is recipient country a Communist country? If so, has the President: (a) determined that assistance to the country is vital to the security of the United States, that the recipient country is not controlled by the international Communist conspiracy, and that such assistance will further promote the independence of the recipient country from international communism, or (b) removed a country from applicable restrictions on assistance to communist countries upon a determination and report to Congress that such action is important to the national interest of the United States? Will assistance be provided either directly or indirectly to Angola, Cambodia, Cuba, Iraq, Libya, Vietnam, South Yemen, Iran or Syria? Will assistance be provided to Afghanistan without a certification, or will assistance be provided inside Afghanistan through the Soviet-controlled government of Afghanistan? No.
7. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property? No.
8. FAA Sec. 620(l). Has the country failed to enter into an investment guaranty agreement with OPIC? No.
9. FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5. (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made? No.

14. FAA Sec. 620A. Has the President determined that the recipient country grants sanctuary from prosecution to any individual or group which has committed an act of international terrorism or otherwise supports international terrorism? No.
15. FY 1990 Appropriations Act Sec. 564. Has the country been determined by the President to: (a) grant sanctuary from prosecution to any individual or group which has committed an act of international terrorism, or (b) otherwise support international terrorism, unless the President has waived this restriction on grounds of national security or for humanitarian reasons? No.
16. ISDCA of 1985 Sec. 552(b). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures? No.
17. FAA Sec. 666(b). Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA? No.
18. FAA Secs. 669, 670. Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or

10. FAA Sec. 620(q); FY 1990 Appropriations Act Sec. 518 (Brooke Amendment). (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1990 Appropriations Act appropriates funds?

From time to time, the GOES has been in default under both provisions, which has resulted in prohibition of obligation of new funds; however, such periods have been of very short duration. Currently (as of April 2), the GOES is not in default under either provision.

11. FAA Sec. 620(s). If contemplated assistance is development loan or to come from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? (Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

Yes, taken into account by Administrator at the time of approval of Agency OYB.

12. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

No.

13. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operational Year Budget? (Reference may be made to the "Taking into Consideration" memo.)

This issue was addressed in regard to the FY 1990 program in the "Taking into Consideration" memo dated December 20, 1989.

detonated a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.)

19. FAA Sec. 670. If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device? **No.**
20. ISDCA of 1981 Sec. 720. Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and did it fail to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the "Taking into Consideration" memo.) **No, it was not represented; EL Salvador is not a member of the Non-Aligned Movement.**
21. FY 1990 Appropriations Act Sec. 513. Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been terminated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance? **No.**
22. FY 1990 Appropriations Act Sec. 539. Does the recipient country fully cooperate with the international refugee assistance organizations, the United States, and other governments in facilitating lasting solutions to refugee situations, including resettlement without respect to race, sex, religion, or national origin? **Yes.**

B. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria

No.

a. FAA Sec. 116. Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy?

b. FY 1990 Appropriations Act Sec. 535. Has the President certified that use of DA funds by this country would violate any of the prohibitions against use of funds to pay for the performance of abortions as a method of family planning, to motivate or coerce any person to practice abortions, to pay for the performance of involuntary sterilization as a method of family planning, to coerce or provide any financial incentive to any person to undergo sterilizations, 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.

2. Economic Support Fund Country Criteria

a. FAA Sec. 502B. Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvement in its human rights record that furnishing such assistance is in the U.S. national interest?

Yes. The President has certified that El Salvador continues to make significant progress toward improving its human rights record.

b. FY 1990 Appropriations Act Sec. 569(d). Has this country met its drug eradication targets or otherwise taken significant steps to halt illicit drug production or trafficking?

While the country does not have drug eradication targets, it has taken steps to halt illicit drug trafficking and fully cooperate with relevant international authorities.

c. FY 1990 Appropriations Act Title II. Has the President reported to the Congress on the extent to which the Government of El Salvador has made demonstrable progress in settling outstanding expropriation claims of American citizens in compliance with the judgement of the Salvadoran Supreme Court.

Yes.

Clearances:

LAC/CEN: L. Simard *lj*
LAC/SA: S. Olds (Draft)
LAC/DR: L. Odle (Draft)
ARA/CEN: P. Butenis (Draft)
RLA/USAID/El Salvador: I. Smyer (Draft)
State/IOSB: T. Hobgood (Draft)
LAC/GC: K. Hansen (Draft)

5C(2) - PROJECT CHECKLIST

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

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

YES. SUBMITTED AND APPROVED WITH PROJECT 519-0356.

A. GENERAL CRITERIA FOR PROJECT

1. FY 1990 Appropriations Act Sec. 523: FAA Sec. 634A. If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified? YES. THE CN FOR THE PVO MATERNAL HEALTH CHILD SURVIVAL PROJECT WAS PRESENTED TO CONGRESS BEFORE THE JULY 4, 1990 RECESS.
2. FAA Sec. 611(a). Prior to an 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? N/A
3. FAA Sec. 611(a)(2). If legislative action is required within recipient country with respect to an obligation in excess of \$500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance? N/A

4. FAA Sec. 611(b); FY 1990 Appropriations Act 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.) YES
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 to maintain and utilize the project effectively? NO
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. NO
7. FAA Sec. 601(a). Information and conclusions 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. N/A
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise). N/A

9. FAA 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. THIS PROJECT WILL BE IMPLEMENTED BY PRIVATE SECTOR PVOS WHOSE COUNTERPART CONTRIBUTION IS ESTIMATED AT \$ 8,333,000, OR OVER ONE THIRD OF THE TOTAL PROJECT INPUTS OF A.I.D.
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? NO
11. FY 1990 Appropriations Act Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N/A
12. FY 1990 Appropriations Act Sec. 547. 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? N/A
13. FAA Sec. 119(g)(4)-(6) & (10). 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 N/A

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?

14. FAA Sec. 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

15. FY 1990 Appropriations Act, Title II, under heading "Agency for International Development." If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government? N/A

16. FY 1990 Appropriations Act Sec. 537. If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.? N/A

17. FY 1990 Appropriations Act Sec. 514. If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures? N/A

18. State Authorization Sec. 139 (as interpreted by conference report). Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision). N/A
19. Trade Act Sec. 5164 (as interpreted by conference report), amending Metric Conversion Act of 1975 Sec. 2. Does the project use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? N/A
20. FY 1990 Appropriations Act, Title II, under heading "Women in Development." Will assistance be designed so that the percentage of women participants will be demonstrably increased? THE PRIMARY BENEFICIARIES OF AND PARTICIPANTS IN THIS THIS PROJECT ARE WOMEN AND CHILDREN UNDER FIVE YEARS OF AGE.
21. FY 1990 Appropriations Act Sec. 592(a). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies, has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account? N/A

Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government? N/A

Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes? N/A

If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government? N/A

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FY 1990 Appropriations Act Sec. 546 (as interpreted by conference report for original enactment). 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: (1) 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 (2) in support of research that is intended primarily to benefit U.S. producers?

N/A

b. FAA Sec. 107. Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

N/A

c. FAA Sec. 281(b). Describe extent to which the activity 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 civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

THE PROJECT WILL BE IMPLEMENTED BY BETWEEN 35 TO 50 NATIONAL PVOS AND WILL UTILIZE A CADRE OF TRAINED NATIONAL HEALTH PROMOTERS. THUS, THE PVOS WILL RECEIVE TECHNICAL ASSISTANCE AND TRAINING FOR INSTITUTIONAL DEVELOPMENT. IN ADDITION, COMMUNITY PARTICIPATION IN THE DEVELOPMENT AND IMPLEMENTATION OF SUB-PROJECTS IS AN IMPORTANT ELEMENT IN THE PROJECT'S DESIGN.

d. FAA Sec. 101(a). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

N/A

e. FAA Secs. 102(b), 111, 113, 281(a). Describe extent to which activity will: (1) 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; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries.

COMMUNITY INVOLVEMENT IN DESIGN AND IMPLEMENTATION OF SUB-PROJECT ACTIVITIES INCLUDES WATER SYSTEMS AND LATRINE CONSTRUCTION. BOTH OF THESE ACTIVITIES ARE EXPECTED TO IMPACT POSITIVELY ON THE ECONOMIC WELL-BEING OF THE RURAL AND MARGINAL POOR PARTICIPANTS.

APPROPRIATE TECHNOLOGIES WILL BE EMPLOYED IN THE ECOLOGICALLY SOUND CONSTRUCTION METHODS WHICH WILL BE USED AND THE COMMUNITIES WILL BE EXPECTED TO MAINTAIN THE SYSTEMS ONCE IN PLACE.

THE PRIMARY PARTICIPANTS (BOTH AS BENEFICIARIES AND HEALTH PROVIDERS) WILL BE WOMEN.

f. FAA Secs. 103, 103A, 104, 105, 106, 120-21; FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA." Does the project fit the criteria for the source of funds (functional account) being used?

YES

g. FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA." Have local currencies generated by the sale of imports or foreign exchange by the government of a country in Sub-Saharan Africa from funds appropriated under Sub-Saharan Africa, DA been deposited in a special account established by that government, and are these local currencies available only for

N/A

use, in accordance with an agreement with the United States, for development activities which are consistent with the policy directions of Section 102 of the FAA and for necessary administrative requirements of the U. S. Government?

h. 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)?

YES

i. 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)?

THE RECIPIENT PVOS WILL BE EXPECTED TO PROVIDE 25% OF TOTAL PROJECT COSTS.

j. 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?

YES

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

THE PROJECT WILL BE IMPLEMENTED IN COLLABORATION WITH THE MINISTRY OF HEALTH AND INDIGENOUS ENTITIES INVOLVED IN HEALTH SERVICES DELIVERY. COMMUNITY PARTICIPATION IS A SIN QUA NON TO SUCCESSFUL IMPLEMENTATION.

l. FY 1990 Appropriations Act, under heading "Population, DA," and Sec. 535. 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 made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? NO

Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? YES

In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? 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

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

n. FY 1990 Appropriations Act Sec. 579. What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and N/A

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)?

o. 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: (1) stress the importance of conserving and sustainably managing forest resources; (2) 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; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) 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

N/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; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; and (11) utilize the resources and abilities of all relevant U.S. government agencies?

p. 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: (1) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (2) take full account of the environmental impacts of the proposed activities on biological diversity?

N/A

q. FAA Sec. 118(c)(14). Will assistance be used for: (1) 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 (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas?

NO

r. FAA Sec. 118(c)(15). Will assistance be used for: (1) activities which would result in the conversion of forest lands to the rearing of livestock; (2) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (3) the

NO

colonization of forest lands; or (4) the construction of dams or other water control structures which flood relatively undergraded 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?

s. FY 1990 Appropriations Act Sec. 534(a). If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry?

N/A

t. FY 1990 Appropriations Act Sec. 534(b). If assistance relates to energy, will such assistance focus on improved energy efficiency, increased use of renewable energy resources, and national energy plans (such as least-cost energy plans) which include investment in end-use efficiency and renewable energy resources?

N/A

Describe and give conclusions as to how such assistance will: (1) increase the energy expertise of A.I.D. staff, (2) help to develop analyses of energy-sector actions to minimize emissions of greenhouse gases at least cost, (3) develop energy-sector plans that employ end-use analysis and other techniques to identify cost-effective actions to minimize reliance on fossil fuels, (4) help to analyze fully environmental impacts (including impact on global warming), (5) improve efficiency in production, transmission, distribution, and use of energy, (6) assist in exploiting nonconventional renewable energy resources, including wind, solar, small-hydro, geo-thermal, and advanced

N/A

biomass systems, (7) expand efforts to meet the energy needs of the rural poor, (8) encourage host countries to sponsor meetings with United States energy efficiency experts to discuss the use of least-cost planning techniques, (9) help to develop a cadre of United States experts capable of providing technical assistance to developing countries on energy issues, and (10) strengthen cooperation on energy issues with the Department of Energy, EPA, World Bank, and Development Assistance Committee of the OECD.

u. FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA"
(as interpreted by conference report upon original enactment). If assistance will come from the Sub-Saharan Africa DA account, is it: (1) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (2) being provided in accordance with the policies contained in section 102 of the FAA; (3) being provided, when consistent with the objectives of such assistance, through African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (4) being used to help overcome shorter-term constraints to long-term development, to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take

N/A

into account, in assisted policy reforms, the need to protect vulnerable groups; (5) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks, to maintain and restore the renewable natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

v. International Development Act Sec. 711, FAA Sec. 463. If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (1) the world's oceans and atmosphere, (2) animal and plant species, and (3) parks and reserves; or describe how the exchange will promote: (4) natural resource management, (5) local conservation programs, (6) conservation training programs, (7) public commitment to conservation, (8) land and ecosystem management, and (9) regenerative approaches in farming, forestry, fishing, and watershed management.

N/A

w. FY 1990 Appropriations Act Sec. 515. If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified?

N/A

2. Development Assistance Project Criteria
(Loans Only)

N/A - THE PROJECT IS
GRANT FUNDED.

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. 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?

3. Economic Support Fund Project Criteria

a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA?

N/A - THE PROJECT IS DA
FUNDED.

b. FAA Sec. 531(e). Will this assistance be used for military or paramilitary purposes?

c. 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?

5C(3) - STANDARD ITEM CHECKLIST

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

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

A. PROCUREMENT

1. FAA Sec. 602(a). Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? N/A - US PROCUREMENTS WILL, FOR THE MOST PART, BE HANDLE BY THE GSA OR VA.
2. FAA Sec. 604(a). Will all procurement be from the U.S. except as otherwise determined by the President or determined under delegation from him? YES
3. FAA Sec. 604(d). If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company? YES
4. FAA Sec. 604(e). If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.) N/A

5. FAA Sec. 604(g). Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.) N/A
6. FAA Sec. 603. Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? NO
7. FAA Sec. 621(a). If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? N/A
8. International Air Transportation Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? YES
9. FY 1990 Appropriations Act Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? YES

10. FY 1990 Appropriations Act Sec. 524. If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)? N/A
11. Trade Act Sec. 5164 (as interpreted by conference report), amending Metric Conversion Act of 1975 Sec. 2. Does the project use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? N/A
12. FAA Secs. 612(b), 636(h); FY 1990 Appropriations Act Secs. 507, 509. Describe steps taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services. N/A
13. 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
14. FAA Sec. 601(e). Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? YES

B. CONSTRUCTION

1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used? N/A
2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? N/A
3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the CP), or does assistance have the express approval of Congress? N/A

C. OTHER RESTRICTIONS

1. FAA Sec. 122(b). If development loan repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter? N/A
2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? N/A
3. FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? YES

4. Will arrangements preclude use of financing:
- a. FAA Sec. 104(f); FY 1990 Appropriations Act under heading "Population, DA," and Secs. 525, 535. YES
(1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization; (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; or (4) to lobby for abortion?
 - b. FAA Sec. 483. To make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? YES
 - c. FAA Sec. 620(g). To compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? YES
 - d. FAA Sec. 660. To provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? YES
 - e. FAA Sec. 662. For CIA activities? YES
 - f. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained?
 - g. FY 1990 Appropriations Act Sec. 503. YES
To pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel?
 - h. FY 1990 Appropriations Act Sec. 505. YES
To pay U.N. assessments, arrearages or dues?

- i. FY 1990 Appropriations Act Sec. 506. PRECLUDED
To carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)?
- j. FY 1990 Appropriations Act Sec. 510. PRECLUDED
To finance the export of nuclear equipment, fuel, or technology?
- k. FY 1990 Appropriations Act Sec. 511. PRECLUDED
For the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?
- l. FY 1990 Appropriations Act Sec. 516; State Authorization Sec. 109. PRECLUDED
To be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress?
5. FY 1990 Appropriations Act Sec. 574. PRECLUDED
Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate?
6. FY 1990 Appropriations Act Sec. 582. PRECLUDED
Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law?

3(A)2 - NONPROJECT ASSISTANCE CHECKLIST

The criteria listed in Part A are applicable generally to FAA funds, and should be used irrespective of the program's funding source. In Part B a distinction is made between the criteria applicable to Economic Support Fund assistance and the criteria applicable to Development Assistance. Selection of the criteria will depend on the funding source for the program.

CROSS REFERENCES:	IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED?	YES YES
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A. GENERAL CRITERIA FOR NONPROJECT ASSISTANCE N/A - THIS IS PROJECT ASSISTANCE.

1. FY 1990 Appropriations Act Sec. 523; FAA Sec. 634A. Describe how authorization and appropriations committees of Senate and House have been or will be notified concerning the project.
2. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?
3. FAA Sec. 209. Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs.

4. FAA Sec. 601(a). Information and conclusions on whether assistance 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.

5. FAA Sec. 601(b). Information and conclusions on how assistance 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).

6. FAA Sec. 121(d). If assistance is being furnished under the Sahel Development Program, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of A.I.D. funds?

B. FUNDING CRITERIA FOR NONPROJECT ASSISTANCE

N/A - THIS IS PROJECT ASSISTANCE.

1. Nonproject Criteria for Economic Support Fund
 - 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 assistance under this chapter be used for military or paramilitary activities?

- c. FAA Sec. 531(d). Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so, will at least 50 percent of such local currencies be available to support activities consistent with the objectives of FAA sections 103 through 106?
- 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?
- e. FY 1990 Appropriations Act, Title II, under heading "Economic Support Fund," and Sec. 592. If assistance is in the form of a cash transfer: (a) Are all such cash payments to be maintained by the country in a separate account and not to be commingled with any other funds? (b) Will all local currencies that may be generated with funds provided as a cash transfer to such a country also be deposited in a special account, and has A.I.D. entered into an agreement with that government setting forth the amount of the local currencies to be generated, the terms and conditions under which they are to be used, and the responsibilities of A.I.D. and that government to monitor and account for deposits and disbursements? (c) Will all such local currencies also be used in accordance with FAA Section 609, which requires such local currencies to be made available to the U.S. government as the U.S. determines necessary for the requirements of the U.S. Government, and which requires the remainder to be used for programs agreed to by the U.S. Government to carry out the purposes for which new funds authorized by the FAA would themselves be available? (d) Has Congress received prior notification providing in detail how the funds will be used, including the U.S. interests that will be served by the assistance, and, as appropriate, the economic policy reforms that will be promoted by the cash transfer assistance?

