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United States Agency for
International Development (AID)
Quito, Ecuador

Agencia de los Estados Unidos para
el Desarrollo Internacional (AID)
Quito, Ecuador

ISN 82062

DUPLICATE ORIGINAL

September 28, 1991

Mr. Rudolph von Bernuth
Senior Vice President, Program Division
CARE International
660 First Avenue
New York, NY 10006

Subject: Cooperative Agreement No. 527-0319-A-00-1346-00, MAXSERV-Strengthening Health Institutions Project

Dear Sir:

Pursuant to the authority contained in the Foreign Assistance Act of 1961, as amended, the Agency for International Development (hereinafter referred to as "USAID" or Grantor") hereby grants to CARE (hereinafter referred to as "CARE" or "Recipient") the sum of $3,025,000 to provide support for a program to test the financial and operational feasibility of primary health care models, as described in the Schedule of this Cooperative Agreement and the Attachment 2, entitled "Program Description."

This cooperative agreement is effective and obligation is made as of the date of this letter and shall apply to expenditures made by the Recipient in furtherance of program objectives during the period beginning with the effective date and ending approximately September 30, 1993.

This grant via cooperative agreement is made to the Recipient on condition that the funds will be administered in accordance with the terms and conditions as set forth in Attachment 1, (the Schedule); Attachment 2, (the Program Description); and Attachment 3, (the Standard Provisions); all of which have been agreed to by your organization.

INTERNATIONAL MAIL ADDRESS: U. S. AID Mission to Ecuador – c/o American Embassy – Quito, Ecuador
U. S. MAIL ADDRESS: USAID Quito – APO Miami, Fl 34039
PHONE: 521 – 100

Please sign the original and each copy of this letter to acknowledge your receipt of the Cooperative Agreement. Return the original and all but one copy to USAID/Peru, Attention EXO/PRC.

Sincerely yours,

James J. Dunlap
Regional Agreement Officer

Attachments:

1. Schedule
2. Program Description
~~3. Standard Provisions~~

ACKNOWLEDGED:

CARE

BY: Signature

NAME: RUDOLPH VON BERNUTH

TITLE: Vice President

DATE: 17 OCTOBER 1991

FISCAL DATA

Appropriation:	72-1111021
Budget Plan Code:	LDCA-91-25527-KG13
RCN:	R100313
PIO/T No.:	527-0319-3-10088
Project No.:	527-0319
Total Obligated Amount:	$3,025,000
Total Estimated Amount:	$7,842,000

SCHEDULE

A. Purpose of Cooperative Agreement

The purpose of this cooperative agreement is to provide support for a program to test the financial and operational feasibility of primary health care models in the regions of Puno and Arequipa, and to increase the coverage of primary health care services to specific targeted sub-groups.

B. Period of Agreement

1. The effective date of this Agreement is the signature date of the cover letter. The expiration date of this Agreement is September 30, 1996.

2. Funds obligated hereunder are available for program expenditures for the estimated period from the effective date to approximately September 30, 1993 as shown in the Agreement Budget below.

C. Amount of Agreement and Payment

1. The total estimated amount of this Agreement for the period shown in B.1 above is $7,842,000, of which $5,942,000 will be administered by CARE and $1,900,000 directly by USAID on behalf of the project.

2. USAID hereby obligates the amount of $3,025,000 for program expenditures during the period set forth in B.2. above and as shown in the Financial Plan below.

3. Payment shall be made to the Recipient in accordance with procedures set forth in Attachment 3 Standard Provision, entitled "Payment - Letter of Credit".

4. Additional funds up to the total amount of the grant shown in C.1 above may be obligated by USAID subject to the availability of funds, and to the requirements of the Standard Provision of the Agreement, entitled "Revision of Grant Budget."

D. Agreement Budget

The following is the Agreement Budget, including local cost financing items, which are hereby authorized. Revisions to this budget shall be made in accordance with the Standard Provision of this Agreement, entitled "Revision of Grant Budget." Subject to a variance limit of 15%, Recipient may adjust budget line items to meet program requirements. Greater variances require Agreement

Officer approval. The total of funds obligated to the Agreement by USAID shall not be exceeded.

FINANCIAL PLAN
($U.S. 000's)

1. ESTIMATED AGREEMENT BUDGET

Expense Category/Inputs	Total Estimated Amount	This Obligation	Balance To be Oblgtd
II. NGO Health Providers (SOUTH)	5,942	2,360	3,582
1. Technical Assistance	600	300	300
2. Commodities	500	500	0
3. Short-term Training	490	206	284
4. Operating Costs	1,014	480	534
5. Sub-Grants	2,000	417	1,583
6. Studies/Audits	100	50	50
7. Indirect Costs (Peru cost allocation; CARE-USA overhead)	1,238	407	831
III. Project Monitoring Support	1,400	465	935
IV. Studies/Evaluations/ Pre-Award	500	200	300
TOTAL	7,842	3,025	4,817

2. BUDGET BREAKDOWN FOR THIS OBLIGATION BY IMPLEMENTATION RESPONSIBILITY

Expense Category/Inputs	AID	CARE	TOTAL
II. NGO Health Providers (SOUTH)	0	2,360	2,360
1. Technical Assistance	0	300	300
2. Commodities	0	500	500
3. Short-term Training	0	206	206
4. Operating Costs	0	480	480
5. Sub-Grants	0	417	417
6. Studies/Audits	0	50	50
7. Indirect Costs (Peru cost allocation; CARE-USA overhead)	0	407	407
III. Project Monitoring Support	465	0	465
IV. Studies/Evaluations/Pre-Award	200	0	200
TOTAL	665	2,360	3,025

3. BUDGET BREAKDOWN FOR THIS OBLIGATION
BY FOREIGN EXCHANGE (FX) AND LOCAL CURRENCY (LC)

Expense Category/Inputs	FX	LC	TOTAL
II. NGO Health Providers (SOUTH)	1,277	1,083	2,360
1. Technical Assistance	300	0	300
2. Commodities	470	30	500
3. Short-term Training	100	106	206
4. Operating Costs	0	480	480
5. Sub-Grants	0	417	417
6. Studies/Audits	0	50	50
7. Indirect Costs (Peru cost allocation; CARE-USA overhead)	407	0	407
III. Project Monitoring Support	365	100	465
IV. Studies/Evaluations/ Pre-Award	150	50	200
TOTAL	1,792	1,233	3,025

E. Reporting and Evaluation

1. Financial Reporting

a. Financial reporting requirements shall be in accordance with the Standard Provision of this Cooperative Agreement entitled "Payment - Letter of Credit" as shown in Attachment 3.

b. The original and two copies of all financial reports shall be submitted to the USAID project officer, with one copy to the PSC Project Monitor. The financial report should include a copy on diskette of the Quattro-compatible spreadsheet files.

c. The Recipient is required to maintain books and records in accordance with generally accepted accounting principles. The Recipient also is required to have an annual A133 independent audit performed of the grant and the financial statements of CARE as a whole.

d. The Method of Financing of this Cooperative Agreement will be via Treasury Letter of Credit. Notwithstanding, the recipient agrees that each financial transaction or disbursement recorded under the component agreement will be reported to the USAID PSC on a monthly basis according to the approved line items of this Cooperative Agreement. Sub-grant activity under

MAXSERV will be reported on a trimester basis by CARE. Project counterpart contributions of CARE will be monitored and reported to USAID on a semi-annual basis.

2. Program Performance Reporting

a. Recipient shall monitor performance under the Agreement and where appropriate, ensure that time schedules are being met, projected work units by time periods are being accomplished, and other performance indicators are being achieved. This review shall be made for each program, function, or activity of the Agreement.

b. Detailed program reports will be provided to the USAID Project Officer and PSC Project Monitor by the Recipient on project progress on a semi-annual basis, supplemented by brief trimester progress updates. The semi-annual reports should be accompanied with a diskette copy of the relevant files in Word Perfect 5.1. Recipient shall submit semi-annual performance reports (technical reports) that present the following information for each program, function, or activity involved:

(1) Sub-grant and contract activity

(2) Results of the PHC coverage programs

(3) Technical Assistance Extended

(4) Training Activities Carried Out

(5) Pharmaceutical Procurement System

(6) Sustainability and Cost Recovery Milestones

(7) Other Significant Project Milestones

c. Between the required performance reporting dates, events may occur that have significant impact upon the program. In such instances, the Recipient shall inform USAID as soon as the following types of conditions become known:

(1) Problems, delays, or adverse conditions that will materially affect the ability to attain program objectives, prevent the meeting of time schedules and goals, or preclude the attainment of project work units by established time periods. This disclosure shall be accompanied by a statement of the action taken, or contemplated, and any USAID assistance needed to resolve the situation.