2. Nonproject Criteria for Development Assistance

a. FAA Secs. 102(a), 111, 113, 281(a).

Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) 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; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

b. FAA Secs. 103, 103A, 104, 105, 106, 120-21. Is assistance being made available (include only applicable paragraph which corresponds to source of funds used; if more than one fund source is used for assistance, include relevant paragraph for each fund source):

(1) [103] for agriculture, rural development or nutrition; if so (a) extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, account shall be taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made; (b) extent to which assistance is used in coordination with efforts carried out

under Sec. 104 to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people; and (c) extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

(2) [104] for population planning under Sec. 104(b) or health under Sec. 104(c); if so, extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

(3) [105] for education, public administration, or human resources development; if so, (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education

and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

(4) [106] for energy, private voluntary organizations, and selected development problems; if so, extent activity is:

(i)(a) concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and
(b) facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

(ii) concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

(iii) research into, and evaluation of, economic development processes and techniques;

(iv) reconstruction after natural or manmade disaster and programs of disaster preparedness;

(v) for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;

(vi) for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.

(5) [120-21] for the Sahelian region; if so, (a) extent to which there is international coordination in planning and implementation; participation and support by African countries and organizations in determining development priorities; and a long-term, multidonor development plan which calls for equitable burden-sharing with other donors; (b) has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of projects funds (dollars or local currency generated therefrom)?

DRAFTER:GC/LP:EHonnold:3/20/90:2169J

ANNEX C

CERTIFICATION PURSUANT TO SECTION 611 (e)
OF THE FOREIGN ASSISTANCE ACT, AS AMENDED

Background

The continuing internal conflict in El Salvador has placed a severe budgetary strain on the public sector. The constant need for the GOES to repair damages caused by the conflict has severely limited social services expansion in the country, and, although the Ministry of Health has been able to achieve some improvement in health indicators, there are still large areas, primarily in the more remote parts of the country, where populations lack access to basic health care and which the MOH will not be able to reach in the next five to seven years.

The Maternal Health/Child Survival Project has been designed to help address this gap. The Project will widen the scope and improve efficiency and effectiveness of health care programs of existing Salvadoran private voluntary organizations to help them reach some of the marginal urban and rural poor not now attended by public health programs. The Project is comprised of three major inter-related categories of activities: 1) the Maternal Health/Child Survival Service Delivery activities will provide technical assistance, commodities, training, and some start up costs to experienced PVOs to establish a series of health care interventions at the community level; 2) The Institutional Strengthening of PVOs category will focus on improving the planning, administrative, and financial functions necessary for effective and efficient sub-project development, monitoring, and evaluation; and 3) the Coordination, Policy Development, and Research component will focus on information exchange among health sector PVOs, the MOH, and other donors, and provide a forum for policy dialogue with the GOES to address issues which inhibit the effective implementation of private sector health programs.

Certification

I, Henry H. Bassford, Principal Officer of the Agency for International Development in El Salvador, having taken into account, among other things, the maintenance and utilization of projects in El Salvador previously financed or assisted by the United States, do hereby certify pursuant to Section 611(e) of the Foreign Assistance Act of 1961, as amended, that in my judgment the Salvadoran PVOs that will implement this Project, have both the human resources and financial capability to effectively implement, utilize and maintain the PVO Maternal Health/Child Survival Project (519-0367).

This judgment is based upon the Project analysis as detailed in the PVO Maternal Health/Child Survival Project Paper and is subject to the conditions imposed therein.

Henry H. Bassford
Mission Director

Date _____



March 8, 1990

Mr. Carl Derrick
Contracting/Grant Officer
USAID/El Salvador
Edificio Torre "M"
Avenida Olimpica
San Salvador, El Salvador

RE: Maternal Health and Child Survival Project
RFA El Salvador 90-003

Dear Mr. Derrick:

Medical Service Corporation International (MSCI) is pleased to submit this Application for a Cooperative Agreement to provide management and technical assistance services in support of the El Salvador Maternal Health and Child Survival Project.

MSCI is a health management firm which is committed to improving the health and well-being of mothers and children worldwide. As managers of development projects, we are faced with a continual challenge in developing and maintaining sustainable health care systems. As career public health professionals, we recognize the complexity of this issue as it impedes our efforts to bring good health care to the developing world. The successful implementation of the proposed Maternal Health and Child Survival Project must clearly overcome these two problems.

We believe our approach to this Project is unique and our strategy toward accomplishing its objectives are realistic. They are based on an appreciation of just how difficult it will be to reach a target group of high risk women and children who are at the fringe of El Salvador's health care system. But with this understanding comes a desire to respond to this challenge by applying flexible and innovative approaches involving cooperating PVOs and their strengths in community development.

Mr. Carl Derrick
March 3, 1990
Page Two

The features of MSCI's proposal include:

- Emphasis on a well-defined collaborative working relationship with private voluntary organizations to whom our technical advisors will provide supplementary and complimentary skills;
- The nomination of two technical advisors, Dr. Elizabeth Burleigh and Mr. Andrew Krefft, who have extensive experience in the preparation of Project Papers. They are available for both the Design Phase and the Implementation Phase of this Project;
- A technical approach that emphasizes innovation, community development, self-sustaining and improved PVO cooperation to provide long-term Project success;
- The breadth and depth of MSCI's institutional experience in managing USAID funded maternal health and child survival projects in some of A.I.D.'s most difficult program environments;
- A clear understanding of the cooperative agreement mechanism;
- A cost-sharing plan that addresses itself to the issue of Project self-sustainability; and
- MSCI's strong capability in home office support of overseas projects involving child survival, commodity procurement, management information systems, training, and financial management.

Our intent has been to be completely responsive to USAID's RFA. If you desire amplification or clarification of any point, please contact me at 703 276-3000.

Thank you for your consideration.

Sincerely,



George Contis, M.D., M.P.H.
President

GC/sk

Attachments

AGENCY FOR INTERNATIONAL DEVELOPMENT
UNITED STATES OF AMERICA A. I. D. MISSION
TO EL SALVADOR
C/O AMERICAN EMBASSY.
SAN SALVADOR, EL SALVADOR, C. A.

- 94 -

Issue Date: November 24, 1989.

Closing Date: March 08, 1990.

Subject: Request For Applications (RFA) El Salvador 90-003,
Maternal Health and Child Survival Project

The United States Agency for International Development (USAID) Mission to El Salvador is seeking applications from private voluntary organizations (PVO) or other institutions based in the U.S. or Central American Common Market (CACM) region interested in designing and implementing the program described in Attachment No. 2 (Program Description) of this RFA. This effort will be funded through a cooperative agreement utilizing the collaborative assistance mode described in Appendix 6B of AID Handbook 13. Although commercial or profit-making organizations are not excluded from applying for participation in this activity, all such organizations should be aware that no fee or profit will be allowed under the resulting cooperative agreement.

To this end, we are issuing this Request for Applications (RFA) consisting of the following attachments:

- I. Attachment No. 1 - Schedule
- II. Attachment No. 2 - Program Description
- III. Attachment No. 3 - Selection Criteria
- IV. Attachment No. 4 - Standard Provisions

If you decide to submit an application, it must be received no later than 4 p.m. El Salvador Time on the closing date indicated above. All application, and modifications thereof, should be submitted with the name and address of the applicant and RFA No. inscribed thereon and be submitted to:

Mailing Address:

USAID Contracting Officer
American Embassy (San Salvador)
APO Miami FL 34023

If hand carried:

**USAID Contracting Officer
Edificio Torre "M"
Avenida Olimpica
San Salvador, El Salvador**

NOTE: The U.S. Postal Service will not accept registered mail for APO addresses, therefore, any applications sent via USPS should be sent by certified mail.

Evaluation and ranking of applications will be done in El Salvador, by a panel of A.I.D. employees, and possibly Government of El Salvador officials, using the selection criteria set forth in Attachment No. 3 hereof. After the evaluation is completed a limited number of higher ranked firms may be invited to send representatives to El Salvador for discussions and negotiations. Costs associated with this travel will be reimbursable under the cooperative agreement for the selected institution only.

It is contemplated that a cooperative agreement will be awarded to that institution whose application is determined to be most advantageous to the Government, all factors considered. Although present plans are to enter into discussions with those institutions most highly ranked following evaluation of applications, the Government reserves the right to award without discussions. Hence, applications should be submitted initially on the most comprehensive terms from a standpoint of information about the institution and any cost sharing aspect which the applicant wishes to propose to the Government.

Issuance of this request for applications does not constitute an award commitment on the part of the Government nor does it commit the Government to pay for the costs incurred in the submission of applications. Further, the Government reserves the right to reject any or all applications received, and to negotiate separately with an applicant, if such action is considered to be in the best interest of the Government.

Telegraphic applications or telegraphic notices of intent to apply are not authorized for this requirement and will not be accepted.

Any explanation desired by an applicant regarding the meaning or interpretation of this request for applications must be requested in writing and with sufficient time allowed for a reply to reach all applicants before submission of their applications. Inquiries may be made by commercial telex to the undersigned through telex number 20648 or by fax to (503) 98-0885. Oral explanations or instructions given before the award of the agreement will not be binding. Any additional information given to a prospective applicant will be considered an amendment of this request for applications and will be provided to all other prospective applicants, if such information is determined to be necessary to applicants in submittal of applications or if the lack of such information would be prejudicial to uninformed applicants.

Any questions concerning this Request for Applications should be addressed to the undersigned at the address indicated above. Offerors should retain for their records copies of any and all enclosures which accompany their applications.

Sincerely yours,

Carl Derrick
Contracting/Grant Officer
USAID/El Salvador

Attachment: a/s

RFA El Salvador 90-003
Attachment No. 1
Page 1 of 8 pages

SCHEDULE

I. Authority, Purpose and Program Description

The purpose of this cooperative agreement is to design and implement a program to expand community based Maternal/Child Survival Services through a collaborative effort involving USAID/El Salvador, local Salvadoran PVOs, and the Recipient. The concept of this program is more fully described in Attachment No. 2 entitled, "Program Description". Funding will only be provided initially for the design phase of this program. Subject to a successful design effort and subsequent AID administrative approvals, this cooperative agreement will be amended to incorporate the design and add funding to enable the Recipient to continue through the implementation phase. Implementation will also be carried out in a collaborative manner through continued involvement of USAID/El Salvador, local Salvadoran PVOs, and the Recipient.

II. Funds Obligated, Payment, Estimated Cost and Cost Sharing

1. A.I.D. hereby obligates the amount of \$ _____ for purposes of this agreement. Funds obligated hereunder are available during the period of the agreement for program expenditures as set forth in the Financial Plan contained herein.

2. Payment shall be made to the Recipient in accordance with the procedures set forth in the Standard Provision entitled "Payment - _____", contained in Attachment No. 4, Standard Provisions for U.S. Non-Governmental Grantees.

3. Total estimated cost of the program described herein is \$ _____. Recipient agrees to provide funds in the amount of \$ _____.

III. A. Objective of the First Phase of the Work, Project Design.

The objective of this work is to assist USAID in the preparation of a Project Paper following the format described in the Agency for International Development's Handbook 3. The PP shall also follow the Project Identification Document.

While the work of the selected PVO has been broken down into suggested specific scopes of work for the individual members of the PVO team, the general intent is to bring together a group of technical specialists which in the aggregate has the balance of academic background, specific work experience and technical expertise needed to understand the work and to produce a quality document. In this connection, it is paramount that the individual consultants work as a team so that the end product is natural, well coordinated discussion of the individual components of the project paper. The selected PVO shall provide two specialists for a period of six weeks each. The scope of work and qualifications follow. The selected PVO will designate one specialist as team leader.

1. Community Development Specialist

Specific Tasks: Prepare a report that will at least:

- Develop the project's technical approach for assisting rural and marginal urban communities.
- Describe the manner in which AID, the coordinating PVO, and the MOH will interact.
- Describe in as much detail as possible the mechanism for identifying community needs and the process for translating these needs into proposals to be funded.
- This report shall cover the complete evolution of this process including the procedural steps and the involvement of the targetted communities, AID, and MOH at each step.
- A discussion of the feasibility of fee for service systems and how they will work.

Qualifications

- At least a Master's degree in Public Health, Sociology, Development, or related field.
- At least ten years of experience in Community Development or closely related field.
- Excellent conceptual and writing skills.

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Attachment No. 1
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- Spanish FSI S-3, R-3 or equivalent and cultural sensitivity.
- Experience in preparing project papers desirable.

2. Management/Logistics Specialist

Specific Tasks: Prepare a report that will at least:

- Lay out the general lines of the project management responsibilities and the roles of the organizations.
- Prepare detailed personnel needs for the coordinating PVO and AID. Prepare Scopes of Work and qualifications for these positions.
- Detail the procurement, warehousing and distribution systems for commodities.
- Detail the system for financial management.
- Prepare list of commodities for immediate procurement. This list would generally include those items necessary for the coordinating PVO to begin operations.
- Prepare a work plan for the first six months of project.

Qualifications

- Spanish language at least at FSI S-3, R-3 or equivalent level.
- Advanced degree in Management, Administration or related field.
- Ten years of general experience in developing countries with at least 3 years in Latin America.
- Accounting/Financial Management experience.
- Previous experience with PVO and AID systems desirable.

B. Objective of the Second Phase of the Work; Project Implementation

The objective of this phase of the work is to implement the project. While the exact nature of the responsibilities of the coordinating PVO will be determined during the project design, it is probable that the coordinating PVO will have to field the following positions during the life of the project:

1. Project Director

General Description of Responsibilities

The Project Director will have overall responsibility for implementation of the project. He will chair the Project Advisory Committee and will be the principal liaison between the coordinating PVO, GOES, and the participating PVO systems. He will be responsible for setting project policy and insuring that project activities conform to the general GOES, PVO, and USAID health policy and strategy.

Specific duties and responsibilities will include:

- Liaison with other health care providers; keeping them informed on project activities and reporting on other health programs.
- Supervision of the work of the Project Administrator and Community Health Specialist.
- Representation of the coordinating PVO and the project at donor committee meetings.
- Developing general guidelines for project implementation.

Qualifications

- Advanced degree in Public Health, Anthropology, Community Development, or related field.
- Considerable and increasing responsibility (preferably more than ten years) in management of development programs.

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- Strong interpersonal skills.
- Strong administrative and supervisory capacity.
- Experience working with PVOs.
- Spanish language at at least the Foreign Service Institute Level S-3, R-3 or equivalent.
- Experience in implementing Community Development Programs.

2. Project Administrator

General Description of Responsibilities

The Administrator will have overall responsibility for logistics, planning, commodity procurement, transportation and financial reporting. He will report to the Project Director.

Specific duties and responsibilities will include:

- Serving as Executive Secretary of the Project Advisory Committee.
- Planning and organizing the Annual Health Conference.
- Developing and implementing the overall plan for project commodity management in coordination with USAID.
- Reception, storage and transshipment of project commodities.
- Development of a system of inventory and reporting for all commodities as well as a system for monitoring their use.
- Development and maintenance of a system of accounting and financial reporting; preparation of project vouchers (in collaboration with the AID Project Manager); liaison with USAID Controller.
- Assisting the AID Project Manager in the preparation of semi annual reports for the project.

- Supervising the project's support staff (secretaries, clerks, chauffeurs).

Qualifications: Same as for short term Management Logistics Advisor.

In addition to the two long term positions above, the recipient will be expected to engage a number of local hire support personnel. These will include administrative assistants, accountants, secretaries, and chauffeur/messengers. The recipient will also be responsible for providing short term technical assistance as required to carry out the objectives of the project.

C. Substantial Involvement Understandings

USAID/El Salvador, through its Office of Health, Population, and Nutrition (HPN), will participate under this agreement in the following manner:

Participate in such areas, as selection of subgrantees, geographical distribution, and technical program mix. It is the general intent that AID will accomplish this via, inter alia, membership in a Project Advisory Committee. The membership of this committee will also probably include representatives from the MOH, Ministry of Education, and several local PVOs. This Committee will also be part of a review mechanism to coordinate this project's activities with those of the APSISA (519-0308), Public Services Improvement (519-0320) and Family Health Services (519-0363). In the design phase, the PVO consultants will work in close collaboration with the USAID representatives and other project design consultants. They will be expected to schedule their arrival and work in country in coordination with the other Project Paper design consultants.

IV. A. Period of Agreement

The effective date of this agreement is the date on which award is made. The expiration date is estimated to be three months thereafter. Subject to a successful design phase and AID administrative approvals, this cooperative agreement may be extended to include the implementation phase.

B. Methodology

Detailed guides for the design phase of this work are found in Handbook 3, whose outline is found in Attachment 5. The team will be expected to review a wide variety of background information available from, inter alia, USAID/ES, the Salvadoran Demographic Association and the Ministry of Public Health. After reviewing this material the team will conduct a series of in depth interviews with appropriate officials from involved organizations. Field visits will be required where possible.

The team will be expected to set up its own working area/office (usually at the hotel) and will be expected to provide its own secretarial support and translation services. The team should plan to locally rent Personal Computers for preparation of the Project Document.

The team will be expected to abide by Regional Security Office regulations for personal safety.