(2) Favorable developments or events that enable time schedules to be met sooner than anticipated or more work units to be produced than originally projected.

(3) Other pertinent information including, when appropriate, analysis and explanation of cost overruns or high unit costs.

d. If any performance review conducted by the Recipient discloses the need for change in the budget estimates in accordance with the criteria established in the Mandatory Standard Provision 4, the Recipient shall submit a request for budget revision.

3. CDIE Copies

The Recipient shall prepare and submit 2 copies of each major report required by this grant to the bureau for Program and Policy Coordination, Center for Development Information and Evaluation, Development Information Division (PPC/CDIE/DI). All documents should be mailed to :

PPC/CDIE/DI
ACQUISITION
Room 209, SA-18
Agency for International Development
Washington, D.C. 29523

The title of all reports forwarded shall include a descriptive title, the author's name(s), agreement number, the project number and title, contractor's name, name of the USAID project office, and the publication or issuance date of the report.

F. Indirect Cost Rates

1. CARE International

Pursuant to the Standard Provision of this grant entitled "Negotiated Indirect Cost Rates - Provisional," a rate or rates shall be established for each of the Grantee's accounting periods which apply to this grant. Pending establishment of revised provisional or final indirect cost rates for each of the Grantee's accounting periods which apply to this grant, provisional payments on account of allowable indirect costs shall be made on the basis of the following negotiated provisional rate(s) applied to the base(s) which are set forth below.

Type	Rate	Base	Period
Provisional Overhead	7.60%	*	7/1/91 until amended

*Total direct costs less exchange fluctuations; less ocean freight; less non cash donations including agricultural commodities, ocean freight and contributions in-kind, and less U.S. government grants that due to legal restrictions do not permit indirect cost recovery.

2. CARE Peru

Under SHIP, AID will pay its fair share of CARE Peru's fixed mission costs (FMC's), based upon a prorata cost allocation method. A proposal will be submitted as soon as possible to the Agreement Officer detailing the proposed methodology and its results, to include how CARE proposes to be paid (percent of direct costs, dollars per month, etc.) For the first program year, these costs are budgeted at not-to-exceed $192,000.

These costs shall be renegotiated annually.

G. Substantial Involvement Understandings

It is understood that USAID/Peru will be substantially involved during performance of this cooperative agreement as follows:

1. Annual work plan review/approval, and other work plans or scheduling as required,

2. Key personnel approval. Those personnel identified in this project as key to successful project implementation will require USAID approval prior to selection and contracting by CARE. These include the MAXSERV Project Director, the MAXSERV Regional Coordinators in Puno and Arequipa, and the MAXSERV Child Survival Advisor. Any deviation from the number of support personnel as specified in the Cooperative Agreement Program Description will require the prior approval of USAID.

3. Selection criteria approval for Subcontract/Subrecipients, as well as local contracts for technical services and consultants. USAID will approve the criteria mechanism devised for review and approval of subgrants under the Cooperative Agreement. In addition, USAID will approve the scopes of work for subcontracts made by CARE for local technical services and consultants.

4. Participation in periodic briefings, assessments and evaluations. The USAID PSC Project Monitors will have open access to project meetings, briefings, and reviews. CARE's project and sector management staff will consult with the MAXSERV Project Monitor on those major policy and project issues not expressly requiring a USAID formal approval, as an administrative project resource. CARE will coordinate fully with the MAXSERV Project Monitor on the development of policy dialogues with the Regional Governments and the Ministry of Health relating to the implementation of this project.

5. USAID Direct Management Support. Two project components under this Cooperative Agreement will require direct management by USAID. These components include the Project Monitoring Support provided under Project Element III of two PSC Project Monitors contracted by USAID, and the management of Studies/Evaluations/Pre-Award Survey of Project Element IV. USAID will contract directly for the special studies described in the SHIP Project Paper, the midterm and final evaluations of SHIP, and the Pre-Award Survey for the northern MAXSALUD component. Using funds under this Cooperative Agreement, USAID will conduct a project evaluation during PY 3 and PY 5 as described in the Implementation Plan, coordinating with CARE on the anticipated scopes of work and terms of reference. USAID will use the results of this evaluation, in coordination with CARE, to make adjustments in the project objectives and implementation plan.

H. Special Provisions

1. As set forth in Attachment 3, all mandatory standard provisions for U.S. Non-governmental Grantees apply to this Agreement. Applicable optional standard provisions are indicated by reference in Attachment 3.

2. To assist in the implementation of the project, USAID from time to time will issue cooperative agreement implementation letters furnishing additional information on requirements about matters stated in this Agreement. Such letters shall not modify the terms of the Agreement.

3. Besides the Agreement Officer, the Chief, USAID/Peru Health/Nutrition Office is authorized to issue approvals required by G., above.

I. Close-out Procedures

This section prescribes uniform closeout procedures for this Agreement.

1. The following definitions shall apply for the purpose of this section:

a. Closeout: The closeout of a grant or agreement is the process by which USAID determines that all applicable administrative actions and all required work of the Cooperative Agreement have been completed by the Recipient and USAID.

b. Date of Completion: The date of completion is the date on which all work under Agreements is completed or the date on the award document, or any supplement or amendment thereto, on which sponsorship ends.

c. Disallowed Costs: Disallowed costs are those charges to an Agreement that USAID or its representative determines to be unallowable in accordance with the applicable Federal cost principles or other conditions contained in the Agreement.

2. USAID closeout procedures include the following requirements:

a. Upon request, USAID shall make prompt payments to a Recipient for allowable reimbursable costs under the Agreement being closed out.

b. The Recipient shall immediately refund any balance or unobligated (unencumbered) cash that USAID has advanced or paid and that is not authorized to be retained by the Recipient for use in other Agreements.

c. USAID shall obtain from the Recipient within 90 calendar days after the expiration of the Agreement all financial, performance and other reports required as a condition of the Agreement. USAID may grant extensions when requested by the Recipient.

d. In the event a final audit has not been performed prior to the closeout of the Agreement, USAID shall retain the right to recover an appropriate amount after fully considering the recommendations on questioned costs resulting from the final audit.

J. Authorized Geographic Codes

The authorized geographic codes for procurement of goods and services under this Agreement are the United States (Code 000) and as further described in the Standard Provisions and local cost provisions below, Peru.

Local Cost Financing

a. Costs qualifying as local costs are eligible for financing under the grant in accordance with the terms of this special provision. Local costs are defined as (i) indigenous goods, (ii) imported shelf items, and (iii) services provided by suppliers meeting the requirements contained in subparagraph b. Indigenous goods are those that have been mined, grown or produced in the cooperating country through manufacture, processing or assembly. In the case of produced goods containing imported components, to qualify as indigenous a commercially recognized new commodity must result that is substantially different in basic characteristics or in purpose or utility from its components. Imported items are eligible for financing under the following situation:

(1) All locally financed procurements must be covered by source/and nationality waivers as set forth in Chapter 5 of Handbook 1, Sup. B, with the following exceptions:

(a) Locally available commodities of U.S. origin, which are otherwise eligible for financing, if the value of the transaction is estimated not to exceed the local currency equivalent of $100,000 (exclusive of transportation costs).

(b) Commodities of geographic code 935 origin if the value of the transaction does not exceed $5,000.

(c) Professional services contracts estimated not to exceed $250,000.

(d) Construction services contracts estimated not to exceed $5,000,000.

(e) The following commodities and services which are available only locally:

- Utilities including fuel for heating and cooking, waste disposal and trash collection;

- Communications --telephone, telex, fax, postal and courier services;

- Rental costs for housing and office space;

- Petroleum, oils and lubricants for operating vehicles and equipment;

- Newspapers, periodicals and books published in the cooperating country;

- Other commodities and services (and related expenses) that, by their nature or as a practical matter, can only be acquired, performed, or incurred in the cooperating country, e.g., vehicle maintenance, hotel accommodations, etc.

(2) When local procurement of U.S. origin commodities is planned under a project, such a decision should be supported by an analysis of the prices of goods expected to be procured, and a determination that the prices are reasonable, taking into account comparable delivery terms and prices from the United States, and the implementation schedule of the project.

b. To qualify as local costs, goods and services must also meet the following additional requirements:

(1) They normally must be paid for in local currency.

(2) The supplier must be located in the cooperating country and must be of cooperating country nationality as defined in USAID Handbook 1B, Chapter 5.

(3) Any component from a country not included in USAID geographic code 935 renders a commodity ineligible for financing.

c. Ineligible Goods and Services: Under no circumstances shall the grantee procure any of the following under this grant:

(1) Military equipment,

(2) Surveillance equipment,

(3) Commodities and services for support of police or other law enforcement activities,

(4) Abortion equipment and services,

(5) Luxury goods and gambling equipment, or

(6) Weather modification equipment.

d. Ineligible Suppliers: Funds provided under this grant shall not be used to procure any goods or services furnished by any firm or individual whose name appears on USAID's Consolidated List of Debarred, Suspended, or Ineligible Awardees (USAID Regulation 8, (22 CFR •208)). USAID will provide the grantee with this list upon request.

e. Restricted Goods: The grantee shall not procure any of the following goods and services without the prior written authorization of the grant officer:

(1) Agricultural commodities,

(2) Motor vehicles,

(3) Pharmaceuticals,

(4) Pesticides,

(5) Rubber compounding chemicals and plasticizers,

(6) Used equipment,

(7) U.S. Government-owned excess property, or

(8) Fertilizer.

f. If AID determines that the grantee has procured any of the restricted or ineligible goods and services specified in subparagraphs (c) through (e) above, or has received reimbursement for such purpose without the prior written authorization of the grant officer, the grantee agrees to refund to USAID the entire amount of the reimbursement.

MAXSERV: CARE Cooperative Agreement Program Description

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY 2

II. PROBLEM STATEMENT 3

III. PROJECT STRATEGIES 5
1. OVERVIEW OF CARE, NGOs, AND OTHER INSTITUTIONS . . 5
2. GOALS 9
3. STRATEGIES 11

IV. PROJECT COMPONENTS 13
1. Sub-grants 13
2. Technical Assistance 17
3. Training 20
4. Purchase, Distribution and Rational Use of Pharmaceuticals 24

V. PROJECT MANAGEMENT 25

VI. PROJECT IMPLEMENTATION PLAN 30
1.-Start-up Period 30
2.-Expansion and Consolidation Period 30

VII. PROJECT REPORTING REQUIREMENTS AND EVALUATIONS . . . 31
1. Evaluation Responsibilities 31
2. Auditing of the Project and the NGOs 31
3. Project Reporting Requirements 32

VIII. PROJECT BUDGET 32
1. Budget Detail 32

APPENDIX

1. Grupo QUIPUS - MIS Design Proposal
2. Letter of Cooperative Agreement Proposal Submission to USAID/Peru

STRENGTHENING HEALTH INSTITUTIONS PROJECT (SHIP)
SOUTHERN COMPONENT: MAXSERV

CARE-PERU

I. EXECUTIVE SUMMARY

This document is the proposal from CARE-Peru to implement MAXSERV, the Southern Component of the AID-funded Strengthening Health Institutions Project (SHIP) for the Arequipa Region and the Puno Sub-Region, covering a total of 320 communities. The project is based on the CARE experience in health and basic sanitation programs in the remote rural areas of Peru, as well as in providing financial and technical assistance to non-governmental (NGOs).

Goals and Strategies

The MAXSERV project is designed to achieve sustainable improvements in the coverage and quality of selected primary health care services to 150,000 beneficiaries in the Arequipa region and the Puno sub-region, delivered and organized by NGOs working in the project areas.

The following project strategies will be employed to fulfill this objective:

- Strengthening the NGOs: The NGOs as principal agents for extending health coverage in the communities, are permanent structures which have established strong rapport with the local populations. The project will support a minimum of 18 NGOs in the two regions. One feature of this strategy will be the establishment of two NGO committees whose representatives will coordinate the primary health programs and project supported NGO activities in each geographical area.

- Core Primary Health Care Services: The NGOs will provide, or strengthen the provision of, a core package of PHC services to communities through the sub-grant mechanism. This core will include immunizations, control of diarrheal disease, control of acute respiratory infections, nutrition interventions such as counseling on sound infant feeding practices or growth monitoring and follow-up, pre- and post-natal care, and family planning. Control of other infectious diseases such as tuberculosis, other nutrition interventions, deliveries, and simple first aid care are also encouraged for NGOs which have sufficient clinical capabilities. Targets for increased service coverage levels will be established within seven months and progress on these indicators measured thereafter.

- Coordination between NGOs and Ministry of Health(MOH): -The NGOs will coordinate and complement primary health care activities supported by the MOH program, by joint programming of project funded activities and sharing of information on services and coverage, and in joint programmed activities.

- Community Participation: The communities will participate in diagnosing and prioritizing their needs, and will also implement selected project activities.

Project components:

The following are the project components:

- Sub-grants to the NGOs: The project will finance small primary health projects which NGOs will submit to CARE, according to specific project guidelines. These activities will be monitored by CARE.

- Technical Assistance: As needed, each NGO will receive technical assistance in order to strengthen their institutional capacity to more efficiently manage their programs. External technical assistance will also be provided to develop information systems to standardize service statistics, health information, cost accounting data, training programs, and a pharmaceutical distribution system.

- Training: CARE will support the development of workshops for NGOs and other organizations, covering such topics as: sub-grant development, project sustainability, programming, monitoring and evaluation of activities, child survival, family planning, health program administration, and information system management.

- Distribution and rational use of pharmaceuticals: This component will establish a pharmaceutical distribution system for the project communities to increase access to pharmaceuticals, which will include the purchase of selected medicines through the project. The system will be established by creating a revolving fund between the NGOs and the project's beneficiary communities.

Project Administration:

The project headquarters will be the CARE Central Office in Lima. The CARE Project Coordinator will report to the CARE Health Program Manager, and will be in charge of the direct coordination with USAID.

14

Also, two new CARE offices will be opened, one in Arequipa and another in Puno, and there will be Regional MAXSERV Coordinators in charge of each.

The project will be implemented over five years, and during that time there will be external evaluations in the third year and when the project ends in the fifth year, conducted by USAID. In addition, there will be annual internal evaluations for each sub-grant to be supervised by CARE.

The total budget for the project activities is US$7,842,000, to be financed under a cooperative agreement between CARE\USA and USAID\Peru.

II. PROBLEM STATEMENT

1. Socioeconomic description of the country and of the project areas:

1.1 PERU:

Over the last ten years the country has suffered a profound socioeconomic crisis. The GDP has fallen by 25%. According to World Bank figures, the total population is 22.3 million, and of these, at least six million are living in absolute poverty, while another 3.5 million have become more impoverished.

From 1980 to 1990, wages in the private sector fell by 69% and in the public sector by 83%. Income distribution is one of the most regressive in Latin America. Lack of jobs and government austerity measures have together resulted in a recessive economy, in which 83% of the Economically Active Population is unemployed and/or under-employed.

Health Status:

According to National Statistics Institute figures (INE, 1990), life expectancy at birth is 63 years. Infant Mortality is 80.7 for every thousand live births, and of these deaths, 61% occur in the first year of age. This rate is one of the highest in Latin America. Maternal Mortality is 301 for every 100,000 live births, while in the developed countries it is 3 for every 100,000 live births. The main causes for these rates are maternal malnutrition, lack of pre-natal and post-natal care, and high fertility rates.

Malnutrition in Peru's rural areas is alarming, since 70% of children under six suffer some degree of malnutrition, and 50% of

children between 18 and 23 months show some symptoms of chronic malnutrition.

With respect to health service coverage, the MOH has a wide network of health centers throughout the country but the coverage is low in comparison with Peru's total population. The MOH covers 26% of the population, the Peruvian Institute of Social Security (IPSS) covers 28%, the private sector 11%, and the Armed Forces 3%. This means that 32% of the population has no access to any health service. For the most part, these institutions give preference to remedial rather than preventive care, and operate mainly in central urban areas leaving rural areas and marginal urban areas under-covered.

1.2- Project Areas:

Project activities will be carried out in the Puno and Arequipa regions. The health status in these areas is much lower than the national average. The situation is even worse among the migrant population leaving rural areas, since these people settle in the marginal areas around cities where there is no basic hygiene, resulting in high morbidity and mortality rates.

1.2.1- PUNO

The population in the Puno region is estimated at 997,400, of which 70% is rural. Of these, 65% are living in the three southern micro-regions, which is the selected project area. Infant Mortality is 115 for every 1,000 live births, while the national rate is 81 for every 1,000. Maternal mortality is at 301 for every 100,000.

Health coverage between the MOH, the IPSS and the private sector only reaches 45% of the population, which leaves 55% with no access to health services. The figures reflect the lack of material resources and personnel to run the services. In Puno, including both public and private sectors, there are 12 hospitals, 44 health centers, and 218 health posts. There are few health education services available in these centers, and no system to provide pharmaceuticals.

1.2.2- AREQUIPA

In the Arequipa region the population is approximately 965,000, of which 70% is urban, and health statistics are better than national averages. However, migrants, primarily from Cuzco and Puno, are now forming new marginal urban populations (shanty towns) around Arequipa, where health is at risk due to lack of services.

Infant Mortality is estimated at 73 for every 1,000 live births for the region, lower than the national average. Of these deaths, 44%

is due to dysentery and 41% to respiratory problems. The figure does not include TB or the 15% due to malnutrition.