V. A. Reporting Requirements for the Design Phase of the Work

Pursuant to Section III A1 and III A2, the PVO shall provide USAID with the following reports:

1. Within fifteen days from the day of arrival, the team leader will submit for USAID approval a working outline of the first draft report.
2. The PVO shall provide USAID with a list of proposed in country field trips for approval, at least 48 hrs. in advance of making the scheduled trip.
3. Within five weeks after arrival, the team leader shall give the USAID ten copies of a draft report in English which shall contain the sections outlined in Handbook 3 for PPs. This draft will be reviewed by the USAID and returned to PVO with corresponding comments/recommendations.
4. The PVO shall incorporate the comments and recommendations suggested into the final report. Ten copies in English of a final report will be delivered to USAID prior to departure, as well as a Wang diskette (compatible with USAID system) with the text of the report.

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Page 8 of 8 pages

5. Within 15 days after the departure, PVO will provide USAID with 5 copies of a Spanish translation of the final report.

B. Level of Effort for the Design Phase of the Work

Two consultants will spend approximately forty consecutive work days to perform the work. It is recommended that the team leader arrive in country at least several days prior to the arrival of the rest of the team and that he remain at least two days after submission of the final report. Since the interaction of the team members is critical to the work, it is required that they all be in country at the same time.

Services shall begin within ten days of the signature of the cooperative agreement. The first activities of the PVO should include a review of the literature in the U.S. and preparation of the work plan. The team should arrive in the country as soon as possible after February 1, 1990. The work should be completed NLT April 15, 1990. A six-day work week is authorized.

VI. Negotiated Overhead Rates

(To be completed after selection of recipient.)

VII. Financial Plan

(To be prepared by applicant and subject to USAID approval.)

VIII. Special Provision

1. The Authorized Geographic Code for procurement of goods and services under this agreement is 000 (U.S.) and the Central American Common Market (CACM).

2. Local Cost Financing with U.S. dollars is authorized for this agreement in amounts identified for local costs in the Financial Plan.

IX. Standard Provisions

The Standard Provisions applicable to this agreement are contained in Attachment No. 4.

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Attachment No. 2
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PROGRAM DESCRIPTION

A. Perceived Problem

In spite of the severe economic problems and the violent conflict and resulting social upheaval and population displacement over the past decade, national indicators of health status show that the people of El Salvador have experienced generally improving health status since 1950. Some dramatic indicators of this are: the falling crude death rate; a drop in infant and child mortality rates, from 60 to 50, and 25 to 24 per 1000, respectively, between 1985 and 1988; the increase of life expectancy; and, the increase in the couple years of protection (CYP) from 367,000 in 1985 to 419,000 in 1988.

However, continuing high population growth rates (2.5 percent per year), and the inability of the GOES public health system to meet probable future demands threaten to wipe out these improvements. In 1978, the total population was estimated at 4.0 million. Yet, despite significant outmigration (over 1 million people between 1978 and 1988), the population of El Salvador had grown to an estimated 5.3 million by 1988, making it the most densely populated country in the mainland Americas. Current projections place the population at an estimated 7.0 million inhabitants by the year 2000.

Furthermore, these same national indicators mask an inequitable distribution of gains in general health status by the population of El Salvador. For example, the infant mortality rate for the country as a whole in 1988 was 50 per 1,000 live births (approximately 11,000 children in 1988). In the rural areas, the rate was 56 per 1000 live births. In urban marginal areas, rates are also higher than the national average. In addition, malnutrition has been found to be significantly higher than the national average among children living in rural and marginal urban areas. In part, this discrepancy stems from the fact that the Ministry of Health (MOH) is supposed to serve 85% of the population. However, due to MOH financial limitations, client perception of services, and other constraints, the MOH presently serves no more than approximately 40 percent of the target population. As a result, inequitable gains in health status can be expected to continue.

In order to effectively meet the increased demand for services for the increasing population and to reduce the disparity in health status improvement, the MOH and other public systems must either find considerable additional resources or make quantum leaps in efficiency. Neither appears likely. While the public sector is making some (limited) progress on the efficiency of its programs, it is probable that given the country's overall economic situation the general level of funding (in real terms) will remain at the 1989 level or may even decline. As a result, it is reasonable to assume that a significant part of the population increase and the presently unserved will not receive adequate services from the public sector. Hence, the problem is to devise alternative self-sustaining delivery schemes that do not rely on public sector expenditures. One logical and attractive possibility is the use of self sustaining non governmental providers that are already operational. In El Salvador there are currently 75 PVOs working in the health sector. They provide a wide variety of services but to date have not all offered comprehensive primary health care services.

B. Project Goal and Purpose

The project goal is to improve the health status of the Salvadoran rural and marginal urban population. The project purpose is to expand community based Maternal/Child Survival services to those areas of El Salvador where such services have been weak or non-existent. The project purpose will be achieved by expanding and improving coverage provided by PVOs working in the health sector.

1. End of Project Status

The Maternal Health/Child Survival Project builds on and complements other efforts to improve and extend health services to rural areas. The expected end of project status is a self-sustaining system offering basic prevention and cure for most serious conditions impacting on Maternal Health and Child Survival in 350 communities.

C. Project Outline and How it Will Work

1. The project will have three main thrusts. These are:

- a) Maternal/Child Health Service Delivery. This thrust will establish general awareness on the part of the community that it can and should take steps on its own to improve the quality of life. It will also provide technical assistance, commodities, training and some start up costs for the establishment with community participation of a series of key interventions to address the major threats to Maternal Health/Child Survival.

The objective is to ensure that the basic components of primary health care be available (see list below). Pilot projects will be used to determine the most successful approaches.

The specific activities undertaken will vary from community to community depending on what services already exist as well as the perceived needs and priorities of the intended beneficiaries. A more detailed estimate of the likely range of activities will be possible when the present PVO Survey is completed in November 1989. Present projections for activities and consequently the major project activities include:

- prenatal consultations to instruct mothers on proper diet/care during pregnancy as well as identification of high risk mothers;
- referral of high risk pregnancies to appropriate facility (health center or hospital);
- delivery of normal pregnancies where appropriate;
- surveillance of preschool children;
- nutrition education for mothers;
- provision of family planning services: pill, IUD, Nor-plant, condom, and referral for voluntary surgical contraception;
- general health education;
- vaccination for children;

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- curative treatment for the prevalent health problems using basic, inexpensive, and available medicines. Referral of cases beyond community worker's technical competence;
- maintenance of some basic health statistics;
- basic environmental health measures (potable water and latrines).

b) Institutional Development of PVOs

This thrust will focus on improving planning, administrative, financial, and project development skills of participating PVOs. Activities will include seminars/training for PVO leaders, operational research and procurement of commodities (vehicles, audiovisuals, educational materials, pharmaceuticals).

- c) Coordination/Collaboration. This thrust will focus on the general exchange of information and would probably work mainly through the Intersectorial Health Committee. The project will assist the committee to collect, analyze and disseminate information through select studies, the publication of a periodic newsletter and an annual PVO Conference.

2. Project Beneficiaries

The specific target groups for this project are: Women in fertile ages and children under the age of five years living in some 350 of the country's poorest and smallest rural communities (populations of 200-1500). The secondary target group is the remainder of the residents in the communities where the primary group resides.

The primary target group lives in areas with extremely weak or non-existent services and will receive selective interventions via preventive and curative health care. The components of the health care system will generally include potable water, vaccination, health and nutrition education, growth monitoring, pre-natal care, child spacing and basic curative services. The number of direct beneficiaries in this group is estimated at 350,000 of whom some 160,000 are women in fertile ages and children less than five years old.

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The project will also have an additional secondary group of beneficiaries. This will be some 200 staff members of the participating local PVOs. They will receive training in all of the technical areas related to primary health care as well as planning and management. This in turn will directly strengthen the institutional capacity of the participating local PVOs.

3. Project Management and Implementation

The \$25 million DA grant will be obligated incrementally over a seven year period. The method of implementation will be by means of a registered U.S. PVO as Coordinator, competitively selected at the PID stage, so that the PVO may participate in the PP design. The primary function of this Coordinating PVO would be to act as a development resource and management unit for local PVOs. It would be a place where sub-project design and budgeting assistance can be obtained, where management guidance and institution building interventions can be devised, where local PVOs can bring their ideas and find help in translating them into solid development proposals which may then be suitable for funding. In addition, the Coordinating PVO would develop the sub-project agreements, monitor sub-project implementation, design financial management and reporting systems, participate in evaluations of sub-projects, and maintain USAID sectoral and geographic priorities. It would also organize and deliver technical assistance, management training and commodities.

It is the general intent that the selected Coordinating U.S. PVO will manage the vast majority of the procurement of commodities, services and training, and that USAID will procure only on an exception basis; for example, procurement of pharmaceuticals and vehicles.

SELECTION CRITERIA

The following criteria will be used to evaluate applications from interested institutions. The points shown reflect the relative importance of each category of criteria.

	<u>CRITERIA</u>	<u>MAXIMUM POINTS</u>
A.	RESPONSIVENESS OF PROPOSAL.....	25
	Understanding of Problem and Completeness of Response.....	(10)
	Technical Approach to the Problem.....	(15)
B.	INSTITUTION'S EXPERIENCE AND QUALIFICATIONS.....	50
	*Demonstrated Ability of Institution's Financial Management and Purchasing Systems to Manage Project Activities.....	(15)
	Demonstrated Successful Management and Implementation of Health/Child Survival Programs....	(15)
	Demonstrated Experience in Family Planning Projects.....	(10)
	Demonstrated Experience in Community Development Projects in Latin America.....	(10)
C.	QUALIFICATIONS OF KEY PERSONNEL.....	25
	Proposed Design Team.....	(10)
	Candidates for Implementation.....	(15)

*Applicants should pay particular attention to the following Standard Provisions: (1) "ACCOUNTING, AUDIT, AND RECORDS", which outlines the financial management system requirements for grantees and (2) "PROCUREMENT OF GOODS AND SERVICES", which sets forth the requirements with which grantees must comply for all purchasing actions under the grant. Applications will be evaluated against how well the applicant's existing systems meet these criteria. Applicants who elect to propose the subcontracting of commodity procurement should include sufficient information about the qualifications and experience of the proposed purchasing agent.

ANNEX E

PROFILE OF PVOS WORKING IN EL SALVADOR

It has been noted elsewhere in this Project Paper that there is reason to believe that there are as many as 90 indigenous PVOs working in the health sector in El Salvador. The purpose of this Annex is to present additional information related to characteristics of the PVOs working in El Salvador, and a sketch of several of these organizations and how the Project proposes to work with them. The basis for this and the following statements is a 1989 survey of health sector PVOs carried out by Marcable, specifically as a baseline document for this Project. As noted in this study, to be released by the Mission in August 1990, the PVOs are distributed throughout the country, but with a disproportionate percentage operating along the southern band from Ahuachapan to San Miguel. They programs range from single interventions to a complete range of both curative and preventive services. Approximately sixty of the PVOs surveyed fall in the "small" category, with 10-20 members, which work only at the level of one community and operate as an expanded patronato. The remaining organizations fall into the "medium" (roughly 30%) and large (10%) category, the former of modest size with 20-40 members, working in a series of communities and having a small but specialized administrative structure, and the latter having 40-100 employees/members, operating programs at a regional or national level and having well developed programming and administrative structures.

One of the constant themes that came out of both the Marcable study and the subsequent design team field visits to select organizations was the PVO's lack of awareness of the activities of others working on the same problems in the same geographic areas. This unawareness relates to both the public and private sector activities. Several other important conclusions from this study are:

- No complete record of PVOs that offer services in the health sector exists, and compiling such an inventory is a difficult task. Some PVOs are very reluctant to provide information about their operations. The Ministry of Health has only limited knowledge of, and follow-up and control over, PVO activities.
- As noted above, the level of coordination and information sharing among health sector providers is relatively weak, and as a result, some duplication of effort exists. Existing coordinating organizations involve the participation of 51 public and private groups, a small sub-set of the range of health care providers. Of the PVOs surveyed, only 56% (41) were members of the coordinating organizations.

- Of those surveyed, 50.1% of the PVOs had been working for more than 10 years, 34.5% from 5-10 years, and 12.3% less than five years. This indicates a high level of sustainability among PVO programs.
- The health services offered by PVOs are varied; 70.8% of the PVOs surveyed offered health curative services, and 61.5% preventive services. In addition, 55.3% of the organizations had MCH programs, and 36.9% had maternal health programs.
- In general, PVOs have limited resources; nevertheless, their work ethic and their desire to serve the community tend to insure that their resources are used efficiently.
- Health services are generally provided free or at a very low cost in relation to the private for profit sector. Given data collected from the Health Demand Survey regarding family expenditures on health care and preference for private sector care, cost-recovery and cost-sharing measures should be able to be introduced into the PVO programs.
- Most organizations already have the basic physical infrastructure, equipment and personnel to serve as a base to improve and expand health services. However, in many of these institutions the education of the staff is quite low; they often do not have many professionals, thereby affecting the scope of services that the PVO can offer.
- Only 33.8% of the organizations have a complete system of financial controls, including external audit. Technical assistance and training will, therefore, be necessary to improve these systems in order to meet AID standards.

The Project will assist select PVOs to improve/expand their present activities and to expand their coverage geographically. This geographical expansion would, as far as possible, be aimed at meeting the needs of the highest risk areas. It would take place in areas where the MOH and other PVOs do not plan to work. A parallel objective is to develop an awareness in the PVOs of the need to offer those services that are not being duplicated and that are meeting the needs of the communities served. This will optimally get the PVOs to focus more on basic preventive and promotive activities with an emphasis on reducing infant/child/maternal mortality.

The following descriptions of four PVOs and possible areas for Project support are intended to illustrate the type of activities that will be supported and their potential impact.

Salvadoran Rural Health Association (Asociacion Salvadoreña Pro-Salud Rural -- ASAPROSAR)

ASAPROSAR was the first non-profit foundation founded in the city of Santa Ana, El Salvador, organized in 1972 but only legally registered with the Government of El Salvador as a non-profit organization on August 15, 1986. ASAPROSAR operates preventive and curative health programs, including vaccination, latrines, oral rehydration therapy, MCH and family planning education, nutrition and growth monitoring of children, and general medical attention, including care for malnourished children. The specific objectives of ASAPROSAR are to: provide medical and curative care to communities served; modify attitudes and behavior of individuals to permit cooperative action; train community members in health and sanitation, and mobilize community participation, through volunteer groups, to resolve community problems.

ASAPROSAR has a staff of approximately 50 individuals, including trained medical professionals, 35 volunteer health promoters and community leaders, and an administrative staff (accountant and business manager). In addition, ASAPROSAR enjoys the support of 5 womens groups, each having 12-15 members and 4 youth groups composed of 20-25 members. Its geographic coverage is 23 caserios in the Western zone of the country, and in 1988, ASAPROSAR provided services to approximately 8,000 persons. Their financing comes from services fees (¢5 or \$0.60 approximately per patient), donations from members and the international organizations, such as the Hunger Foundation, U.S. churches, and the production and sale of artesanry products. Service expansion has been prevented due to the lack of adequate financial resources, additional trained technical personnel, and equipment.

ASAPROSAR has plans to extend activities to an additional three geogrpahic areas in the country over the next five years. The Project could assist by providing support for the training, equipment, and initial supervision of the activities in these areas. In addition, the Project could assist ASAPROSAR in improving its potable water and environmental health program through technical assistance and training.

PRO-LIFE MINISTRIES (MINISTERIOS PARA VIDA)

PARA VIDA, a social service agency supported by evangelical and protestant churches, was founded and registered as a non-profit organization in 1984. The organization operates both a preventive and curative health care program, including activities in nutrition, maternal child health attention, diarrheal control, health education, sanitation, pediatrics and OB/GYN, general medicine and some surgery. Currently, PARA VIDA operates in 2 communities and has a clinic in San Salvador, attending approximately 18,000 patients per year. Its staff include 21 technical personnel (including 9 physicians, 2 nurses, and 9 para-medical personnel), 17 operational staff, and 12 other employees. In addition to grants and in-kind support provided by the Baptist Association and MAP International, PARA VIDA charges a minimal service fee to its patients.

This organization is working in one of the highest risk areas in the country -- the northern parts of Chalatenango and Porfiriado en la Herradura. They are prepared to initiate a limited geographical expansion to several surrounding communities if provided with Project resources such as training, equipment, and start-up costs for the first two years.

Happiness and Faith (FE Y ALEGRIA)

FE Y ALEGRIA was founded 20 years ago as a private, apolitical association, developed to foment basic and technical education, provide health assistance, support micro-businesses and otherwise foment community cooperation and development. Fe y Alegria operates a network of 3 clinics and 24 schools, and provides support to 3 cooperatives; through their three clinics they serve approximately 45,000 patients in Soyapango, a neighboring municipality of the capital, and rural areas in the Department of La Libertad. Fe Y Alegria's current staff includes 248 employees, including 142 teachers paid by the Government, 7 physicians and 2 nurses. The clinics are supported through a minimal cuota per visit of 1-5 colones and donations of medicines and medical supplies by the Knights of Malta and the Salvadoran American Foundation, as well as proceeds derived from raffles and donations.

This organization is also assisting in the resettlement of several groups of families from conflictive areas to the Department of La Libertad, where Fe Y Alegria has obtained title for some land for these families. Fe y Alegria is initiating/strengthening health activities in these areas, but have a real need for more health promoters and for assistance to solve a serious dry season water shortage problem. The Project will explore assisting Fe y Alegria to train and equip five health promoters and to drill 12 small bore tubewells.