The material resources in Arequipa are as follows: 4 hospitals, 41 health centers and 134 health posts, with a total number of 1,298 beds. Of this total number of beds, 73% are in the urban area.

The MOH, IPSS, and formal private sector cover approximately 55% of the population, which indicates that 45% have no access to health services despite being an urban population.

1.3 Problem Description:

Health status in the whole country, including Arequipa and the Puno regions, is alarming. Health services coverage is low, and over the last ten years the MOH has lost budget and coverage. With improving new economic conditions, and the new regionalization of health care activities it will take some time for the MOH to restructure itself and increase coverage and quality of health care.

The NGOs' focus has been more in health promotion, and negligible in providing preventive and remedial direct health services. NGOs would like to increase and expand their efforts at health promotion and delivery of primary services, but due to the lack of technical, material and human resources, are not able to. The NGOs have excellent rapport with the local communities, and one way to increase health services coverage would be to channel assistance and resources to NGOs.

This project will increase health services coverage by expanding and improving NGO programs, assure coordination with the MOH, and permit community organizations to participate in determining health actions, as representatives of the beneficiaries.

III. PROJECT STRATEGIES:

1. OVERVIEW OF CARE, NGOs, AND OTHER INSTITUTIONS IN TARGET AREAS

1.1 CARE

CARE INTERNATIONAL

CARE was founded in 1945 as the Cooperative for American Remittances to Europe, with the objective of sending food packages to Europeans suffering the aftermath of World War II. Over the course of the last 45 years CARE has provided technical assistance and resources in primary health and food, community development,

agriculture and natural resources, small enterprise development and emergency relief programs to more than 100 countries in Africa, Asia and Latin America. CARE International came into existence in the late 1970s with the purpose of expanding support and providing greater resources to development efforts throughout the world. CARE International is comprised of 11 member countries: CARE-Great Britain, CARE-France, CARE-Italy, CARE-Denmark, CARE-Austria, CARE-Germany, CARE-Japan, CARE-Australia, CARE-USA, CARE-Norway, and CARE-Canada. CARE International taps financial and technical resources available in each of the member countries. In addition, CARE-USA provides ongoing technical assistance and administrative back-stopping, as needed.

CARE-Peru

CARE began its operations in Peru immediately after the 1970 earthquake in the department of Ancash with disaster relief activities. Over the past 20 years CARE has worked in rural communities in the departments of Puno, Cuzco, Ayacucho, Lima, Ancash, La Libertad, Cajamarca and Piura, and in marginal-urban communities in Puno, Lima, Callao, Chimbote, Cajamarca, Trujillo, Piura and Tumbes. Additionally, CARE is involved in reforestation activities in Junin, Apurimac and Huancavelica. Currently, CARE has seven coordinating zonal offices located in the peri-urban areas of Lima, Piura, Chimbote and Cuzco, and five regional offices in Puno, Cajamarca, Huaraz, Trujillo and Iquitos. CARE is contemplating increasing activities and presence over the next year in Cuzco, Chiclayo and Piura.

CARE focuses its efforts on four sectors in Peru: 1) Primary Health Care, including potable water systems, nutrition education and training, and food distribution; 2) Small Economic Activity Development, with activities in financial planning and management, technical training, credit to small business owners, and a variety of income generating projects with women and youth; 3) Agriculture and Natural Resources, where emphasis is placed on promoting environmental protection and sustainable agricultural practices; and 4) Emergency Assistance. This year, it is anticipated that 800,000 men, women and children will benefit directly from CARE-Peru's activities nationwide.

CARE is able to provide a significant amount of technical assistance as needed to different types of development projects through national and ex-patriate staff in Peru, as well as through CARE-USA technical expertise based in New York and throughout the Latin America region.

CARE-Peru, Puno Office

CARE-Peru has an office in the city of Puno, which is the organization's largest regional operation, with a staff of 66 technical and administrative personnel. Eleven of the 54 technical positions are in health and nutrition, with the majority of the remaining positions devoted to agricultural activities.

The Puno office of CARE-Peru currently manages eight projects in both rural and urban areas: PRODIA (community kitchens), WAWAWASI (a child nutrition project which includes feeding, growth monitoring and training activities, and local food production), Integrated Agricultural Development, ARCA (an agro-forestry and soil conservation project), Hand Pumps and Greenhouses, Women's Income-generation Project, WARU (agricultural development in high altitudes), and COPEME (a consortium for NGOs involved in small business development).

Given CARE's extensive and very active involvement in Puno, the organization has ongoing relations and agreements with the Regional Government of Puno, regional offices of the Ministries of Health and Education, ONAA (National Office for Food Support), DGFF (National Flora and Fauna Directorate), local and international NGOs, and community-based women's groups.

1.2 NGOs and other Institutions in Puno

There are eight major NGOs providing health-related activities in the sub-region of Puno. These include CARE, CARITAS, MSF, PLAFAMI, World Vision, ADRA\OFASA, UNCA, and the Colegio de Enfermeria. NGO programs include health/nutrition education and promotion; child and community feeding programs; child survival promotion; and provision of medications and water and sanitation activities. There are also a number of small NGOs which provide community-level organization and support on a small scale.

Medicos sin Fronteras (MSF) has provided medical care for several small areas to the north of the city of Puno, while PLAFAMI manages one Family Planning clinic in this same area. The other NGOs are considered to have the necessary base on which to build PHC health services. NGOs currently do not provide PHC clinical services.

Some of the current NGO health services consist of child feeding and health promotion programs, including the work of women in mothers clubs and community kitchens. NGOs do not have a referral system to the MOH health posts and centers. Effective referral services could help assure that children 0-6 receive PHC services (e.g. immunizations, treatment for ARI and diarrhea), including the treatment of women with prenatal and postnatal needs, and family

planning needs. The NGOs generally do not provide follow-up assistance for women and children. Follow-up is necessary to ensure that treatment regimes are implemented and medications are taken when they return from health facilities.

CARE, CARITAS and others provide feeding centers for children 3-6 years of age which usually include a balanced mid-day meal and nutrition education for parents. The activities of these centers are coordinated to some extent with the work of nearby MOH health centers for vaccinations and growth monitoring.

Reported coverage of NGO health services and activities vary. In Puno the estimated total coverage of NGOs is reportedly only 10% of children 0-6 and approximately 20% of women in mothers clubs with training activities. Services are provided on a sporadic basis to the communities, with some communities covered by Nutrition Centers and Child Survival (CS) promotion, while others receive assistance in water supply and sanitation services. CARE's 100 nutrition centers cover 3,000 children 3-6. The CS program covers another 3,000 children age 0-3. CARE's "comedores" program covers 300 communities -- with approximately 30 mother's club members each providing assistance to ten communities. CARITAS states coverage of more than 900 nutrition centers in 25 parishes. CARITAS has recently started a Child Survival program covering 1,667 children aged 0-3 years. CARITAS mothers club activities include child weighing. Their Food for Work programs, designed to cover 48 communities, include health promotion activities.

The quality of the CARE and CARITAS programs vary, however the training, management and monitoring function under CARE programs is strong. CARE and CARITAS have relatively new and smaller Child Stimulation/Survival programs for children 0-3 years, which use community volunteer health animators to visit households and provide health education and child stimulation. Some of these CS programs for the 0-3 group are connected to Nutrition Centers for the 3-6 group. NGOs have also begun to link the Centers to their other programs, for example, providing water and sanitation inputs to the centers for a more integrated package of services.

NGOs provide limited clinical programs in PHC. MSF for example is working in the MOH clinics, while the Adventists (ADRA\OFASA) have a hospital in Juliaca. CARITAS has several small posts in parishes. NGOs have few technical health personnel such as physicians, nurses and nutritionists. The technical personnel they do have are used to design and management of PHC promotion activities rather than provision of clinic services.

NGO programs do not provide medications with the exception of World Vision and MSF on a limited basis. Community botiquines usually consist of limited first aid supplies, but typically at high cost,

or conversely are subsidized for individual drug purchases by World Vision. Medications are not purchased in bulk nor are there available lists of basic drugs.

UNCA (Union Campesina Aymara)

Campesino groups organize women's clubs which provide assistance in production and social services. UNCA has organized 200 women's clubs in Aymara-speaking communities of approximately 200 families each. Primary objectives are promotion of production and social services. UNCA has established communal botiquines with UNICEF-provided iron and vitamins, as well as with CARITAS medications. At present, UNCA is unable to provide clinical services. However, they have a proposal to establish a primary health care system that will provide basic preventive and curative services to the maternal and child population within their purview.