SALVADORAN AMERICAN FOUNDATION (FUSAM)

FUSAM was founded in 1982 by Dr. Luis Poma, a prominent Salvadoran businessmen, to stimulate and provide support for activities designed to promote health, education, and wellbeing of Salvadorans. Its specific objectives, to be accomplished through its Salvadoran and American sister organizations, is to: support through donations institutions that provide services to needy Salvadorans; promote health care in areas most lacking in such services, such as rural areas; and to raise funds for the above purposes. FUSAM's program includes the distribution of donations in-kind and financial support for the opening and maintenance of clinics and the establishment of sanitation programs. Its staff is small, consisting of 4 persons including one social worker, which it believes commensurate with its role of providing funding to other organizations. During 1988, FUSAM provided support in the form of materials, equipment and medicines to 400 institutions.

FUSAM perceives a need to increase coordination between PVO/service providers within El Salvador, as well as with international PVO/donors. It routinely receives relatively large donations of medical equipment, supplies and pharmaceuticals. However, these goods are distributed based on incomplete information regarding areas of highest need. The PVO coordination activities to be financed under this Project could assist FUSAM in improving the distribution of its many donations.

In addition, FUSAM is considering initiation of some direct health service delivery points in high risk areas. The Project could assist with this effort by providing technical assistance, training, equipment and some start-up costs.

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ANNEX F

SOCIAL SOUNDNESS ANALYSIS

A. Introduction

This social soundness analysis is intended to provide background sociocultural information about El Salvador in order to guide the development and assess the probable social effects of the Maternal Health and Child Survival Project. It discusses the feasibility of the Project and examines the possible effects of the Project, especially as these relate to diffusion of technologies used during Project implementation, and impacts the Project may be expected to have on the participating institutions and communities. The analysis will also address some of the larger social consequences and benefits that may be expected to accrue during Project implementation.

B. Description of the Project

The Project is made up of the following inter-related categories:

- * Maternal health and child survival service delivery;
- * Institutional strengthening of private voluntary organizations;
- * Coordination and development of cooperation among involved PVOs, the Coordinating Organization of the Project, USAID and other donor supported projects.

The two beneficiary levels of this Project are those persons to whom health care will be extended under this Project, and the private voluntary institutions themselves. The principal populations to be served by the Project are those that are at high geographical risk (those living in areas that are currently under-served) and those that have high mortality and morbidity risk (women of childbearing age and children under five years of age). As in the case of most development projects, other persons outside of the aforementioned maternal-child risk group who live in the Project catchment regions will also benefit.

Preventive care will be a significant output of the Project. Under the Project, a system of community health promotion will be organized that includes interventions in birth spacing, prenatal and postpartum care, immunization, vitamin A, oral rehydration, and acute respiratory infection interventions. In addition to the medical-technical interventions, considerable emphasis will be placed on community education efforts in the areas of birth spacing, nutrition, infectious disease and hygiene. In those communities where access to water is deficient, the Project will support activities to build water systems.

Community health promotion will rely heavily on community participation. The Project will assist the PVO organizations in training Health Promoters whose task it will be to deliver the basic medical-technical interventions and provide community education. Working in conjunction with health committees and water committees, the Health Promoters will be engaged in a number of community organizing activities. These efforts will establish the basis for the development of other community activities.

The Project is designed to be an institution-building effort that will foster a sustainable private sector initiative in the provision of health care in El Salvador. For this reason, commodities and training resources will go to the participating PVOs. The Coordinating Organization will channel both the commodities, training and technical assistance efforts within a decision making matrix that involves members of the PVO organizations, members of one or more inter-sectoral coordinating groups, USAID, other donors and the Salvadoran Ministry of Health.

The Project will enhance the capability levels of the participating PVOs in the area of management and finance and the technical areas of curative and preventive medicine. Training in administration, budgeting, financial accounting, and commodities monitoring are essential areas that will not only contribute to the ability of the PVOs to execute the Project during their five years of participation, but it will also contribute to their overall institutional viability. In the interest of institutional development, these key areas are designed to generate self-sustaining institutions, which with their financial and managerial staffs, will become more effective fund raisers in their continuation of activities in El Salvador. The experience gained by the PVOs through an expansion of their activities under the Project should equip them for future challenges. Training and technical assistance in commodity monitoring techniques and service delivery, and the use of innovative measures and planning contingency fall-backs should help make the participating PVOs highly adaptable to the changing sociocultural scene of El Salvador.

C. Relevant Background

The Sociocultural Context: El Salvador is a small country, comprising approximately 21,000 square kilometers of area. Before civil war erupted in 1979, El Salvador was experiencing a prosperous growth rate of four percent per annum (between 1960 and 1978). The class structure, nevertheless, was highly skewed with a concentrated land tenure system. By 1980, forty percent of the cultivatable land was owned by less than one percent of the population. Concentration of the population was compounded by a high fertility rate of 3.0 percent (in 1977) that was pushing El Salvador's population well beyond the land's carrying capacity. Over this period, economic disparity was increasing as the number of landless households in the country increased.

In 1979, regional conflict engulfed El Salvador. Eleven years later

this conflict continues. The strategy employed by the Salvadoran army has been to secure the country's urban centers, infrastructure, and its productive land areas from guerrilla attack. The guerrillas, meanwhile, remain entrenched principally in the regions that border along the Honduran and Guatemalan borders and on the upper slopes of volcanoes that lie along the Pacific piedmont. During the height of the insurgency, as much as a quarter of the country remained under guerrilla control. Today, their territory is significantly less. Yet they have been able to stage significant attacks, including the recent one on San Salvador in November 1989. Nevertheless, there is an emerging optimism that worldwide and regional events -- the melt-down of the Iron Curtain in Europe and the transition from Marxist Sandinista-dominated politics to an elected democratic government in Nicaragua, in addition to the recently initiated dialogue between the government of El Salvador and the guerrillas -- will have a tempering effect on the guerrillas' ability and willingness to continue the conflict.

The civilian population is caught in the middle of this conflict. Violence between the opposing factions initially sent thousands of people fleeing from their homes. It is estimated that roughly half a million persons had become internally displaced by 1985. However, the situation at present indicates that many of the early waves of refugees have become incorporated into their present domicile and the prevailing market economy. Although they are displaced from their original homes, the longevity at their current site and their societal re-integration places them in a non-refugee or displaced persons category.

In addition to the direct human toll, the destruction to economic infrastructure has been devastating. At the peak of the war around 1982, communications and services, including health services, had essentially come to a standstill. Water systems, were badly damaged during this period resulting in a 17 percent decrease in the rural population's access to potable water: from 30 percent in 1984 to only 21 percent today.

War-related economic slowdown has been exacerbated by recessions in the international market of El Salvador's traditional export commodity crops of cotton, coffee, and sugar. The country's agricultural production has been effectively squeezed by falling market prices and increased costs including rising prices of chemical fertilizers, pesticides, and herbicides. Per capita food production in El Salvador has fallen twenty percent from pre-conflict times to the present. El Salvador's traditional prime export, coffee, fell 154 percent from 1978 to 1988.

The Provision of Health Services in El Salvador: Health care in El Salvador is currently provided by both the private and public sectors. Private for-profit services operate primarily in urban centers and provide health care on a fee-for-service basis. This coverage by the private sector is limited to those who can afford it. In the private sector there are also non-profit health care delivery services largely operated by private voluntary organizations. There are approximately 75 to 90 PVOs that deliver non-profit

health services. Only nine of these have less than five years' experience in the country, so the collective experience of these PVOs is extensive, and forms one of the rationales for undertaking this Project.

The bulk of public sector health care is carried out through three principal institutions, the Salvadoran Social Security Institute, the Military Health Battalion, and the Ministry of Health. The first of these, ISSS, provides compulsory health coverage to employees of private and public institutions that have a minimum number of workers. Relatively speaking, its coverage is small and limited to the full-time work force. The second of these is primarily for the members of the military and their families, but relief efforts are also provided by this unit, particularly through the Civic Action Programs of the army. The Ministry of Health coverage to the population is based on the following levels of delivery:

- * Community Health Promoters (CHP) are the first line of health services delivery. The CHPs dispense basic medicines, contraceptives and provide some community health education.
- * Community Health Posts are the next level of health care delivery. These are run by non-permanent staff and function as first-aid posts and immunization centers.
- * Health Posts are staffed by a permanent auxiliary nurse and provide basic ambulatory care. These Posts are visited by health teams operating out of larger centers.
- * Health Units are permanently staffed by physicians and usually contain a small laboratory and pharmacy. In addition, there are nurses, nurse auxiliaries, and a health inspector. In some malaria endemic regions, a malaria coordinator also works. Outpatient care, some dentistry services (tooth extraction, mainly) is provided.
- * Health Centers are similar to the above mentioned Units, and include limited in-patient care services.
- * General Hospitals are fully staffed hospitals, which may have up to hundreds of beds.
- * Specialized Hospitals are medical facilities which specialize in the areas of psychiatry, maternity, cancer, etc.

There are definite limitations to the MOH's ability to provide adequate health care coverage. During eleven years of war, many health posts have been forced to close; in El Salvador's Eastern region, 25 of the 100 health posts had to be closed in the face of medical neutrality violations. The other principal inhibiting factor to health care delivery is budgetary limitations. Between 1980 and 1985, for example, the purchasing power of the MOH dropped by

half; in 1986, the devaluation of the colon and tariff adjustments brought on a doubling of the cost of medicines.

The USAID strategy has been to revitalize the MOH system in the face of these constraints. Since 1987, significant infusions of funds and resources have been put into the MOH, with some commendable results. A falling crude death rate and drop in infant (60 to 50 per 1,000) and child mortality rates (25 to 24 per 1,000) between 1985 and 1988 attest to this success. The overall fertility rate has fallen, in large part due to the 14 percent increase in the Couple Years of Protection (CYP).

However, the coverage afforded by the MOH remains limited. Designed to cover 85 percent of the population, it currently is reaching approximately only 40 percent. In the next five years the amount of total U.S. foreign assistance to the MOH will decline by 40 percent. If the U.S. reduces military assistance, the Salvadoran government will have to divert additional resources to sustain its battle against the insurgency unless a cease-fire is negotiated. The future for expansion of health care services through the public sector looks rather stark unless a brighter political outlook is on the horizon. Hence the rationale for the current Project.

D. Sociocultural Feasibility of the Project

The Project considers both community members and institutions as participant beneficiaries. Accordingly, this Social Soundness Analysis treats both the PVOs and the community inhabitants in the high risk areas where the Project will be implemented as part of the same sociocultural system. Of course, there are major differences between these two societal elements, but since they will be working together in a common community goal, they can be regarded as elements that operate within a singular social system.

Sociocultural feasibility of the delivery of maternal health and child survival services in the community:

A primary assumption on which the rationale for the Maternal Health-Child Survival Project rests is that Salvadoran PVOs will continue to work in the sites where they are presently providing health care services, or will expand to new areas where, in the course of the Project, they already will have undertaken studies of MHCS needs. PVOs operating in the Salvadoran health care field possess considerable knowledge and experience. In short, the PVOs will know their population, they will know the potentialities and limitations of certain community dynamics, and they will know specific individuals who can be effectively incorporated into the Project, as well as certain individuals who should be avoided.

The Project will place relatively heavy reliance on a front-line cadre of community health promoters (CHPs). Interviews with a number of PVO representatives indicate that this is their preferred modus operandi for delivering preventive services. The model proposed in the Project design is,

therefore, not experimental. It is a method that is known to work effectively in most areas of the world. In addition to the 'goodness of fit' of the community promoter health care model embraced by USAID/ES and the potential group of participating PVOs, there is also a sound goodness-of-fit between the health care delivery system and the communities; this arises out of the strong precedent for grass-roots community organization in El Salvador. The fact that community health promoters and health and water committee members will be participating in the decision making processes related to the Project will enhance their own sense of community solidarity and worth.

In this Project, much of the health educational efforts will be undertaken by community health promoters working in an effective promoter-population ratio of 1 : 500. Since the high-at-risk target population of fecund women and young children account for roughly 45 percent of the population, the effective ratio is about 1 : 200. The community health promoters will conduct educational sessions alongside the 70 community health trainers (CHTs) that will work as liaisons between the PVOs and the communities. In addition, the promoters will provide commodities, such as contraceptives, prenatal vitamins, ORS, and Vitamin A. With appropriate coordination, the new Family Health Services Project (519-0363), to be implemented by the Salvadoran Demographic Association (ADS), utilizing a similar system of community health workers, will help achieve the objectives of the Maternal Health/Child Survival Project through improving and expanding its delivery of family planning and health services in rural and marginal areas.

There is another community health care model run by the MOH that functions quite efficiently and lends additional credence to the use of the community model in health care. In malaria endemic regions of the country where control measures for this disease are in effect, there are various human resources on which to draw. The system of malaria control relies on malaria control "colaboradores voluntarios" (volunteers) who help in the diagnosis and treatment of malaria afflicted persons by taking blood slide samples from persons suspected of being infected and then give those slides to the paid malaria control personnel. These persons also help distribute the appropriate medication and help in anti-malarial community activities, such as spraying and hydraulic control of the vector population. There are approximately 2,500 malaria volunteers, most of who are located in hyperendemic regions, such as southern Ahuachapan. The efficiency of this malaria program is largely dependent on the motivation of its volunteers.

Community Medical Providers and Their Incorporation into the Project

There are several specific types of persons that could be incorporate into the front-line health promoter group. It is recognized that PVOs already working in the area of community health have identified key community members with whom they work. These persons have probably been recognized for some time as workers. Since this Project is intended to work with PVOs that already have ongoing community health projects, neither this Project Paper nor this Social Soundness Analysis wishes to offer prescriptive norms for how a

community health system should function. However, because the Coordinating Organization will function as a development resource in the implementation of the Project, it should have a strong voice among the participating PVOs. Therefore, the following discussion relating to possible types of persons to be included in the Project is intended as a guide to Project development and as basic information which PVOs can use at the appropriate decision making period. In subsequent sections of this Social Soundness Analysis, similar advocacy positions are advanced.

Traditional Medical Practitioners. Traditional medical practitioners perform at various levels of competency and community acceptance. There are different types of native healers, some who are therapeutic healers for somatic illnesses and who treat using herbs and physical manipulation, such as massage and bone setting. There are other types of healers who engage in more occult forms of therapy. Although common in Central American countries which have high indigenous populations, such as Guatemala, or Caribbean Black populations, such as Belize, in El Salvador the number of practitioners of traditional medicine are relatively few; still they exist.

In El Salvador, the most common type of traditional practitioner is the birth attendant (TBA). Traditional birth attendants generally are well accepted by community members, and from a medical standpoint, operate with reasonable competence. According to a recent study of TBAs (Mendez 1990), 65 percent of births in El Salvador are attended by TBAs. From the sample of TBAs interviewed, these practitioners are primarily women over 40 years of age who have learned the profession empirically. Only 14 percent were 40 years or younger, and 30 percent were women over 60. TBAs usually practice an average of 20 years. They often share the same general level of illiteracy as their constituents, and they practice midwifery as a secondary occupation after that of homemaker. In most countries, they are amenable to additional training; the same has been the experience in El Salvador. Between 1981 and 1984, for example, 900 TBAs were trained by the MOH and were provided the essential birthing equipment in kit form. At present, the MOH recognizes 1,613 active TBAs. Still, according to some countrywide calculations reported in the recent study, only 16 percent of the TBAs have had some formal training.

The TBA generally begins her role with a pregnant woman during the second and third trimesters. She follows the woman's pregnancy through the birth experience and sees her through the one month postpartum period. TBAs sometimes do not charge money and receive some compensatory repayment in kind, usually with foodstuffs. Increasingly, TBAs are receiving monetary remuneration, especially those who have had more dealings with the formal medical sector through training. TBAs generally attend one to six births per month, usually at the home of the patient. According to Mendez's 1990 study, which interviewed mothers as well, women choose TBAs because of cost considerations and the convenience of not having to travel. During the data gathering phase of this Project Paper, there was a case mentioned in which the only available TBA in a region in which 5,000 people lived would not assist a birth outside of her own home, and the patients had to travel to the

TBA's home to birth. In a country that experienced considerable dislocation of population, communities without TBAs are probably more common would be the case in stable populations.

TBAs would be highly desirable candidates for inclusion in a promoter health system. They are well-suited for a project involving maternal and child health because that population segment is the principal focus of their activities. They tend to be mature women which gives them obstetric credence. They also could function quite capably in the other child survival key intervention areas. Although their limited educational level is a constraint for their participation, illiteracy is less of a drawback than is lack of community acceptance because of young age. In many communities throughout Latin America the youth of the promoter limits acceptance.

The Project could also consider some other indigenous practitioners as candidates to be used at the community level: for example, those persons who provide treatment for traumatic disorders (such as wounds, fractured bones, and venomous bites from scorpions and spiders) as well as common illnesses. These practitioners employ a variety of techniques including physical manipulation and herbal remedies. Others may also intervene to cure benign forms of supernatural-based (psychosomatic) disorders such as "mal-de-ojo" (evil eye). Generally it is respected women in the community who function as curers of evil eye. These women could also be considered for inclusion in Project implementation.

There are traditional healers who practice methods which might be harmful to the patient, such as withholding fluids during diarrhea. In many communities these practitioners may have the confidence of the community to which they have been providing curative services for years, therefore, they should not be discounted. However, offsetting these harmful practices will require an active educational effort, complete with trainers and promotional material that can reduce the influence of negative beliefs at the community level. Because health promoter activities will be selected in part by community consensus, it can be expected that the specific Project interventions at the local level should avoid major obstacles to credibility and acceptance.

Male health promoters should be significantly involved in health at the community level. One way in which the specific site implementations could function is to create teams that are paired by gender -- a male promoter and a female promoter. In this manner, the male promoter could concentrate heavily on the male segment of the adult population, promoting male responsibility in birth spacing through male contraception techniques. The male promoter could sell condoms at subsidized price and promote vasectomy as a desirable technique among optimum candidate fathers (those already having two or more children). Another area men promoters could have a significant impact is in the organization of water system development and community sanitation measures, such as waste disposal. Acceptance levels for these categories should develop to a high degree.

Trainers and Training. The reliance on community health trainers from the participating PVOs will enhance the relationship between the CHPs and the PVOs. In the Project design, the chain of training is optimal: one community health trainer for 10 CHPs. In this manner, the CHP should have frequent contact and supervision by the trainers, and informational flow from the community to the PVO and back again should be quite smooth. Where possible, the CHTs should live in the region where the project communities are located.

The chain of information flow from the promoters and trainers on the PVO level is completed by the three community health specialists (CHS) based in the Coordinating Organization who have a functioning ratio of 1 : 12.

Use of Medical Resources and Professionals. The Project envisions a health care delivery system that is not exclusively preventive in focus, but has a curative component to it as well. Curative interventions are more costly than preventive care. However, these interventions are badly needed in some areas of the country. Furthermore, the availability of curative services in previously under-served communities provides health promoters with a referral site. It also lends credence to the Project and will stimulate motivation to participate. In other words, the sociocultural feasibility of the preventive health dimension can be greatly furthered by instituting appropriate levels of curative service.

To strengthen the coverage of the Project, it would appear logical to rely on local professional resources, that is, physicians (and nurses) who practice in the community to be served or in its vicinity. Physicians sometimes have poor reputations locally. A careful screening should be done to assess the risk of incorporating them into the Project. In some cases they may function very effectively in the community and enjoy excellent relations with members of the local population; in these cases, it will be advisable to rely on already practicing medical personnel.

E. Institutional Strengthening of Private Voluntary Organizations

The Project has the dual purpose of providing health care to the at-risk population described above and developing institutional strengths among the PVOs that will participate in the Project. This section will detail some of the dimensions related to the sociocultural feasibility of institutional strengthening.

Approximately 35 PVOs will participate in the Project. This number was determined after analyzing the 1990 MARCABLE Consultants' report on PVOs that are working in health care and by interviews held with approximately a dozen PVOs during the Project Design. The range of capabilities and experiences of the PVOs varies widely. There are particular strengths that specific PVOs have developed and some of them bring with them experience garnered in other parts of the world.

The Project will enhance the capabilities of PVOs by providing them with commodities and training support, vehicles, some computers, office equipment, instructional aids, and some limited financial support. Donated vehicles will increase mobility of personnel and materials and make each individual PVO's program function more effectively. The computers that will be purchased for the more technically capable PVO's should facilitate information flow and allow a more efficient processing of services. The same can be said of office equipment that will be purchased through the Project.

Both the training and commodities provided to the PVOs will stimulate a strong esprit de corps among the participating PVOs and the Coordinating Organization. The basic guidelines for community health care delivery and participation outlined in this Project Design combined with the necessary adjustments that the individual PVOs will bring to it should assure success.

F. Coordination among Involved PVOs, the Coordinating Organization of the Project, the Ministry of Health, and other projects.

One of the key areas of the Project is to coordinate the actions of the various PVOs involved. With the Coordinating Organization providing guidance, the particular strengths of each participating PVO can readily be utilized. When the strong and weak areas of each PVO are identified, the Coordinating Organization will play the role of information facilitator, ensuring that a cross-fertilization of ideas takes place through various forums, including formal conferences and through printed dissemination of materials. It can be predicted that as the Project develops, adjustments of the basic health care delivery model will be set in motion, as each PVO continues with its own programs and enhances the model with new ideas and technologies. In a sense, pilot sub-models will be developed within the structure of the model, and through operations research, information about the merits of the different models can be channeled, generated, and shared with other participating PVOs.

As mentioned earlier, the Coordinating Organization will play a guidance role. The role will not be overly strong, nor should it be. PVOs enjoy their relative autonomy, and too strong a leadership role on the part of the Coordinating Organization may create resentments that would contribute to the dissolution of the institutional arrangement.

Three coordinating PVO bodies pool information in the area of community-based health care and child survival. One of these is the Inter-Sectoral Committee for Child Survival (CISI). This agency is made up of 39 institutions which are mainly PVOs, but also includes four universities and the MOH, which established the committee to coordinate the diverse activities of PVOs working in the area of health. CISI has expressed strong interest in continuing its role as coordinator of activities in the area of child survival strategies. A possible arrangement could be that the Coordinating Organization would support CISI in maintaining a leadership role in the domain of information gathering and dissemination. CISI would sponsor seminars, and act as a conduit for informational materials that are developed during the

course of the Project. The feasibility of carrying out this relationship in an ideal form is quite promising; nevertheless, a good measure of diplomacy and tact on the part of the Coordinating Organization will be a factor in its achievement.

The MOH relationship with PVOs is mostly on an informal and regional basis. The MOH is a large institution and plays a role of sizeable magnitude in the delivery of health care to maternal and child populations. The very fact that it established CISI attests to its willingness to work with PVOs and assures its desire to see the PVOs assume a larger role in the provision of health care. The MOH, especially through its Office of International Cooperation, can play a dynamic and productive role in the Project.

In order to promote a democratic forum for policy and strategy formation, the Project has built an Advisory Committee into its design. The Advisory Committee will be composed of representatives from the Coordinating Organization, USAID/ES, CISI, the MOH, and some participating PVOs. The Project also includes strong training and informational components that will create a climate for the dynamic flow of ideas and creativity. The ombudsman role of the Coordinating Organization will provide a firm advocacy for the Project to fix its sights on the goals established and help guide policy design and specific strategies. In sum, the sociocultural feasibility of the Project is secure through its various authority and decision making levels. The participatory nature of the Project, with its goals, strategies, structure, and process firmly rooted in a proven health care delivery model consistent with features of various levels of Salvadoran social organization, extending from professional medical circles in the capital city to the marginal poor in urban and rural settlements.

G. Spread Effects of the PVO/MHCS Project

There are a number of indicators that will measure the impact the Project will have on the communities in which it will be working. These, of course, are standard measurements of fertility, morbidity, and mortality. However, there are a number of areas that are not so tangibly measured. This Project has a strong educational focus and, as is the case for most educational projects, the outcomes are not always easily demonstrated. However, the potential development of human capital resources is considerable.

Perhaps most important is consideration of the development potential of the communities themselves. The Project will assist PVOs to organize and train rural health promoters who will serve a population catchment area of an estimated 350,000 persons. In addition to these Community Health Promoters, the Project will also involve and train groups of community members who will serve on community self-help committees in the areas of health, environmental sanitation, and water. A community organization, buttressed by a strong training component working toward the general well-being of the population, can become a factor that will extend far beyond the boundaries of the community itself. A multiplier effect will develop, and the involved PVOs

themselves certainly are not restricted to working in the communities that will be on the Project's roster for seven years. The PVOs, which already have a proven track record of success and longevity in El Salvador, will continue after the Project is completed, and they will continue to engage in activities of volunteerism and promote self-determination among their constituent communities. Thus spread effects will continue over the life of Project and after the Project ends.

The MOH should also gain by its participation in this Project. Models will be developed out of specific activities of the Maternal Health-Child Survival Project that may be considered for incorporation into MOH programs. Although the MOH has an ongoing health promoter program, the Project model brings delivery to an even more basic grass-roots level. The models that will develop out of the participation of a multitude of PVO experiences with this project will create a bank of methodologies that can be drawn upon by the MOH.

If the Project is successful in achieving its goals, it is not too immodest to foresee that the experience of the Project will be of interest to the public health community throughout the region.

H. Social Consequences and Benefit Incidence

Assuming that the 1990s will bring a reduction in hostilities and economic expansion in El Salvador, a growing participatory role in community development strategies will contribute to the general development of the Salvadoran economy and society. However, if the war continues, the net benefits of projects such as this one will be minimized. In the charged climate of war, community organization and participation can be perceived as threatening, and the security of individuals and organizations may be at stake.

Barring this negative scenario and assuming that the political and economic climate improves, the Project will increase opportunities for communities. General health conditions will improve and communities will become better organized and more likely to take an active role in improving other areas of their lives. Principles of self-determination will be strengthened through this Project, and communities will begin to actively seek greater participation in the benefits of growth.

Another category of traditional practitioner includes those who practice almost exclusively in the realm of the supernatural. They are variously known as witches, wizards, spiritists, or spiritualists. While to a sophisticated society, resorting to this type of medical service may seem backward; it should be recognized that even in more developed societies, people are drawn to the supernatural, as evidenced by the popularity of evangelists, palmists, astrologers etc. in our own society. There are a number of less common disorders that often are taken to practitioners of this type; some of these include cases of magical fright, or "susto," or more overtly categorized "witchcraft." The structures of beliefs and practices surrounding these types of illnesses is highly complex. It consists of a deep structure of belief with roots in pre-Colombian native society, overlays of Medieval Catholicism, and contemporary Protestantism. These practitioners should not be considered as promoters during the implementation of this Project.

ANNEX G

INSTITUTIONAL ANALYSIS

1. Introduction

The goal of the Maternal Health and Child Survival (MHCS) Project is to improve the health status of the Salvadoran rural and marginal urban population. The Project purpose is to expand community based maternal health and child survival services to those areas of El Salvador where these services are weak or nonexistent. This analysis assesses the technical, administrative, logistical, financial, and personnel capabilities and needs of private voluntary organizations working in health in El Salvador in order to determine if PVOs are a viable mechanism to achieve the Project goal and purpose.

2. Overview of Private Voluntary Organizations

Perhaps as many as 90 private voluntary organizations currently work in some capacity in the health sector in El Salvador. They vary widely in size and organizational focus - religious, relief, development, social service, as well as organizational structure, geographic service areas, years of in-country service, management capabilities, and other characteristics. While they have significant differences in organizational capabilities and needs, by and large they have shown great resourcefulness and creativity in delivering curative and preventive health care with limited human, financial, and material resources.

A recent study (MARCABLE, 1990) of health sector PVOs in El Salvador used the following seven criteria to determine what type of organization would be most suitable for participation in the Maternal Health and Child Survival Project. Following are basic criteria listed in the study:

- * At least five years of in-country health experience;
- * A strong interest in maternal health and child survival activities;
- * Strong human resource base;
- * Well established financial controls;
- * Agency capacity to generate resources for the continuation of maternal health and child survival activities;
- * A strong interest in participating in the Maternal Health and Child Survival Project; and
- * A strong absorptive capacity.

Based on the above criteria, only 23% of PVOs responding to the survey were classified as primary candidates for Project participation, with another 51% considered secondary candidates. However, four out of five agencies expressed considerable interest in increasing maternal health and child survival activities and three-quarters expressed interest in obtaining assistance from USAID. Moreover, two-thirds of responding PVOs were qualified as having a high absorptive capacity, as determined by population coverage with available resources.

Few PVOs in El Salvador are involved only in development activities. The MARCABLE study indicates that only 26% are engaged predominantly or exclusively in development activities, while 38% are involved in relief, social, or religious activities, and the remaining 36% can be described as mixed relief/development organizations. In fact, 45% have an affiliation with a religious group of some kind, but the great majority of these offer health care to the general public and do not limit services to members of a specific church. Twenty-eight percent serve only a limited and clearly defined target population, such as orphans, the physically or mentally handicapped, cerebral palsy victims, cancer patients, accident/disaster victims, rural women, or other groups. Some PVOs, such as the Knights of Malta, serve principally in procuring commodities for other institutions.

4. PVO Technical Capabilities

PVOs in El Salvador have mixed technical capabilities in the areas of community development and maternal-child health. On the positive side, they have a unique capability to provide health services at the community level because they are recognized as part of the private sector and are able to reach communities that are unserved or underserved by the public sector. They are innovative and effective in encouraging community participation, due in large part to their knowledge of and sensitivity to local needs and priorities and sensitive to sociocultural obstacles to providing health services at the community level. PVOs have served in El Salvador for small scale and pilot testing of new primary care concepts and techniques. They have the advantage of being able to observe results directly and incorporate necessary technical modifications quickly and easily. Perhaps most important of all, in El Salvador PVOs are able to work in areas of conflict which are difficult for government personnel to reach on a regular basis.

The wide range of technical services provided by private voluntary organizations in El Salvador is also an asset. Of the PVOs surveyed in the MARCABLE study, 60% have clinical facilities, trained medical staff, and clinical services related to some aspect of maternal-child health and 35% are involved in maternal-child health through preventive or community development activities. However, 80% of PVOs surveyed are interested in initiating or increasing maternal health and child survival activities. The extent of community development activities differs greatly from one organization to another. Some PVOs work in a small number of communities but include a wide range of programmatic areas, such as water, health

education, housing, income generation, and agriculture. Others provide a more limited range of services but over a larger geographical area.

Technical weaknesses of PVOs include insufficient technical support for programs. At times service delivery is favored over necessary technical analyses. Inadequate attention to information monitoring and reporting systems often results in failure to collect data needed to monitor program progress and impact. A lack of attention to the importance of program evaluation can mean inadequate or nonexistent baseline data. Due to weak coordination with other PVOs and governmental agencies, PVOs do not always have significant information exchange or even an effective working relationship with fellow agencies. Consequently, services and activities are at times duplicative and overlapping.

5. Administrative and Logistical Capabilities

The administrative and logistical functioning of many PVOs in El Salvador depends largely on a small number of administrators and leaders who tend to maintain systems mentally. Often actions are taken on an ad hoc basis and administrative and logistical systems are informal. When policies, procedures, and systems are formalized in written manuals, manuals are frequently not kept up to date and staff may not bother to reference them when needed. Systems and procedures for identifying commodity needs, selection, procurement, warehousing, inventory and distribution are weak or nonexistent. When an administrator or leader leaves a PVO, his or her successor must often start from scratch, precisely because policies and procedures are unwritten and informal.

Transportation, warehousing, and procurement systems in particular are weak areas for many PVOs. 38% have no vehicles at all and another 14% provided no information on this point for the MARCABLE study. Many PVOs that do have transportation report ten or even twenty-year-old vehicles. Only 8% report owning or using a separate building as a warehouse, while the large majority store drugs, medical supplies, and equipment at offices, clinics, and pharmacies. Only 18% have a formal procurement system, with most organizations making purchases on an as needed basis.

On the other hand, private voluntary organizations in El Salvador typically use management systems that are well adapted to local conditions and which can easily be modified. They are able to identify administrative and logistical problems before they become overwhelming and can move quickly to institute the necessary changes in a relatively cost effective and efficient manner. PVOs tend to have imaginative, hard working staff free of crushing organizational bureaucracy and are often flexible and open to operational improvements.

6. Financial Management

PVO financial management systems and practices in El Salvador are more formalized than administrative and logistical systems, but areas for improvement are evident. Three-quarters of all PVOs use some kind of accounting system, although only 34% have a complete financial management operation, including a formal accounting system, budget, and internal and/or external audits. Only 18% report formal monitoring and evaluation systems, and these systems in most organizations are weak or nonexistent in fact.

Private voluntary organizations in El Salvador have a proven track record of providing maternal health and child survival services which are less expensive than for profit firms, and can often be financially sustained once outside funding is terminated. When financial sustainability is achieved, it is typically due to PVO success in obtaining in-kind contributions, achieving active community participation, establishing user fees for services, and charging for drugs and medical supplies at cost. Two-thirds of PVOs included in the MARCABLE study were characterized as having a high absorptive capacity, as determined by population coverage with available financial resources.

7. Human Resources

Salvadoran private voluntary organizations are known for their dedicated personnel. PVO staff members often risk their lives in carrying out their duties, especially in areas and times of heightened conflict. During the November, 1989 offensive, ambulances and personnel from the Salvadoran Red Cross, Green Cross, and other PVOs entered areas inaccessible to government personnel, administered first aid, and rushed victims to clinics and hospitals. In a less dramatic manner but no less important, PVO personnel daily serve rural, isolated, and otherwise abandoned populations outside the net of government services.

Many PVOs interviewed both during the MARCABLE study and the Project design phase indicate a desire, and even enthusiasm, for program expansion and diversification in maternal health, child survival, and community development. However, there is a clear consensus among PVOs that program expansion and diversification will not be possible without additional staff. PVOs rely to a large degree on volunteers and in many cases these volunteers work at all organizational levels, from the community to the central or headquarters level. The salaried personnel who supervise these volunteers receive relatively low wages and are fully occupied with current work loads. Expecting supervisors whose span of control is already too wide to further stretch their supervisory range is not realistic.

8. PVO Needs

The needs which private voluntary organizations in El Salvador have to effectively carry out program improvement, expansion, and diversification are many and diverse, but fall into four broad categories: technical assistance, training, commodities, and personnel.

Technical assistance and training are perhaps the two most crucial PVO needs. As is evident from the above sections, there is an urgent need for T.A. and training of PVO personnel in the technical, administrative, logistical, and financial areas. On the one hand, well established organizations experienced in community health need only financial assistance and commodity support to expand into new geographical high risk areas. These organizations have adequate administrative and logistical systems, a sound grasp of primary health care, and understand the importance of generating community involvement, in addition to understanding the medical-technical issues and challenges involved in community health. They have little or no need for training in the concepts and philosophy of maternal health and child survival.

On the other hand, there are many more organizations in El Salvador which require not only financial aid and commodities for program expansion, but also intensive and sustained technical assistance and training. PVOs whose philosophy centers around relief and curative medical services cannot be expected to substantially modify their organizational identity. However, they must be willing to expand and add to activities so that primary health care, including genuine community participation, can be encompassed in their new range of activities. The innovative and imaginative use of technical assistance and training in the areas of maternal health and child survival will be critical in convincing curative, relief-oriented organizations to venture into maternal-child health activities. This technical assistance and training is one of the most vital PVO needs for successful program expansion and diversification.

Technical assistance and training in the areas of administration, financial management, and logistics are also important. Administrative and logistical systems are weak in many PVOs and need strengthening to ensure maximum program efficacy and impact. PVO financial systems tend to be better developed but also need strengthening.