The Nursing Council (Colegio de Enfermería) has provided assistance with baseline data to NGOs for their program development. The College is a non-profit association skilled in program design, administration, training and evaluation for small PHC projects. However, the physical plant and equipment of the College are limited.

The Universidad de los Andes medical and nursing faculties do not as yet assist NGOs or manage health clinics for student clinical practice sites. No clinical care is provided to the Puno area population. The University's Institute of Investigation in Development Studies of the Andes (IIDSA) provides internationally funded social science, nutrition, economic and other research assistance to the Puno area. Although IIDSA's strength is investigation, they possess some training capability given that members are comprised of university faculty.

Security of NGO health personnel and facilities has generally been adequate in the Puno region, although most NGOs provide services only in the south portion of the region, due to the security threat in the northern provinces from Sendero Luminoso. NGOs have recently been limiting their health and community development outreach/promotion programs, and are considering reprogramming activities to focus on an even smaller area in the South.

1.3 NGOs and other Institutions in Arequipa

There are a only small number of NGOs in Arequipa which are active in health related activities. CICICAP, AMAUTA and ASDE are primarily community development organizations which have included some health promotion activities. Relations with the MOH personnel are good, with NGOs promoting vaccination campaigns in their

communities, and providing transport and per diem to MOH personnel. AMAUTA is another of the community development organizations which works closely with community organizations. Their coverage is primarily urban and complements MOH vaccination and MCH promotion, water and sanitation activities. AMAUTA also helps fund MOH/NGO joint conferences and meetings for technical and coordinating purposes.

AUPA is a large community development organization working in approximately 360 urban slum areas and covers some 200,000 people. Programs include work with adolescent development and small business, urban sanitation, water protection and housing. AUPA is capable of leveraging funds for their urban projects, and have plans for expansion into rural areas.

UNICEF works with a number of community organizations directly providing funds, assisting with community botiquines and training community leaders. UNICEF grants to mothers clubs and other community organizations allow direct control by the community who can, in turn, request technical assistance from NGOs. Only a few NGOs provide clinical care. Principally INNPARES provides family planning, MCH and some pediatric services through a series of "visiting/one time a week" clinics. Their staff, in addition to direct clinical care, provides training and technical assistance to other NGOs. Their clinics provide for some cost recovery and cross subsidization.

Coverage of services by the NGOs, with a mix of health promotion and health related activities such as water and sanitation, are estimated to be 70,000 people. NGO coverage in the area is reported to be 28 percent for children under five, and 35 percent of women in the 15-45 age group. Health information systems are not sufficient to report on the actual numbers, or the types and quality of services. The majority of the NGO population covered resides in urban slum areas in the city of Arequipa. NGO activities in rural areas are smaller and less coordinated than those in urban Arequipa. UNICEF has developed an NGO activities/services map which is a first step to reallocation of NGO programs for more effective coverage.

One small NGO, EKIPO, works with physical health infrastructure development, and has a staff of architects, engineers, physicians, and nurses.

Management and administration systems of the NGOs are generally good. NGOs recognize that growth and increased complexity of programs will require strengthening of their administrative systems. None of the NGOs in Arequipa reported receiving USAID funding, although most are supported to varying degrees by international organizations.

The Universidad Catolica and the Universidad de San Agustin, in Arequipa, provide direct clinical care by utilizing students in medicine, nursing and nutrition in the hospitals and peri-urban health centers and posts in Arequipa. In addition to clinical care areas, Universidad Catolica includes the services of CEMPOS (Centro Multidisciplinarios de Proyeccion Social), which has been formed to provide technical capability in research and training.

The Arequipa regional government's Consejo de Asuntos Sociales is in the first phase of establishing an umbrella organization for private and public sector cooperation in multisectoral efforts (production, environmental improvements, sanitation, health service delivery and social services) for improved health. A Regional Council of Health has been formed within the Consejo which is to coordinate efforts within the health sector. Cooperation between NGOs and the MOH is good.

2. GOALS:

2.1 Final Goal:

To achieve sustainable improvements in the coverage and quality of health services provided to 150,000 beneficiaries in the Arequipa region and in the Puno sub-region by September of 1996, via the strengthening and expansion of health information and services implemented through NGOs in the project areas.

Due to the nature of this goal, its attainment will be measured at the intermediate goal level.

2.2- Intermediate Goals:

2.2.1 Expansion of coverage, quality, and efficiency of primary health care services in Puno and Arequipa. Indicators will be developed to measure the project's impact on PHC service levels in the project communities. Targets for these indicators will be based on the conclusions of the NGO study and the proposals approved for sub-grant and medicine distribution, in the seventh month of the project. The regional NGO and Technical Advisory Committees will participate in this process.

The project will, through the mechanism of the sub-grants, contribute to the improvement of coverage of basic health services:
a. % children < 1 receiving DPT3, OPV3, BCG, and measles vaccine
b. % of childhood diarrheas appropriately treated with home fluids, ORS, continued feeding or breastfeeding
c. % of children < 4 months old exclusively breastfed

d. % of women of reproductive age using modern contraception
e. % of children with ARI treated per MOH norms
f. % of pregnant women receiving at least 2 pre-natal visits
g. % of pregnant women receiving 2 doses of TT vaccine
h. % of deliveries attended by trained personnel
i. % of women delivering who obtain a post-partum checkup within 2 months
j. % of population with 5 kms. of a primary health care center who use it.

2.2.2 The effectiveness and scope of 18 NGO programs will be improved through the provision of training and technical assistance for their staff, and through channelling sub-grants for extending and consolidating the areas of programming, execution and administration of the primary health services.

Indicators:

18 NGOs with improved administration and accounting systems. This will be verified by the annual internal audits, and the external audits half-way through and at the end of the project.

18 NGOs carrying out key PHC services and information funded by the project. These will be verified through the quarterly reports, the annual evaluations and the external evaluations half-way through and at the end of the project.

The establishment and functioning of two pharmaceutical distribution systems in Arequipa and Puno, by the end of the project, having distributed $1,000,000 worth of medicines and managed at least 80% cost recovery in the revolving drug fund.

2.2.3 Improved collaboration and coordination among the NGOs operating in the target areas, the regional governments, and the Ministry of Health.

Indicators:

Two operational NGO committees established and operating in Puno and Arequipa which will facilitate coordination among the institutions, and between themselves and the MOH. This will be verified by the annual evaluations, the quarterly reports, and the external evaluations conducted half-way through and at the end of the project.

Two Technical Advisory Committees established and operating in Puno and Arequipa, composed of professional people from each region and

the MOH, providing permanent technical assistance to the NGOs. This will be verified by the AID monitoring reports, the CARE Health and Training Advisors' reports, quarterly project reports, and the evaluations made half-way through and at the end of the project.

Two information networks, established and operating for the NGOs, linked to the MOH HIS developed under the USAID Child Survival Action Project, in Puno and Arequipa, with which both parties will be able to maintain permanent communication. This will be verified by the AID monitoring reports, the CARE Health and Training Advisors' reports, and the evaluations conducted half-way through and at the end of the project.

2.2.4 Increased participation by the 320 beneficiary communities in the health activities, in the design and implementation of NGO health projects which meet the people's prioritized needs, and in the demand for health services.

Indicators:

Representatives of the 320 community organizations participating in the annual evaluation and programming meetings. This will be verified by the annual evaluation reports and the evaluation made half-way through and at the end of the project.

320 community health committees running health activities and dispensing pharmaceuticals in their respective communities. This will be verified by the annual evaluation reports and the evaluations made half-way through and at the end of the project.

70% of the community members receiving continuous health education. This will be verified by the quarterly reports, the CARE Training and Health Advisors' reports, the annual evaluations, and the evaluations carried out half-way through and at the end of the project.

3. STRATEGIES

The intermediate goals serve as strategies to achieve the final goal. The following section provides a more comprehensive description of each:

3.1- Strengthening the NGOs

As the overall project goal is to increase the coverage of health services, the project will focus activities on those NGOs and programs capable of providing a wide range PHC information and services.

The identified targeted NGOs, will develop sub-grant proposals for financial, material, and technical support, which will be reviewed, approved, monitored, and evaluated by CARE according to the established criteria to be approved by USAID.

The project will also support the creation of two NGO Coordinating Committees for NGOs participating in the project. One will be established in each of the project zones of Arequipa and Puno. Each NGO will be represented, in order to coordinate strategies and health activities. This will enable the NGOs to develop a more constructive and effective partnership relationship among themselves and with the regional government or other private providers of health care.

These committees will be chaired by the project Regional MAXSERV Coordinator, and contemplates the participation of a high-ranking MOH representative. The MOH Secretaries from the Arequipa and Puno regions have already indicated their interest in collaborating and coordinating through this committee mechanism.