PVO commodity needs for program expansion include vehicles; medical supplies, equipment, and pharmaceuticals; office supplies, furniture, and equipment; educational materials and supplies; and water and sanitation equipment. Personnel needs vary from organization to organization but include administrative personnel, community health trainers, medical personnel, and staff experienced in community development and organization.

9. Conclusions

There are as many as 90 health sector PVOs currently working in El Salvador. They vary widely in size, organizational focus, organizational structure, geographic service area, years of health experience, and management capabilities, but generally they deliver a wide range of services with limited resources. They have mixed technical capabilities, demonstrating weaknesses in technical support for programs and coordination with other agencies and significant strengths in community development and organization. Administrative and logistical systems are weak; financial management practices are better established but evidence areas for improvement as well.

Private voluntary organizations in El Salvador have a proven record of providing maternal health and child survival services in a cost effective manner, due in large part to their success in obtaining in-kind contributions, achieving active community participation, establishing service fees, and charging for drugs and supplies at cost. Salvadoran PVOs are known for their dedicated personnel and are able to reach otherwise abandoned populations outside the net of government services. However, administrators are fully occupied with current work loads; expecting them to further stretch their supervisory range is unrealistic.

Despite technical, administrative, logistical, and financial management weaknesses, overall private voluntary organizations in El Salvador have great potential for program diversification and expansion in maternal-child health. PVOs are a viable means to achieve the Project goal and purpose, as is demonstrated by the fact that they are already providing a wide range of curative and preventive health services in a cost effective manner in all health regions of the country. With institutional strengthening made possible by technical assistance, training, commodity aid, and short-term personnel from the Maternal Health and Child Survival Project, PVOs will be able to further extend community based maternal-child health services in El Salvador.

ANNEX H

PROJECT MANAGEMENT

1. Introduction

The mode of Project assistance will be a cooperative agreement between the Government of the United States, represented by USAID/El Salvador, and the Coordinating Organization. The \$25 million development assistance grant will be obligated incrementally over a seven year period. Project assistance provided through the Coordinating Organization will include technical assistance, training, commodities, and limited support costs to private voluntary organizations (PVOs) by means of sub-agreements.

The purpose of the assistance provided to PVOs is to foster the institutional development of the PVOs themselves and to strengthen, expand, and diversify their maternal health and child survival services and thereby contribute to the Project purpose of expanding community based maternal-child services to areas where these services are weak or nonexistent.

2. Role of Participating Agencies

Coordinating Organization: One of the most important functions of the Coordinating Organization will be to act as a development resource and management unit for private voluntary organizations. It will be a place where PVOs can bring their ideas and obtain assistance in translating them into sound proposals suitable for funding. The Coordinating Organization will assist PVOs in identifying their technical assistance and training needs in areas such as: project planning and development, financial management, management information systems, technical interventions, logistics, monitoring and evaluation, and other areas identified by PVOs.

In the first six months of Project implementation, the Coordinating Organization will identify at least eight PVOs as initial candidates for Project assistance. This identification will be accomplished by visiting PVOs, interviewing their personnel, and interviewing community members served by their programs. In order to receive assistance from the Project, PVO's will generally be required to meet the following eligibility criteria:

- a) Meet financial management and accounting requirements detailed in Annex J, Financial Annex (the Coordinating Organization will conduct pre-award assessments to determine and certify that the PVO meets certain minimum requirements for financial accountability;
- b) Organizations may be of any religion or creed, but must be nonsectarian and apolitical in the provision of maternal health and child survival services;
- c) Larger organizations must have a history of acceptable financial

accountability in their operations, or, if problems of funds accountability have been experienced in the past, demonstrate that appropriate steps have been taken to rectify these problems; and

- d) PVOs must have at least two years of health experience in El Salvador, or, lacking this experience, demonstrate adequate organizational capability to effectively and efficiently utilize Project assistance and have adequate staff trained in the delivery of health services.

The need for and conceptualization of PVO projects generally is expected to originate with interested PVOs. After meeting with PVOs and exploring their ideas, needs, and priorities, staff of the Coordinating Organization will continue to work with the organizations, when necessary, in project development. A Project Advisory Committee will be formed in order to facilitate coordination and collaboration among the Project, PVOs, other key USAID projects, and the MOH. This Committee will consist of the USAID Project Manager for this Project, a representative of the Coordinating Agency, a representative from the MOH's Office of International Coordination, the Project Managers of each of the three USAID health projects, and a CISI representative (and the other two PVO coordinating committees if appropriate). The principal task of this Committee will be to advise the Coordinating Organization on project implementation. One of the principal tasks of this committee will be to review proposals for sub-grants and make recommendations for final approval. In the event that the recommendation by the PAC is not unanimous, approval will be required by the A.I.D. Director or his designee. PVOs whose proposals are not approved may request technical assistance from the Coordinating Organization in improving and strengthening proposals and may then re-submit them for consideration by the Project Advisory Committee.

The Coordinating Organization and the Project Advisory Committee will evaluate PVO proposals to assure that the projects:

- a) Require minimal or no funding of recurrent program costs;
- b) Support activities which fall within the range of maternal health and child survival interventions outlined in Category I of the Project Paper;
- c) Include mechanisms which maximize community engagement in the planning, implementation, and evaluation of program activities;
- d) Involve the extending of services to priority geographical areas (rural and peri-urban areas now unserved or underserved);
- e) Include provisions supporting partial or total program sustainability;
- f) Include at least a 25% cash and/or in-kind match on the part of the organization seeking assistance;
- g) Demonstrate an understanding of the maternal health and child survival needs of target populations, especially those which address the most prevalent and serious health problems of the most vulnerable groups; and
- h) Consider the issues of severity (severe and/or compelling needs), magnitude (how many Salvadorans will benefit), and impact (the degree to which a need will be met).

After A.I.D. approval of PVO proposals, sub-agreements (SAs) will be developed between individual PVOs and the Coordinating Organization. SAs will be used throughout the Project as the formal and legal link between participating PVOs and the Coordinating Organization. SAs will include PVO project proposals as annexes and specify the technical assistance, training, support costs, pharmaceuticals, medical supplies and equipment, vehicles, and other commodities to be provided. The value of technical assistance, training, commodities, and support costs granted to a PVO is expected to range between U.S.\$1,000 and U.S.\$100,000, although smaller or larger requests will be considered on a case by case basis.

PVO sub-agreements will have a minimum duration of one year and a maximum of five years. Technical assistance and training will be provided as needed throughout the SA period. Although sub-agreements may provide for multi-year objectives and financial support (up to the five-year limit), Project resources will be sub-obligated on a year by year basis, however, disbursements will be on a periodic basis and contingent upon, proper liquidation of outstanding project resources and receipt and approval of annual PVO implementation plans and illustrative budgets. Coordinating Organization personnel will aid PVO staff as required in the preparation of annual plans and budgets. The SA instrument will be developed in the first three months of Project implementation. Inasmuch as it will serve as a legal instrument, appropriate legal counsel will be obtained both with its initial development and at the time of any subsequent revisions.

In order to fulfill its role, the Coordinating Organization will receive Project support for staff both in the United States and in El Salvador. The staff of the Coordinating Organization in El Salvador will include at least two expatriates: the Project Director and the Project Administrator. The Project Director will function as Chief of Party and have overall responsibility for Project implementation. He/she will chair the Project Advisory Committee and will serve as the principal liaison between the coordinating agency, participating PVO's, USAID/ES, and the GOES. He/she will be responsible for setting Project policy and ensuring that Project activities conform to GOES and USAID health policy and strategy.

The Project Administrator will have overall responsibility for management information systems (financial and programmatic), commodity procurement, and logistics, including warehousing, inventory systems, distribution, and transportation. He/she will report to the Project Director and serve as Executive Secretary of the Project Advisory Committee. The Project Administrator will also serve as Acting Chief of Party in the absence of the Project Director. Detailed job descriptions for the Project Director and Project Administrator are included at the end of this annex.

Whenever possible, the Coordinating Organization will make full use of in-country resources, including participating PVOs, to conduct needs assessments, training courses, evaluations, and selected technical assistance to fellow PVOs. The Coordinating Organization will procure these services

through local contracts. In the first few months of implementation, the Project Director will conduct a thorough review of required personnel services. Based on this review, he or she will make the recommendations concerning the final configuration of core staff for the Coordinating Organization and their corresponding job descriptions. It is expected that the Coordinating Organization's long term core positions in El Salvador might include the following: a Procurement/Logistics Officer, a Training Coordinator, Community Health Specialists, a Water-sanitation Engineer, a computer programmer, and support staff. One quarter of the costs of the HPN/US/PSC Procurement Specialist and the cost of a bilingual secretary in the USAID/ES Office of Health, Population and Nutrition will be paid by the Project. The HPN/US/PSC will allot 25% of his time to Project procurements.

The Coordinating Organization's U.S. core support staff will probably include:

- * 1/2 Time Procurement Specialist
- * 1/2 Time Secretary/Administrative Assistant;
- * 1/4 Time Project Manager;
- * 1/12 Time Financial Analyst/Accountant

In addition, the Coordinating Organization may need to engage select short-term assistance from either its own core staff or from outside the organization on an as-needed basis. The Coordinating Organization's U.S. Project support will also include site visits, seminars and conference attendance in the U.S. for PVO staff from El Salvador.

USAID/El Salvador: The USAID Mission will oversee all Project activities through close coordination with the Coordinating Organization and the Project Advisory Committee. Primary USAID responsibility for project management will rest with the USAID/ES Project Manager. The USAID Project Manager will report to the Chief of the Health, Population, and Nutrition Office, or his designate. The USAID/ES Procurement Specialist in HPN will assist with commodity procurements as described below.

The role of the USAID Mission will include standard oversight and project management responsibilities. These functions will include, but not be limited to:

- * oversight of all the activities of the Coordinating Organization;
- * coordination of Project activities with other Mission health projects, specifically the Family Health Services Project, the Public Services Improvement Project, and the Health Systems Support Project;
- * participation in field visits to PVO implementation sites, at Mission discretion;

- * review of PVO and Coordinating Organization narrative reports, statistical reports, and financial statements;
- * participation in meetings of the Project Advisory Committee; providing final approval of PVO proposals and guidance on their overall geographical distribution, philosophical and service focus and technical methods mix;
- * review of the results of internal and external audits of PVO projects and the Coordinating Organization;
- * review of the results of technical evaluations of PVO projects;
- * participation in annual PVO conferences and periodic training seminars;
- * approval of all U.S. and third country advisors and consultants and issuance of necessary clearance cables; and
- * oversight and participation in mid-term and final evaluations of the Maternal Health and Child Survival Project.

Project Advisory Committee: The Project Advisory Committee (PAC) will provide general guidance to the Coordinating Organization on overall Project implementation, policy, and direction. Members of the PAC will include representatives of the MOH Office of International Cooperation, the Inter-Sectoral Committee for Child Survival, several local PVOs, and possibly a representative from the Coordinating Council for Private Institutions in Human Promotion in El Salvador (CIPHES). The Project Director and Project Administrator of the Coordinating Organization will be nonvoting members. The Project Administrator will also serve as PAC Executive Secretary. The Project Advisory Committee will hold regular meetings bimonthly and meet on an ad hoc basis to deal with special tasks and problems. A.I.D. will participate at its discretion and provide final approval of all PVO proposals.

The duties of the Project Advisory Committee will be to:

- * provide guidance to the Coordinating Organization and PVOs on Project implementation, policy, and direction;
- * review PVO proposals and provide guidance on their overall geographical distribution and technical aspects mix;
- * review the results of technical evaluations of PVO projects and suggesting program improvements;
- * ensure that PVO proposals are complimentary with A.I.D. policies, and not duplicative of, health projects of USAID/ES and other agencies;

- * work to facilitate maximum possible communication and coordination among PVOs, USAID, other donors, and the Ministry of Health;
- * submit PVO proposals that meet all of the selection criteria to A.I.D. for approval.

PVO Coordinating Groups: At least three PVO coordinating groups are currently working in El Salvador:

- a) The Inter-Sectoral Committee for Child Survival (CISI);
- b) The Coordinating Council for Private Institutions in Human Promotion in El Salvador (CIPHES); and
- c) The Development and Social Promotion Corporation of El Salvador (CODEPROSES).

A CISI representative will be invited to be a member of the Project Advisory Committee (PAC). Once the PAC has been formed, the Coordinating Organization will study the possibility of CIPHES and CODEPROSES membership and make a recommendation to the PAC. The Project Advisory Committee will make the final decision regarding CIPHES and CODEPROSES membership. Whether or not CIPHES and CODEPROSES participate in the Project Advisory Committee, the Coordinating Organization will maintain contact with these two groups in order to facilitate maximum coordination and collaboration among health sector PVOs.

Private Voluntary Organizations: Private voluntary organizations will be the pillar of the Maternal Health and Child Survival Project. It is the PVOs who will conceive, design, and implement maternal health and child survival services and activities. With their active and enthusiastic participation, the Project can meet its outputs, purpose, and goal.

PVOs will be responsible for preliminary elaboration of project proposals. They will also be responsible for involving target communities as much as possible in proposal planning and design. If technical assistance in project development is needed, they will be required to formally request such assistance. Participating PVOs will be required to abide by all applicable USAID policies and regulations.

Each PVO recipient of financial support will be required to open and maintain a separate, non-interest bearing bank account for Project funds and will also be required to submit periodic financial reports to the Coordinating Organization. An illustrative list of line items which PVOs will be required to report on follows:

- a) Salaries
- b) Per diem

- c) Transportation
- d) Local Purchases
 - Medical Equipment
 - Medical Supplies
 - Office Equipment
 - Office Supplies
 - Educational Materials and Supplies
- e) Building Materials (for renovations)
- f) Building Rental (office/warehouse)
- g) Surveys, Evaluations, and Operational Research
- h) Miscellaneous

All participating PVOs will be required to report, on a quarterly basis, statistics on program outputs, i.e., number of patients attended, health talks given, ORS packets distributed, health promoters trained/re-trained, etc. In developing and updating formats for statistical reports, the Coordinating Organization will seek to assure programmatic integrity without placing undue administrative burdens on PVOs. Formats for statistical reports will be prepared within six weeks of Project initiation. The creation of information systems, however, is a dynamic process and is expected to continue beyond its initial design period. Ongoing feedback from field operations throughout Project implementation will allow periodic fine tuning of both financial and programmatic reports.

Ministry of Health: The Ministry of Health will participate in the Project through its Office of International Cooperation. The head of this office will be a voting member of the Project Advisory Committee and as such will have the specified Committee duties:

- * provide guidance to the Coordinating Organization and PVOs on Project implementation, policy, and direction;
- * review PVO proposals and provide guidance on their overall geographical distribution and technical mix;
- * review the results of technical evaluations of PVO projects and make suggestions for program improvements;
- * ensure that PVO proposals are complimentary with, and not duplicative of, health projects of other agencies; and
- * work to facilitate maximum possible communication and coordination among PVOs, the USAID Mission, and the Ministry of Health.

Additional Project related functions may be identified for representatives of the Ministry of Health, depending upon MOH interest in and availability for participation.

3. Financial Management

As the conduit of financial support and commodity aid to PVOs, the Coordinating Organization will have legal and operational responsibility for all assistance provided. Financial forms and systems of the Coordinating Organization's U.S. headquarters will be used and adapted as needed for the financial management and control of its in-country operations. Standard USAID accounting and fiscal management procedures will be followed to ensure compliance with all applicable USAID regulations.

The Coordinating Organization will request periodic advances from the Mission and will in turn provide TA, training, commodities and some limited operational funds to participating PVOs in strict accordance with the terms of signed sub-agreements (SAs). All SAs will be supported by proposals formally reviewed by the Project Advisory Committee and approved by A.I.D. Although SAs will allow for up to five years of financial support, actual financial grants will be disbursed on a periodic basis and contingent on a pre-award assessment and certification of adequate financial controls. Commodity donations will also be provided on a periodic basis and all Project assistance will be contingent upon the Coordinating Organization's receipt and approval of annual PVO implementation plans and budgets, quarterly status reports and periodic financial and Project resource liquidation reports. Project funds will be maintained by the Coordinating Organization in a central account and each PVO will be required to maintain a separate account for funds received. PVOs will also be required to submit financial reports, as described above. Periodic site visits and annual audits of participating PVOs will be conducted by the Coordinating Organization to assure programmatic and fiscal integrity.

With respect to the financial management of PVOs, the Coordinating Organization's guiding principle will be assuring fiscal integrity without becoming onerous or burdensome to the participating organizations. For this reason, PVO financial systems and reports required by the Project, while adequate enough to ensure proper accountability, will be kept uncomplicated. For the smaller PVOs, a simple accounting system capable of identifying and controlling variances between planned and actual revenues and disbursements will be designed with the USAID Controller's review and concurrence. A financial reporting format will also be designed for use by the participating PVOs by the Coordinating Organization with the concurrence of the USAID Controller.

Technical assistance and training will be provided to ensure that PVOs have adequate monitoring and accounting systems. It is planned that an external audit will be carried out on each PVO approximately one year after it begins participation in the Project.

The results of the MARCABLE survey and information obtained in interviews with several PVOs during Project design indicate that many prospective participants are currently operating at a relatively

unsophisticated level. Therefore, the ability of each PVO to absorb and effectively use Project resources will be carefully examined prior to approval of individual proposals.

Financial data will be made available to USAID on an ongoing basis for inclusion in the Mission Accounting and Control System. Programmatic data will be submitted to the USAID Project Officer on a quarterly basis, with special attention paid to submitting this data on a timely basis for inclusion in USAID Semi-annual Reports. All Coordinating Organization records and books will be available for review by the USAID Mission at any time.

The Coordinating Organization will maintain a data base of financial and program data for all participating PVOs. Reports will be available by PVO, by department, by health region, and nationwide.

4. Commodity Procurement

Commodity procurements will be carried out by the Coordinating Organization. Only items which require USFDA quality assurance and must be purchased through AID/W (pharmaceuticals, contraceptives, and oral rehydration salts) will be done through Mission PIO/Cs and purchase orders. However, the possibility of in-country procurement of pharmaceuticals with local currency funds will be explored in the early months of Project implementation in order to determine how drugs can be purchased most economically and better prepare the participating PVOs to continue a sustainable flow of medicines after the end of this Project. The possibility of obtaining appropriate pharmaceutical donations will also be explored.

The Project Administrator will be responsible for overseeing commodity procurement and will establish and oversee a comprehensive Project Procurements System. He/she will also be assisted by the USAID/ES Procurements Specialist in HPN in the design of the procurements system, and a Procurement Specialist in the U.S. Office of the Coordinating Organization who will work fifty percent of his/her time on procurement for this Project.

The procurement process will begin with a determination of requirements, but in the first few months of Project start up this determination will be difficult due to two significant unknowns: the number of PVOs that will actually participate in the Project and the precise amount of drugs, equipment, materials, and supplies which they will require. Therefore, one of the Administrative Officer's first tasks will be to draft a basic drug list, in consultation with PVO medical personnel and using MOH basic drug lists as a starting point. It is anticipated that approximately 30 basic pharmaceuticals will be procured for PVO use. Similarly, basic lists for equipment, materials, and supplies will be prepared in order to give interested PVOs a frame of reference in preparing requests. These basic lists will be refined as more PVOs come into the Project and as the PVOs themselves become more experienced in preparing their commodity requests.

After the first six months of Project implementation it is anticipated that commodity needs will be better known. The Coordinating Organization's central warehouse will then be stocked with an extra supply of sensitive items in order to minimize the possibility of stock outs.

In the first few years of Project implementation, the Coordinating Organization will of necessity use U.S. Embassy duty-free import privileges. The Coordinating Organization is not expected to have duty-free privileges for at least two to three years. Obtaining these privileges will require three steps:

- a) The establishment of the Coordinating Organization as a nonprofit entity in El Salvador, with officers and written organizational by laws and constitution;
- b) The legalization (personeria juridica) of the Coordinating Organization in El Salvador; and
- c) The processing and approval of duty-free privileges (franquicia) for the Coordinating Organization.

The necessity and feasibility of obtaining duty-free import privileges for the Coordinating Organization will be studied in the first three months of Project implementation.

U.S. commodity procurement by the Coordinating Organization will involve the following steps:

- a) The Administrative Officer will, in coordination with the US/PSC in the USAID Office of Health, Population and Nutrition prepare a commodities procurement list; the procurement list will include commodity descriptions, amounts, costs, specifications, catalogue numbers, and all other relevant information;
- b) The procurement list will be reviewed by the Project Director and approved by the USAID/ES Project Officer;
- c) Following all applicable USAID and USG regulations and procedures, the Coordinating Organization will procure commodities and have them consigned to the USAID Mission;
- d) Upon arrival of commodities in country, the Coordinating Organization will submit necessary documentation for Mission review and approval;
- e) The USAID Mission will review documentation and forward to the Shipping and Customs Office in the U.S. Embassy for customs clearance; and
- f) After customs clearance, the Coordinating Organization will oversee commodity storage, inventory, and distribution to PVOs.

For items purchased through the USAID Mission, the Administrative Officer will, in collaboration with the HPN/US/PSC, prepare complete procurement lists which will include commodity descriptions, amounts, costs, specifications, catalogue numbers, and other relevant information. Procurement lists will require little or no modification by the USAID/ES Procurements Specialist, who will be responsible for reviewing the lists, preparing PIO/C cover sheets, and tracking necessary documentation within the Mission.

Local procurements by PVOs will be limited. PVO staff lack experience with USAID procurement regulations and at times demonstrate weak planning and selection skills. PVO purchases will therefore be limited to local shelf items such as office supplies, educational materials and supplies, and limited medical supplies and equipment.

5. Project Logistics

Two types of administrative services will be contracted by the Coordinating Organization: 1) moving services for commodity transfer from the international airport to San Salvador; and 2) security services to safeguard the Coordinating Organization's office and warehouse. All commodities will be consigned to USAID/El Salvador in order to avoid any problems with using U.S. Embassy duty-free import. When products arrive in country, the Coordinating Organization's Administrative Officer will be alerted and will be responsible for tracking customs retrieval and overseeing commodity transfer to San Salvador.

The Coordinating Organization will rent an office and central warehouse. If feasible, the warehouse will be procured through a lease-buy arrangement and donated to the Ministry of Health upon Project termination. The central warehouse will be nearby or adjacent to the office, if possible, thereby facilitating supervision and reducing security expenses. All orders will be inventoried for completeness and corrective actions taken when necessary. All warehouse storage bins and boxes will have labels indicating the contents and, when applicable, expiration dates. Commodities with expiration dates will be distributed strictly on a first-in, first-out basis. Cold room facilities will be available at the central warehouse.

A computerized warehouse and inventory control system will be developed by the Administrative Officer in the first six months of Project implementation. Information on the distribution to PVOs of pharmaceuticals, equipment, materials, and supplies will be entered into this central system. The inventory system is expected to record commercial name, generic name in Spanish, amount, preparation, cost, lot number, and expiration date for all pharmaceutical lots received. Site visits to PVOs by the Project Administrator will include verification of computerized commodity distribution lists with actual commodities received.

Since vehicles will be one of the major commodity items provided to

PVOs, no formal commodity distribution system to PVO implementation sites is contemplated under the Project. PVOs will be expected to pick up commodities at the central warehouse, even those with offices in outlying departments. However, the Coordinating Organization will actively encourage organizations to pool transportation and distribution efforts whenever possible. Special arrangements will be made for distribution of vehicles and unusually large or bulky items, such as water and sanitation equipment and materials.

Project Director - General Description of Duties

The Project Director will function as Chief of Party and have overall responsibility for Project implementation. He/she will chair the Project Advisory Committee and will serve as the principal liaison between the coordinating agency, participating PVOs, USAID/ES, and the GOES. He/she will be responsible for overseeing the implementation of general policy established by the Project Advisory Committee and ensuring that Project activities conform to GOES and USAID health policy and strategy.

Specific Tasks

1. Chair the Project Advisory Committee, overseeing the implementation of general policy established by the Committee, and developing specific Project implementation guidelines.
2. Supervise the Project Administrator and all employees of the Coordinating Organization.
3. Liaise with private voluntary organizations, PVO coordinating groups (CISI, CIPHES), USAID/ES, the Coordinating Organization's U.S. headquarters, international donors, the Ministry of Health, and other GOES agencies; keeping up to date on health sector programs in El Salvador and keeping other agencies apprised of the MHCS Project activities.
4. Represent the Coordinating Organization at Project Advisory Committee meetings, donor committee meetings, health sector meetings, training seminars, and other events.
5. Oversee the development, implementation, monitoring, and evaluation of Project technical strategies and interventions; in particular, the implementation of strategies designed to generate and sustain active community participation in all Project phases.
6. Assist PVOs in the identification of sustainability strategies and monitor PVO efforts to achieve financial self reliance, including developing schemes for in-kind contributions, community participation, and user fees.

7. Participate in field visits to PVO implementation sites.
8. Identify, in a timely manner, problems and obstacles in the Project implementation process and suggest realistic solutions and alternatives to the problems identified.
9. Submit periodic reports to the AID Project Manager.
10. Review PVO and Coordinating Organization narrative reports, statistical reports, and financial statements.
11. Review the results of technical evaluations and financial audits of PVO projects and ensure that Coordinating Organization personnel monitor remedial actions suggested or required by evaluations and audits.
12. Participate in the mid-term and final evaluations of the Maternal Health and Child Survival Project.
13. Carry out other duties and responsibilities as assigned by the Project Advisory Committee and the Coordinating Organization's U.S. headquarters.

Project Administrator - General Description of Duties

The Project Administrator will have overall responsibility for the Coordinating Organization's management information systems, financial management, commodity procurement, and logistics, including warehousing, inventory systems, and distribution. He/she will report to the Project Director and serve as Executive Secretary of the Project Advisory Committee. The Project Administrator will also serve as Acting Chief of Party in the absence of the Project Director.

Specific Tasks

1. Supervise Coordinating Organization personnel on a daily basis; oversee the development and administration of a complete personnel system, including the preparation and up to date maintenance of descriptions, annual personnel evaluations, personnel leave records, etc.
2. Serve as Executive Secretary of the Project Advisory Committee; preparing Committee agenda and minutes, with appropriate input from Committee members; take responsibility for timely scheduling of meetings and for notifying members of time and place.
3. Plan and organize the administrative and logistical aspects of the Annual PVO Health Conference.

4. Oversee Project procurements and the administration of Project logistical systems, including warehousing, inventory systems, and commodity distribution.
5. Supervise the design, use, and updating of a quarterly statistical report on PVO outputs; ensuring the timely consolidation of PVO statistical reports each quarter.
6. Supervise all aspects of financial management for the Coordinating Organization and participating PVOs; ensure compliance with all applicable USAID accounting and fiscal management procedures; and submit monthly financial reports to the Controller's Office of USAID/El Salvador.
7. Oversee the development and maintenance of a comprehensive data base of Project financial and program data; monitor the generation of reports by: PVO, department, health region, and on a national level.
8. Assist the USAID/ES Project Officer in the preparation of Project semi-annual reports.
9. Oversee contracted administrative services, such as customs, security, and moving services.
10. Assist the Project Director with representational and liaison functions, as required.
11. Assist the Project Director and PVOs in the identification of strategies for enhancing PVO financial sustainability.
12. Participate in field visits to PVO implementation sites.
13. Identify, in a timely manner, administrative and logistical problems in Project implementation and make suggestions to the Project Director for resolving the problems identified.
14. Supervise the preparation of Coordinating Organization's narrative, statistical, and financial reports; reviewing PVO statistical reports and financial statements.
15. Review technical evaluations and financial audits of PVO projects and monitor the remedial actions instituted in response to evaluation and audit recommendations.
16. Participate in the mid-term and final evaluations of the Maternal Health and Child Survival Project.
17. Carry out other duties and responsibilities as assigned by the Project Director.

ANNEX I

TRAINING PLAN

This annex provides further detail about the training to be provided by this Project. Any project that aspires to improve, expand, and maintain the quality of basic health care services requires a capable group of qualified and motivated managers as well as health care providers. Proper training can provide this.

AID evaluation documents stress that significant components of sustainable primary health care programs involve appropriate project design, sound financing, and solid management. In addition, a cadre of qualified and motivated community health workers and strong support and participation by the community in the planning and implementation of project activities is crucial to success. Translating this into operational terms, this PVO/MHCS Project must have a trained management staff, a functioning management information system, a qualified technical staff, and a system for monitoring progress.

Evaluations of PVO managed maternal/child health programs (see AID Evaluation Paper No. 23) routinely point to shortages of staff and supplies, lack of information for planning, poor supervision of field workers, and inadequate record keeping as factors contributing to nonsustainability. It is said that while programs with poor management are able to continue delivering services, a strong management presence undoubtedly lowers cost, minimizes wasted efforts, and increases the overall impact on health.

This Project will be implemented by private and voluntary agencies working in El Salvador. It is important to Project objectives and to the delivery of quality health care services that the participating PVOs uniformly measure up to Project standards. Training of PVO staff to carry out the Project will be directed to a) participating PVO management, supervisory, and professional personnel and b) health care delivery personnel, that is, personnel at the community and clinic levels. An assessment of the training and resources requirements of individual PVOs to carry out a sub-project will be a part of the PVO's project proposal. Training will also be provided for the staff of the Office of International Cooperation (OIC) of the MOH and for the three other coordinating units that will occupy a place on the Project Advisory Committee, namely CISI, CIPHES, and CODEPROSES.

Evaluations of other PVO managed MCH programs (Zaire Project 097 Final Evaluation) urge that training assessments be conducted prior to final definition of illustrative training programs. In this Project, the Coordinating Organization will assist in the preparation of these assessments, especially with regard to preparation for the organizational/management training programs.

1. PVO Management Training for Institutional Strengthening

Each of the 35 indigenous PVOs that will likely participate in the Project are quite distinct from one another, and their training needs will

vary considerably. The institutional analysis has shown that if the PVOs' programs are to expand as expected, most of them will need management training as a prerequisite to starting implementation of Project activities as well as on-the-job training. Therefore, the Coordinating Organization will work with each participating PVO during its project proposal preparation phase to assess and define the training needs of management and supervisory personnel. While it is difficult to prescribe the training packages for the PVOs in detail at this point, it is expected that the training areas will include:

Project Preparation: The Coordinating Organization initially will market the Project to eligible PVOs. When a number of PVOs develop interest in submitting a proposal for participation in the Project, the Coordinating Organization will provide a one week training course in proposal development to assure that the PVOs follow the uniform guidelines developed by the Coordinating Organization in preparing their request for Project funding. To assure that such proposals contain the minimum information required for project consideration, approval and implementation, the Coordinating Organization will design a project proposal instructional unit for use in training an appropriate person from each PVO. The potential number of persons to receive this training is estimated at 50 persons for a 1 week training period for a total of 12 person months of training.

Financial/Accounting/Budgeting Training: This training will be arranged for the appropriate staff of each PVO as the organization enters the Project. The major portion of this training will be carried out by using in-country capacity. There are many recognized U.S. CPA affiliate accounting firms in El Salvador that have packaged training programs which can be adapted to meet this training requirement. The number of PVO personnel estimated to receive this training is 70 persons. Each will receive a combined short term training course followed up with with on-the-job training totaling 3 months for 210 person months of total financial management training.

Cost Recovery Initiatives: This topic will be a consistent concern of the Project Coordinating Organization. From the beginning, each PVO will be expected to include an illustrative cost recovery plan in their project proposal. Appropriate PVO staff will participate in short intensive seminars, carried out by the Coordinating Organization to become familiar with optional cost recovery methodologies as well as attend conferences during which PVO participants will exchange information about their cost recovery efforts with the other PVOs. This area of training will involve up to 35 PVO management personnel for 30 days of combined training seminars and periodic follow-up conferences, for a total of 35 person months of training.

Supply Management Training: This area will include the sub-topics of procurement, warehousing, distribution, and inventory control. All commodities for the PVO Maternal Health/Child Survival Project will be procured by the Coordinating Organization and transferred to participating PVOs for use in their programs. The Project Coordinating Organization will subcontract with a competent local firm to prepare and implement a supply management training program tailored to the needs of the PVOs as defined in the illustrative resource requirements portion of the their project

proposals. Supply management training will be carried out at all personnel levels of PVO activities from the central management/administrative level to the delivery and utilization sites. This type of training, along with the training of technical personnel, is the most critical training input of the Project. It is important that Supply Management Training reach PVO personnel at all levels. Therefore, this category of training will involve in-service and on-the-job training of a potential group of 105 trainees: 35 at the central offices of the PVOs; and 70 at the warehousing, clinic and community levels. The training and re-training/reinforcement process will be on-going throughout the LOP and is estimated at three months per capita for a total of 315 person months of training.

Monitoring: This topic is an essential activity in the implementation of development assistance programs. The definition of a detailed project monitoring plan will be a prerequisite to approval of a PVO's project application. Monitoring is the process for reviewing which project inputs are leading to outputs and how the output is happening. It is reasonable to assume that most potential participating PVOs will not have a systematic, disciplined monitoring program in place. It is likewise reasonable to expect that to put such a system in place will require training appropriate PVO personnel in the concepts, purpose and process of project monitoring. Again this is an area of training that will need to reach PVO personnel at all implementation levels.

Project monitoring and project evaluation courses have been developed by AID. These courses will be explored as sources for initial training in monitoring, at least for a critical group of PVO personnel who, when trained, will provide training for other PVO staff in country. This approach will lower training costs enough so as to encourage development of an indigenous training capability that could extend to non-Project PVOs. It is estimated that 50 persons will receive training in monitoring and evaluation techniques and, with follow up on-the-job training totaling 3 person months, will accumulate a total of 150 person months of training.

Systems Evaluation: Like monitoring, evaluation is essential to measuring and documenting project success or failure. The PVOs that participate in the Project should be expected to do comparable evaluations and report on these evaluations accordingly. AID has developed evaluation instructional materials which will be consulted by the Coordinating Organization, and with PVO participation, be adapted to the evaluation needs of the Project. Training in evaluation methodology will reach 50 PVO staff with 3 weeks of training for a total of 35 person months of training.

2. Community Level Training

Since the intent of the PVO MHCS Project is to maximize community participation in the provision of health care, a number of participants at various levels will require training in technical areas as well as in community education. A tiered system of coordination and training will be necessary to elevate health and community organization skills of participants to desired levels.

Community Health Promoters: At the very lowest tier of the health delivery system are the community health promoters (CHPs) and the members of the two proposed committees--the Comite Pro-Salud (health committee) and the Comite Pro-Agua y Saneamiento (water and sanitation committee). There will be approximately 1,000 community health promoters for the target population. These CHPs will be a mixture of both men and women who will be trained by regular staff members working with the PVOs. The 70 Community Health Trainers (CHTs) will do mostly on-site training of health promoters. In addition, several formal mass training sessions will be carried out. The total training level of effort for each Community Health Promoter (CHP) is one month over LOP, or 1,000 person months.

Persons involved in these activities will be trained by the Community Health Trainers, and hence CHP training costs will be relatively low. Periodic regional training sessions that will require transportation and per diem expenses have been budgeted.

Health and Water/Sanitation Committee Members: In similar fashion to the CHPs described above, committee members in these areas will be trained by the Community Health Trainers. Again, there are relatively low direct training costs for this group, although transportation, per diem costs, and rental of large meeting locales may be more significant. Over LOP, it is expected that 1,000 persons will participate in training sessions of 2 weeks each. Translated into person months, the training effort for this component is 467 PMs.