3.2- Coordination between NGOs and Health Authorities:

One of the project strategies is to promote coordination and this will include levels and categories, as follows:

- The NGO primary health programs and projects will respond to regional health policies, strategies and programs.
- Where the MOH has health programs, the project will complement and not duplicate these services.
- The NGO and MOH staff will program and carry out activities jointly.
- Through the coordination committees the NGOs and MOH will collaborate and coordinate to improve the information exchange on coverage, in order to better plan all efforts reaching the most needy populations.

This coordination will be maintained from the start of the project, and will be an important feature in each NGO sub-grant projects to be financed by MAXSERV.

3.3- Community participation:

It is imperative that local communities take part in diagnosing their needs and in selecting and implementing solutions. One of the strategies to ensure project success will be for all NGO

programs funded by MAXSERV to be carried out in close collaboration with an already established community organization.

The community will collaborate in the program planning, and priorities will be established with each community, and these will be applied based on an agreement or charter between the NGO and the community.

In the programming of health services, local organizations will be informed in advance, so they can report to their communities, and decide whether the activities will be beneficial to their communities, and also have the opportunity to make suggestions as to how to best implement activities.

The project will require the NGOs to use this approach in order to have greater impact on the health in the communities.

3.4 Sustainability

Project sustainability is one of CARE's programming principles and will form part of all project components. It is considered to be a continuous process which should be taken into account in the planning of each project event or activity. Successful efforts at ensuring sustainability include financial viability, the ability to continue certain activities after the project funding terminates, delivery of cost-efficient services through well managed programs, and well trained and informed NGO program personnel who can continue providing PHC information and services.

The most important project initiatives to address sustainability will be the following:

- Coordinating and working jointly with the MOH since it has the largest network of facilities in the project areas, which would be able to pick up future PHC program costs.
- Community participation in programming as well as carrying out activities. The communities should take an active part in the project, so that they later see it as their own.
- CARE will develop clear written guidelines to NGOs on sustainability initiatives and provide training on how some of these strategies can be applied to their programs.
- The NGOs will submit sustainability strategies as part of their proposals, this being a prerequisite for their approval.
- The pharmaceutical distribution system should be implemented with reference to strategies necessary for making it permanent. Hence, CARE suggests that this component should gradually be taken over by the NGO Committee so that its members will be capable of its management when the project is over.

The establishment of the NGO Committee so that criteria and actions are unified, with agreement among the NGOs, and between the NGOs and the other entities implementing health projects in the region.

CARE has structured this proposal to provide NGOs with resource, technical, and managerial skills to improve their operational efficiency and to expand service delivery. It is strongly anticipated that many NGOs supported under this project will continue their operations and service delivery, and where necessary will be capable of finding donors to support selective levels of activity. In addition, the project will make every effort to analyze the most efficient and effective models for service delivery, encouraging substantial efforts in cost recovery where possible. The project sub-grant mechanism will seek as well a 10% counterpart contribution from in-kind resources from potential grantees.

IV. PROJECT COMPONENTS:

The "systems" discussed in the AID Project Paper are presented as components in this proposal. These components together provide the foundation of the project:

- Sub-grants to the NGOs
- Technical Assistance
- Training for NGO and MOH staff
- Distribution and Rational Use of Pharmaceuticals

In order to fulfill the proposed objectives, these components will be implemented through the NGOs and private health entities in the Puno and Arequipa areas which could include: NGOs, PVOs, university institutions, religious entities and other legally recognized associations. In each region, these entities have already been preliminarily identified with which the project could begin working.

1. Sub-grants

Funds will be donated to private agencies to establish, extend and improve the quantity and quality of the primary health care services in the Arequipa and Puno regions.

1.2- Sub-grant Mechanism:

The sub-grant process will begin when a private entity as potential grantee requests CARE to provide the approved guidelines, and submits a project proposal to CARE. If this proposal is approved, the entity will sign a legal agreement with CARE to guarantee the payment of the funds and the execution of the activities proposed in the project.

1.3 Elements for Preparing the Proposal:

Each project must include the following prerequisites:

- An executive summary of the proposal.
- The institution's experience, such as past projects, current projects and evaluations if any.
- A description of the project area, the population, the economic situation.
- Problem statement.
- Description of activities.
- Activities implementation plan.
- Staffing or personnel requirements.
- Budget and counterpart contribution.
- Required Technical Assistance.
- Project length.
- Sustainability plan.

This list is illustrative and will be further developed by CARE project staff.

1.4 Criteria for Proposal Approval

The following constitute the basic criteria for project approval; again, this list is illustrative:

- That the beneficiaries are poor people.
- That there is a significant degree of community participation.
- The type of services to be offered should include from among the following: vaccination, control of acute diarrheal infections and acute respiratory infections, nutrition, growth checks, breast-feeding, supplementary feeding, pre- and post-natal care, control of high-risk children, especially the new-born, and family planning.
- Coordination with other entities in the target communities.
- Training plan.
- The institution's technical and administrative capacity.
- Project replicability/adaptability in other areas.
- Community contribution.

- A realistic system for recovering costs, particularly with pharmaceuticals.
- Information system.
- Monitoring and evaluation plan.
- Sustainability of activities.
- Ratio of direct program to administrative costs.

A coordination strategy with the MOH in both planning and carrying out the project will be an important criteria for sub-grant selection. Potential grantees must also be prepared to program and implement their activities in coordination with the MOH health establishments in the field.

1.5 Grant Amounts

Each sub-grant will have a ceiling of US$100,000 per year for activities and projects will average three years. Should larger sums be solicited, the proposal will be considered by CARE in consultation with the USAID Project Officer. Sub-grant requests submitted at the midpoint of the project would be for up to two years duration, so as to permit time for evaluation.

Of each proposal's budget, at least 60% should go toward direct investment in the community health activities, and no more than 40% to administrative costs, including pharmaceuticals, so that the private entities are encouraged to put greater effort, time and resources into increasing their health services coverage.

1.6 Proposal Approval Process:

Proposals will be submitted by each of the private entities to the Regional MAXSERV Coordinators in Arequipa and Puno, who will make the pre-selection, following technical review. The Technical Advisory Committees, the project's PHC Technical Advisor, and the USAID Project Monitor will be consulted by the Regional MAXSERV Coordinators for their views on each proposal, albeit without direct decision-making authority. Initial approvals will be made by the MAXSERV Coordinator, and the final decision will be taken by CARE management in Lima as will the signing of agreements with private entities, in compliance with the institution's established legal procedures.

The dates for the reception and selection of proposals will be established by the Regional Coordinators together with the Project Coordinator. The period from when the first proposals are submitted to final approval and the first disbursement is estimated at two months, provided that the proposal does not need reformulation. This period is considered necessary for the relevant analyses and

processing within CARE. The disbursements will be made according to the timetables submitted by the NGOs to CARE.

1.7- Project Models

The sub-grants may be requested for nutrition, family planning, child survival, and primary health care activities. Preference will be given to projects which offer increased services to the target population, while respecting project selection criteria. The models described below are examples of projects which could qualify for MAXSERV funding. Section III.1. provides additional information on many of the institutions/programs summarized here.

1.7.1 Activities which are exclusively education and promotion, or have some preventive elements:

Institutions such as CEDER and CECYCAP in Arequipa work in preventive health care and health promotion. With these activities, the institutions can back up MOH coverage by complementing each other's programs and activities. The sub-grants will enable them to extend their coverage.

1.7.2 Activities which are exclusively promotion and prevention, and include direct health care activities:

There are private entities such as AMAUTA and ASDE in Arequipa and VISION MUNDIAL in Puno, which in addition to health promotion and prevention programs, offer direct health services to the sectors of the population within their project areas. The sub-grants could support expansion of their current program, including both services and promotion, to extend reach to a larger population.

The health promotion, prevention, and direct assistance activities -- particularly the latter -- should be focused in close collaboration with the MOH provision of services.

1.7.3 Programs which are exclusively Supplementary Feeding and Promotion, or with preventive health care activities:

CARITAS and CARE currently fall into this category. In these programs, the purchase, handling, distribution, and monitoring of food for children is essential. When the families meet to receive the rations, the institutions could use this opportunity to undertake preventive health care activities.

CARE-Puno, as an NGO, will be able to take advantage of the sub-grant program in order to extend its nutrition, promotion and

prevention programs which currently reach 3,000 children of between 3 to 5 years of age through 100 Wawawasis, 9,000 women of fertile age through 300 soup kitchens, and 300 children of up to 3 years of age through the PIETBAF program.

1.7.4 Promotion, referral and counter-referral of patients:

To decrease morbidity and mortality rates, workable patient referral and follow-up systems need to be developed. These systems are essential in rural areas. They would involve the promoter or health auxiliary who refers a patient from a community to a health center providing a written referral note stating the patient's symptoms and the treatment given. This will allow the health center to provide more efficient and effective service.

In turn, the hospital staff will be encouraged to write referral notes to the health worker who submitted the case with precise instructions as to follow-up care. Incomplete treatments can be avoided, and the number of chronic illnesses will be reduced, particularly in the case of children.

1.7.5 Programs exclusively providing direct health care, family planning services, or other specialized attention:

There are entities such as CEMPOS (dependent on the University of Arequipa), INNPARES (Arequipa), PLAFAMI and the Nurses College in Puno, which have family planning programs, general mother and child attention, and general services for the poor.

Normally, to extend their services, these institutions will require equipment, personnel, and/or logistical support. Similarly, these institutions may extend their health services coverage and collaborate in education and preventive health care in these communities.

1.8 Component Budget:

The projected budget for sub-grants or sub-contracts totals US$2,000,000.

Initially, the project could work with 6 private entities in the Arequipa and Puno regions. With support provided to up to 18 institutions, an average of US$100,000 would finance one project per entity over the five years of the program.

2. Technical Assistance:

The technical assistance necessary for the project is divided into two large groups: external technical assistance, and the assistance which the project itself will provide to the participating private entities.

External technical assistance will be chiefly aimed at formulating systems for implementing the project, in order to establish an effective flow of information between the project and the NGOs, and to control and evaluate the various programs and actions.

The assistance which the project will provide to the NGOs will be aimed at increasing their technical and administrative capacity.

2.1- External Technical Assistance:

2.1.1- Research of the needs and capacity of the NGOs:

A study will be conducted in order to determine the precise needs of each of the NGOs which may take part in the project, prior to the phase of sub-grant proposal development. It is always difficult for any institution to recognize its own limitations, but if the NGOs are to be strengthened it is necessary to have such a detailed analysis. On the basis of this information, a training plan will be developed to support their capacity for running the various health programs in the target communities.

Similarly, determining the capacity of each entity will enable the project to continue self-education and the exchange of experiences between NGOs. The 18 NGOs preliminarily identified are willing to collaborate in the study, since they understand the benefits of participating in **MAXSERV**.

This study will be conducted at the project start-up. A consultant will be hired, such as IDDSA in Puno (see section 1.2), which has this type of expertise and experience, for a period of three months.

The approximate cost of the study would be US$14,000.

2.1.2- Formulating a Health Management Information System (HIS):

The health management information system will permit rapid decision-making at all project levels, allow for each funded project to be controlled and monitored, and allow for prompt reporting.

The HIS should also enable each NGO to be at all times informed of the degree of progress made towards the goals programmed for each of the health programs, to make readjustments in their programming, to provide regular feedback to the different project levels and the beneficiaries, and review and appraise their experiences. A system for programming and evaluating activities, accounting, and for pharmaceutical supply logistics will be developed.

The CARE HIS will be upwardly and downwardly compatible with the MOH HIS/MIS being developed by contract with PRISM, under the USAID bilateral Child Survival Action Project (CSAP). In addition, when formulating the system, the different information systems in use in the NGOs will be taken into account. In the former case, it must be clear that there is no intention to create a parallel system. To the greatest extent possible, the project information system will be adapted to the regional and MOH priorities, in an attempt to create one single information system throughout the region. A modem will be procured for each MAXSERV office to facilitate transmission of data to the respective UDES and the MOH (as well as CARE) in Lima.

The information system will consist of the following:

- Base-line Data.
- A standard form for collecting data from the communities, and the participating NGOs, to correspond to each program.
- A standard form for consolidating the information or transferring information.
- A standard computer system for data processing.

The system will be developed by a specialized consultant with extensive HIS design experience. It may prove possible to fully adapt the new MOH HIS/MIS system to project requirements. The consultant will help CARE analyze the new MOH system. The technical assistance requirements may be for a period of up to nine months, from project startup.

The budget for formulating the information system includes the following:
- Consultant expenses
- Training for CARE and the other NGOs in computerized HIS management.

CARE has already received one proposal from the Grupo QUIPUS for the design of the system, which is included as Appendix 1. It will review with USAID and PRISM the configuration of the new MOH system prior to contracting for this technical assistance.

The budget for this component, has been estimated at US$70,000. In this sub-component, there will be no computers purchased for the individual NGOs. They would be purchased as appropriate as part of individual sub-grants.

2.1.3- Creating a pharmaceutical distribution system:

The technical assistance for creating a pharmaceutical distribution system will directly benefit the NGOs and communities, since they will then have a purchasing, distribution, and counter-referral pharmaceutical system which will provide the communities with better access to reasonably-priced pharmaceuticals.

The creation of this system will take 180 days, in the project's start-up stage, and will require an external expert.

This consultancy will include the preparation of an essential drug list and guide for using the pharmaceuticals, and the list of pharmaceuticals to be used at different levels such as by doctors, nurses, nurse auxiliaries, and health promoters.

The approximate budget for this technical assistance is US$18,000.

2.1.4- Training Plan Design:

There will be two levels of project technical assistance in training: for NGO staff and for the communities.

For the NGO staff there will be a training plan designed on the basis of the results of the initial study of the NGOs. The plan is necessary because the NGOs must strengthen their staffs' current capacity in order to structure and improve their own organization and become more efficient and effective in delivering the basic package of primary health care services.

For community education, there will be a permanent training and refresher course plan. At present, 90% of the NGOs carry out community education activities, but each follows a different pattern and with little relation of methodology or content. This frequently causes confusion among the beneficiaries, since they see different rules and criteria in the health projects, depending on the institution involved.

The project will hire an expert in adult or non-formal education, for a period of three months, who will design the training plan beginning in the sixth month of the first year of the project. The preliminary plan presented in section 3 will be updated as the output of this consultancy and the NGO Study (2.1.1).

The approximate cost of this consultancy would be US$9,000.

2.1.5- CARE Regional Health and Training Advisors (RTAs):

CARE has technical advisors for Health and Training for the region. They will be invited in the first and third years of the project, on each occasion for ten days, in order to have offer their assistance in programming, monitoring and evaluating **MAXSERV**, especially the NGOs' Child Survival programs. They will also be available for problem-solving as backstops when needed, serving as adjuncts to the PHC Technical Specialist.

The approximate budget for the RTA visits will be US$20,000.

2.2- Project Internal Technical Assistance:

The project will provide technical assistance to the NGOs through their staff, in the necessary areas and/or others requested. Two principal areas are foreseen for this technical assistance:

- Child survival, including categories such as: diarrheal diseases and ARI, growth monitoring of children, and maternal health including family planning and nutrition, and others which will appear during the project.
- Administration, including: information system, preparation of proposals, accounting system, combined programming and accounting reports, and coverage statistics.

The following staff will provide the technical assistance. Detailed descriptions of their duties are given in Section VII of the proposal:

2.2.1- Project Coordinators:

The overall CARE **MAXSERV** Coordinator in Lima, like the Regional Coordinators, will offer assistance in programming and administration and will also provide technical assistance to the NGOs in institutional support, such as in preparing proposals and reporting.

2.2.2- PHC Technical Advisor:

The PHC Technical Advisor will work exclusively in providing technical assistance to the NGOs, particularly in maternal-child health and child survival programs, giving guidance in the technical criteria for each health activity, and in program design for the particular situation each NGO is attempting to address.

The advisor will also support the NGOs with statistical analysis of their coverage, so that the NGOs will be better able to make the relevant adjustments in their programs.

He/she will also work closely with the Technical Advisory Committee in order to determine specific, appropriate technical assistance needs and expertise available.

2.2.3- Auditor and Accountants:

These will support the NGOs in improving their current accounts systems and in preparing the quarterly accounting reports which must be submitted to CARE and subsequently to the USAID Project Officer.

2.2.4- Technical Advisory Committee:

The establishment of two Technical Advisory Committees is envisaged for the project, in Arequipa and Puno. These committees will be composed of professionals from different institutions and fields, including professionals from the MOH. These technicians will advise and offer technical assistance to NGO and MOH personnel, to the degree that USG sanctions permit.

The services of this group may be requested for specific technical work, such as administration, statistics and specific health programs.

These services will be voluntary, and those involved will receive reimbursement for travelling expenses when they have to monitor activities in the communities.

The budget for the Technical Advisory Committees is estimated at US$25,000.

The total budget for the Technical Assistance component will be approximately US$261,000.

3. Training:

In the proposal, training and technical assistance are dealt with as separate components, although in practice it is very difficult to define the division. However, the importance of each for the project must be emphasized.

Technical assistance is seen as support offered in specific, individual cases, whereas training is seen as continuous technical support in different fields.

For the project, training is one of the keys for strengthening the NGOs, since it is through this mechanism they will acquire the skills to operate sustainable health service activities. CARE will seek to avail itself of support from a number of project and institutional resources for training, including USAID.