Community Health Trainers: The 70 Community Health Trainers (CHTs) will need solid grounding in training techniques as well as in the substantive health areas in which they will be teaching health promoters. Therefore, the level of training they will require is significant. It is estimated that the 70 health trainers will each require 2.5 months of training, or a LOP total of 175 person months.

Community Health Specialists: There will be three Community Health Specialists (CHSs). These individuals will have fairly high levels of skills in both substantive medical areas and in didactic techniques. CHSs will be based at the Coordinating Organization's headquarters. These individuals will be largely responsible for training the CHTs working with individual PVOs. One of the principal criteria for CHS selection as staff members will be their possession of an advanced level of knowledge regarding health education in the community context. Still, they will need additional training.

The 3 Community Health Specialists will oversee CHT training. The CHSs will be working during the start-up period of the Project at the Coordinating Organization's headquarters, and thus will receive considerable 'hands-on' training as the office gets going. The proposed training period for the 3 CHSs throughout LOP is 8 months each, for a total of 24 person months.

Training for the MOH and Other Coordinating Groups: The Project intent is to maximize cooperation and coordination among participating PVOs, other

health sector projects, and the MOH. CISI, CIPHES, CODEPROSES, and the MOH will all function as a part of the coordination/collaboration effort of the Project and will be members of the Project Advisory Committee. They will be recipients of Project inputs, including technical assistance, commodities, and training.

The fledgling MOH Office of International Cooperation (OIC/MOH) is the indicated contact point for Project coordination with the MOH. Discussions with that office show it is not presently prepared to provide even the minimum level of coordination of international donor activity in the maternal health/child survival sector. Although the office will add staff, it needs a better understanding of its own mission, functions, and coordination potential.

The Project will work with the OIC/MOH to prepare a training/orientation plan for this important MOH office. The plan will include an observation trip for the director of the OIC to selected countries which are known to have successful international cooperation offices. The program for the OIC will also include training for personnel named to the office. This will include training in the techniques and methods for the collection and dissemination of information on programs supported by international donors.

CISI, CIPHES, and CODEPROSES are organizations with on-going programs of PVO coordination. The Project will strengthen and enhance their capacity to deal with the task of coordination. In addition to providing vehicles and commodities, the Project will plan a strengthening program jointly with these agencies. This program will include training for staff and new hires in a manner consistent with organizational objectives. It is anticipated that all of these organizations, and the OIC, will play a role in Project coordination/cooperation activities, including the collection and dissemination of materials and management training activities for their members. Seventy-five person months of training is programmed for these organizations.

National and regional seminars and conferences will be planned as forums for the exchange of experiences among PVOs. The topics for these meetings will emerge from suggestions made by the PVOs themselves, the Coordinating Organization, and members of the Project Advisory Committee. The first conference will be held at the national level within six months following Project initiation. This conference will provide a venue for sharing the Project goal, purpose, and methodologies with PVOs. Subsequent conferences and seminars will be held at least annually and follow a workshop training format.

TABLE XII
TRAINING CHART

TYPE OF PERSONNEL	TYPE OF TRAINING	PERSON/MONTHS
PVO MANAGEMENT TRAINING		
1. Planners/Proj. Dev.	Short-term in-service	12 PM
2. Fin./Acct./Budget	Short-term in-service, refresher	210 PM
3. Cost Recov. Spec.	Short-term seminars, conference topics	35 PM
4. Supply Mgt. Per.	Short-term workshops	315 PM
5. Project Monitors	Short-term workshops	150 PM
6. System Evaluators	Short-term workshops	35 PM
COMMUNITY LEVEL TRAINING		
1. Community Health Promoters	Short-term in-service	1,000 PM
2. Water & Sanitation Committee Members	Short-term in-service	467 PM
3. Community Health Trainers	Short-term in-service	175 PM
4. Community Health Specialists	Short-term in-service	24 PM
TRAINING FOR THE MOH AND OTHER COORDINATING GROUPS		
1. MOH Office of Intl. Coop. and others	Study tours, conferences, seminars	75 PM

ANNEX J

FINANCIAL ANNEX

All PVOs participating in the Project are expected to receive technical assistance and training of some kind. Most will also receive commodities in order to strengthen and expand services. However, the majority of participating organizations will receive little or no financial support. Therefore, the financial reporting requirements will be simple following the A.I.D. Special Development Activities (SDA) model described in the body of the project paper. The SDA model has proven effective in ensuring financial accountability for small community action group beneficiaries of A.I.D.'s special community development grants.

For each organization requesting financial assistance, a pre-award assessment will be carried out by the Coordinating Organization in order to evaluate and certify to the adequacy of the PVO's existing financial and inventory controls. The pre-award assessment will determine whether the applicant PVO meets the established criteria to properly manage and account for Project resources or if training and/or technical assistance is required in order to ensure proper management and accountability for financial or commodity resources. The Coordinating Organization will certify that any PVO receiving financial assistance from the Project has adequate financial controls in place to ensure proper accountability for Project funds. When necessary, the Coordinating Organization will contract the services of a local auditing firm to assist with the pre-award assessment.

Following are criteria which have been established as a basic guide for assessing the organizational and administrative structure of applicant PVOs. The assessment will use the criteria listed below to rate each organization fairly according to its basic structure and size. For example, small organizations with three or four employees will not be expected to produce written personnel policies. The pre-award assessment will:

- * Assess the overall management and technical competence of the PVO in planning and implementing planned activities;
- * Assess the PVO's ability to practice adequate methods of accountability for funds and other assets and provide accurate, current, and complete financial and programmatic information in accordance with the standardized reporting requirements established by the Coordinating Organization;
- * Review the PVO's financial records to compare the accuracy of planned versus actual expenditures and whether the system used identifies the source and application of all funds;

- * Determine whether the financial system used is supported by documentation which can identify, segregate, accumulate, and record all costs incurred by the PVO, and accurately record the amount and disposition of income, and that the PVO maintains such other records as will facilitate an effective audit;
- * Identify whether the PVO has in place, or is capable of establishing a systematic method to ensure timely resolution of audit findings and recommendations;
- * Assess whether the PVO has policies and procedures in place which ensure payment of only reasonable and allowable costs for goods and services, and whether income generating and cost recovery schemes are being implemented.

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TABLE XIII (ILLUSTRATIVE)
 CATEGORY 1, MATERNAL HEALTH/CHILD SURVIVAL SERVICES
 SUMMARY COST ESTIMATE BY LINE ITEM AND YEAR
 MATERNAL HEALTH/CHILD SURVIVAL PROJECT
 Project No. 519-0367
 (US Dollars)

Line Items	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	TOTAL
1. TRAINING								
a. U.S./Third Country (21 PM)	17,691	17,691	17,691	17,691	17,691	17,691	17,691	123,846
b. Community Health Promoters (1000 PM)	42,857	42,857	42,857	42,857	42,857	42,857	42,857	299,919
c. Water & Sanitation Com. Members (467 PM)	20,014	20,014	20,014	20,014	20,014	20,014	20,014	140,098
d. Community Health Trainers (175 PM)	22,500	22,500	22,500	22,500	22,500	22,500	22,500	157,500
e. Community Health Specialists (24 PM)	3,086	3,086	3,086	3,086	3,086	3,086	3,086	21,612
SUBTOTAL	106,148	106,148	106,148	106,148	106,148	106,148	106,148	743,063
2. TECHNICAL ASSISTANCE								
a. Project Admin. (136 PM LT US/TCN)	242,857	242,857	242,857	242,857	242,857	242,857	242,857	1,699,508
b. Project Admin. (294 PM LT Local)	63,630	63,630	63,630	63,630	63,630	63,630	63,630	445,410
c. Mat. & Child Health (28 PM ST Local)	3,200	3,200	3,200	3,200	3,200	3,200	3,200	22,400
d. Comm. Part./Dev. (21 PM ST Local)	2,400	2,400	2,400	2,400	2,400	2,400	2,400	16,800
e. Mat. & Child Health (14 PM ST US/TCN)	35,000	35,000	35,000	35,000	35,000	35,000	35,000	245,000
SUBTOTAL	347,087	347,087	347,087	347,087	347,087	347,087	347,087	2,429,105
3. COMMODITIES								
a. Vehicles (3)	20,000			20,000		20,000		60,000
b. Office Equipment	8,000	6,000	6,000	1,501	1,501	1,501	1,501	26,004
c. Pharmaceuticals	96,000	240,000	420,000	420,000	420,000	324,000	180,000	2,100,000
d. Med. Equip./Supplies	7,000	7,000	7,000	7,000	7,000	7,000	7,000	49,000
e. Water & San. Equip.	0	545,000	545,000	545,000	545,000	545,000	0	2,725,000
f. Building Materials	0	420,000	420,000	560,000	0	0	0	1,400,000
SUBTOTAL	131,000	1,218,000	1,398,000	1,553,501	973,501	897,501	188,501	6,340,002

:4. PERSONNEL	:	:	:	:	:	:	:	:	:
:	:	:	:	:	:	:	:	:	:
: a. Clinic Staff	:	0	27,000	54,000	90,000	81,000	63,000	35,914	350,914
: (1500 PM Local)	:	:	:	:	:	:	:	:	:
: b. Admin. Staff (252 PM)	:	26,075	26,075	26,075	26,075	26,075	26,075	26,075	182,525

: SUBTOTAL	:	26,075	53,075	80,075	116,075	107,075	89,075	61,989	533,439

:5. PROGRAM ADMINISTRATION:	:	:	:	:	:	:	:	:	:
: MISC. OPERATING COSTS :	:	:	:	:	:	:	:	:	:
: (Category I - 50%) :	:	:	:	:	:	:	:	:	:
:	:	:	:	:	:	:	:	:	:
: a. Rent	:	48,000	48,000	48,000	48,000	48,000	48,000	48,000	336,000
: b. Office Supplies	:	1,750	1,750	1,750	1,750	1,750	1,750	1,750	12,250
: c. Travel/Trans/Per Diem:	:	29,280	29,280	29,280	29,280	29,280	29,280	29,280	204,960
: d. U.S. Project Support:	:	110,751	110,751	110,751	110,751	110,751	110,751	110,751	775,257
: e. Miscellaneous Local :	:	34,000	84,000	84,000	84,000	84,000	84,000	84,000	588,000

: SUBTOTAL	:	273,781	273,781	273,781	273,781	273,781	273,781	273,781	1,916,467

:6. EVALUATIONS & AUDITS :	:	:	:	:	:	:	:	:	:
: (Category I - 50%) :	:	:	:	:	:	:	:	:	:
:	:	:	:	:	:	:	:	:	:
: a. Evaluations	:	:	50,000	:	:	:	:	50,000	100,000
: b. Audits - Coordinating:	:	:	:	:	:	:	:	:	:
: Organization & PVOs :	:	55,000	55,000	55,000	55,000	55,000	55,000	55,000	330,000

: SUBTOTAL	:	0	55,000	105,000	55,000	55,000	55,000	105,000	430,000

: TOTAL	:	884,091	2,053,091	2,310,091	2,451,592	1,862,592	1,768,592	1,082,506	12,412,555

:7. INFLATION AND	:	:	:	:	:	:	:	:	:
: CONTINGENCIES	:	176,818	410,618	462,018	490,318	372,518	353,718	216,501	2,482,509

: GRAND TOTAL	:	1,060,909	2,463,709	2,772,109	2,941,910	2,235,110	2,122,310	1,299,007	14,895,064

3. COMMODITIES									
a. Vehicles (70)	160,000	240,000	300,000	0	160,000	240,000	300,000	1,400,000	
b. Motorcycles (14)	8,500	8,500	10,200	0	0	0	0	27,200	
c. Desks (70)	4,000	6,000	7,500	0	0	0	0	17,500	
d. Chairs (70)	1,600	2,400	3,000	0	0	0	0	7,000	
e. Typewriters (35)	6,400	9,600	12,000	0	0	0	0	28,000	
f. Calculators (35)	400	600	750	0	0	0	0	1,750	
g. Filing Cabinets (70)	2,560	3,840	4,800	0	0	0	0	11,200	
h. Pers. Computers (50)	14,290	14,285	14,285	14,285	14,285	14,285	14,285	100,000	
i. Misc. Office Equip.	24,000	334	334	334	334	334	334	26,004	
j. Educ. Materials (Avg. \$600/PVO/yr.)	15,000	15,000	15,000	15,000	15,000	15,000	15,000	105,000	
k. Tape Recorders (35)	280	420	525	0	0	0	0	1,225	
l. Projectors (70)	7,700	0	0	0	0	0	0	7,700	
m. Building Materials	20,000	30,000	30,000	20,000	0	0	0	100,000	
SUBTOTAL	264,730	330,979	398,394	49,619	189,619	269,619	329,619	1,832,579	
4. PERSONNEL									
a. Community Health Trainers (25% of 4200 PM = 1050 PM)	4,800	12,000	21,000	21,000	21,000	16,200	9,000	105,000	
b. Adm. Staff (252 PM)	26,075	26,075	26,075	26,075	26,075	26,075	26,075	182,525	
SUBTOTAL	30,875	38,075	47,075	47,075	47,075	42,275	35,075	287,525	
5. PROGRAM ADMINISTRATION:									
MISC. OPERATING COSTS (Category II - 30%)									0
a. Rent	28,800	28,800	28,800	28,800	28,800	28,800	28,800	201,600	
b. Office Supplies	1,050	1,050	1,050	1,050	1,050	1,050	1,050	7,350	
c. Travel/Trans/Per Diem	17,568	17,568	17,568	17,568	17,568	17,568	17,568	122,976	
d. U.S. Project Support	66,451	66,451	66,451	66,451	66,451	66,451	66,451	465,154	
e. Miscellaneous Local	50,400	50,400	50,400	50,400	50,400	50,400	50,400	352,800	
SUBTOTAL	164,269	164,269	164,269	164,269	164,269	164,269	164,269	1,149,880	
6. EVALUATIONS & AUDITS									
(Category II - 30%)									
a. Evaluations	0	0	30,000	0	0	0	30,000	60,000	
b. Audits - Coordinating Organization & PVOs	0	33,000	33,000	33,000	33,000	33,000	33,000	198,000	
SUBTOTAL	0	33,000	63,000	33,000	33,000	33,000	63,000	258,000	
TOTAL	838,661	945,110	1,051,525	672,750	812,750	887,950	970,750	6,179,495	
7. INFLATION AND CONTINGENCIES									
	167,732	189,022	210,305	134,550	162,550	177,590	194,150	1,235,899	
GRAND TOTAL	1,006,393	1,134,132	1,261,830	807,300	975,300	1,065,540	1,164,900	7,415,394	

:6. EVALUATIONS & AUDITS :	:	:	:	:	:	:	:	:	:	0 :
: (Category III - 20%) :	:	:	:	:	:	:	:	:	:	0 :
: a. Evaluations :	0 :	0 :	20,000 :	0 :	0 :	0 :	20,000 :	40,000 :		
: b. Audits - Coordinating:	0 :	0 :	0 :	0 :	0 :	0 :	0 :	0 :		
: Organization & PVOs :	0 :	22,000 :	22,000 :	22,000 :	22,000 :	22,000 :	22,000 :	22,000 :	132,000 :	

: SUBTOTAL :	0 :	22,000 :	42,000 :	22,000 :	22,000 :	22,000 :	42,000 :	172,000 :		

: TOTAL :	358,754 :	297,088 :	317,088 :	297,088 :	297,088 :	357,088 :	317,088 :	2,241,283 :		

:7. INFLATION AND	:	:	:	:	:	:	:	:	:	:
: CONTINGENCIES :	71,751 :	59,418 :	63,418 :	59,418 :	59,418 :	71,418 :	63,418 :	448,259 :		

: GRAND TOTAL :	430,505 :	356,506 :	380,506 :	356,506 :	356,506 :	428,506 :	380,506 :	2,689,542 :		

TABLE XVI
 DETAILED COST ESTIMATE BY LINE ITEM
 MATERNAL HEALTH/CHILD SURVIVAL PROJECT
 Project No. 519-0367
 (US Dollars)

LINE ITEMS	AMOUNT	PERCENTAGE
1. TRAINING		
46 PM U.S./Third Country	273,602	
2,498 PM Local	1,368,003	
SUBTOTAL	1,641,605	6.6%
2. TECHNICAL ASSISTANCE		
273 PM Long Term US/TCN	3,399,998	
588 PM Long Term Local	890,820	
42 PM Short Term US/TCN	735,000	
112 PM Short Term Local	95,900	
SUBTOTAL	5,121,718	20.5%
3. COMMODITIES		
79 Vehicles @ \$20,000	1,580,000	
16 Motorcycles @ \$1,700	27,200	
Office Equipment	278,462	
Educational and Audiovisual Aids	113,925	
Pharmaceuticals	2,100,000	
Medical Equipment/Supplies	49,000	
Water and Sanitation Equipment	2,725,000	
Building Materials	1,500,000	
SUBTOTAL	8,373,587	33.5%
4. PERSONNEL		
3,306 PM Local Hire	1,003,489	4.0%
5. PROGRAM ADMINISTRATION/ MISCELLANEOUS OPERATING COSTS		
Rent	672,000	
Office Supplies	26,500	
Travel/Transportation/Per Diem	409,920	
U.S. Project Support	1,550,514	
Miscellaneous Local Costs/Contracts	1,176,000	
SUBTOTAL	3,832,934	15.3%
6. EVALUATIONS AND AUDITS		
	860,000	3.4%
TOTAL	20,833,333	
7. INFLATION AND CONTINGENCIES		
	4,166,667	16.7%
GRAND TOTAL	25,000,000	100.0%