In some areas, training should be provided to the staff of all the NGOs, while in others it will be given to only a select group and in others to only one NGO.

The project will implement the following training activities over the five-year period:

3.1- Project Introduction Workshop

At the beginning of the project, a meeting with local NGOs and health authorities will be held where the following project activities will be thoroughly explained:

- Scope
- Objectives
- Components
- Inter-institutional coordination

Similarly, the roles within the project will be explained -- of CARE, the NGOs, the MOH, the community organizations, and the communities.

The sub-grant system -- its programming, technical, accounting and administrative requirements -- will be explained in general terms.

This pharmaceutical distribution component will be discussed, and a separate working meeting programmed for those groups interested in presenting distribution proposals.

This meeting will be attended by representatives from the organizations interested in taking part in the project. The session will be repeated in the second, third and fourth years.

3.2 Sub-grant Mechanism Workshop:

For the NGOs which receive sub-grants, training events for NGO representatives will be held in the first through fourth years:

- To give a detailed explanation of the sub-grant mechanism, its programming, technical, accounting and administrative requirements
- To provide instructions in strict reporting requirements
- Inter-institutional coordination requirements

- Project sustainability
- Personnel management
- Accounting systems
- Administrative control
- Technical updates in priority health services

3.3 Programming, Monitoring, and Evaluation Workshop:

The first Programming workshop will be held after the NGOs have received a sub-grant, at the end of the year one. Each year there will be a workshop on evaluation for the year's activities and programming for the next. The participants will be from the NGOs and other regional institutions. To the degree that USG sanctions will permit, CARE considers that it is vital that the MOH take part since each NGO proposal must be consistent with the MOH regional program, as this is the official, permanent health entity. CARE will request USAID backstopping for these workshops.

3.4 PHC Technical and Community Education Workshop:

Under this heading come the different programs in which the specialized MOH and NGO personnel should take part, in order to explain the rules and technical criteria established in the region. In addition, training will include efforts on coordinated health education messages. The Project Coordinator, PHC Technical Advisor, and CARE's Regional Technical Advisor for Health will also be key facilitators in these workshops.

3.5 Information System Workshops:

a) HIS workshop to review HIS system proposed by CARE. Participants will include USAID, MOH, PRISM, QUIPUS, PRISMA, and other interested agencies.

b) NGO participants will be instructed in the use of the information system. This training will include how to manage a computerized information system. The importance of this training is that the project will standardize the coverage information of the NGOs in one single information system, linked to the new MOH HIS/MIS developed under the CSAP PRISM contract.

3.6 The Rational Use of Pharmaceuticals and Cost Recovery Workshop

Only in this case, training will be provided by international consultants, in workshops for NGO and MOH representatives. USAID will procure this consultancy, per previous discussions with CARE.

3.7 Program Evaluation Workshop

In the third and fifth years, two program evaluation workshops will be held as input into the mid-term and final project reviews. These will be held in either Arequipa or Puno, with representatives (two each) from all participating institutions in both regions.

3.8 Program Management Workshops

-seminar on public-private sector relationships to strengthen PHC services, to be carried out during the project expansion and consolidation
-information and accounting systems
-cost effective approaches
-management skills
-development of a sustainable in-service training program for NGOs

3.9 Clinical Requirements Workshops

-MOH policy and treatment norms
-clinical case management for core services
-referral systems for patients
-updates on PHC and Child Survival technologies

These will be developed in greater detail in the Training Plan, following the NGO study.

3.8 Summary

All these training areas and others which may appear after the initial study of the NGOs will be financed by the project.

The training will be given by MOH and NGO personnel, the Technical Advisory Committee, and other professionals identified both within and outside of the project regions.

The organization for the entire Training Plan will be the responsibility and under the supervision of the MAXSERV Coordinator, with significant input from the PHC Technical Advisor.

A technical library\clearinghouse will be opened in an appropriate institution in Arequipa, and another in Puno, for the use of the project personnel, the NGOs and other entities which request it. The operating procedures will be determined in the pre-implementation stage of the project. The estimated cost of the

libraries is US$10,000. CARE will coordinate with the USAID Project Officer to determine feasible levels of support from centrally-funded projects for these centers.

Training Activities:

Training Workshops	1st yr.	2nd yr.	3rd yr.	4th yr.	5th yr.
Project Introduction	xx	xx	xx	xx	----
Sub-grant Mechanism	xx	xx	xx	xx	----
Pharmaceuticals/ Cost Recovery	xx	xx	--	xx	---
PHC Clinical workshop	xx	xx	xx	xx	----
Community Education	---	xx	---	----	----
Information Systems	xx	---	---	xx	----
Programming, Monitoring and Evaluation	xx	xx	xx	xx	xx
Program Evaluation (joint)	---	---	x		x
	10	12	9	10	3

The approximate budget for the Training component is US$490,000. In sum, there will be a total of 8 introductory meetings and 36 five-day workshops with an average of 30 participants.

4. Purchase, Distribution and Rational Use of Pharmaceuticals

It is evident that the some NGOs are delivering pharmaceuticals to the communities within their scope. These include World Vision, CARITAS, Cempos, INNPARES and Planifam. Other NGOs could implement this as part of their health programs. Pharmaceutical distribution would imply a greater impact of their current programs, and would serve to keep the health promoters as permanent health agents in their communities.

This component would provide community members with greater access to low cost pharmaceutical, or at least at more reasonable prices than those currently available. External technical assistance will help CARE design a system that all participating agencies can "buy into" for service delivery, so as to sustain the advantages of one integrated system.

CARE will coordinate with PRISMA and the MOH in supporting and ensuring the adequate distribution of pharmaceuticals and family planning supplies to the project regions, taking advantage of the existing commodity distribution system.

4.1 Pharmaceutical Acquisitions:

The following requirements are necessary for acquiring pharmaceuticals:

- Low cost
- High quality
- On the 1989 WHO list
- Endorsed by the MOH
- U.S. source\origin or waiver
- Appropriate to the level of personnel prescribing them

4.2- Project Responsibility:

For the pharmaceutical distribution component, the following will come under the responsibility of the project:

- Pharmaceutical acquisition.
- Transport to the port of Matarani (if external source).
- Transport from the port of Matarani to Arequipa and Puno.
- Storage in both regions.
- Allocation to the NGOs from the regional CARE office.

CARE will have a small warehouse, adequate for storing pharmaceuticals, in each of the two regional offices.

The pharmaceuticals will be provided to NGOs on a regular schedule based on plans developed by the pharmaceutical consultant, and approved by USAID.

V. PROJECT MANAGEMENT:

The project will be managed from the central CARE office in Lima. Two offices will be opened, one in Arequipa and the other in Puno, for project execution. Each level will have distinct management, technical, and organizational responsibilities.

1. - The top management will be represented by the **MAXSERV** Coordinator, an international staff position at 100% time to the project, with headquarters in

the CARE Central Office in Lima. The following will be this individual's primary functions:

a. Design, program, and monitor the administrative, financial, logistics, personnel, information, and M&E procurement systems. This will include analysis/selection of consultants with appropriate expertise, hiring of project staff, and significant coordination with large number of mission personnel.
b. Elaborate annual work plans for each of 5 years.
c. Supervise and evaluate all project activities.
d. Responsible for information/reporting on project, as required by CARE and USAID.
e. Monitor project budget and update as necessary.
f. Define, in coordination with the CARE\Peru Health Sector Manager, the technical-administrative requirements/documentation for the project's sub-grant mechanism.
g. Supervise the administration of the sub-grants in both project areas.
h. Supervise/provide guidance for the establishment the NGO Committees and Technical Advisory Committees in each region by field personnel.
i. Oversee field staff collaboration with NGOs in the preparation of their sub-grant proposals.
j. Work closely with field staff and local committees in designing/implementing effective revolving fund for basic pharmaceuticals.
k. Establish and maintain strong relations with private and public organizations working in both regions.
l. Spend 5 working days per month in each project region.
m. Directly responsible for the achievements of project goals and targets.
n. Approve all sub-grants, based on the technical reviews and pre-selection process recommendations.
o. Act as major liaison with the USAID Project Officer.
p. As time permits, additional responsibilities as assigned by the Health Sector Manager -- likely to be in the design of new project initiatives and/or emergency activities.

2.- The field level will be represented by the Regional MAXSERV Coordinators in Arequipa and Puno (national staff positions). Their main duties will be as follows:

a. Programming and implementing the project activities in the region.
b. Organizing, under the supervision of the Coordinator, the NGO Committee and the Technical Advisory Committee in each region.
c. Recommending approval or disapproval of sub-grant proposals, based on the technical review in committee.
d. Controlling the administration and finances of the respective regional office.
e. Managing the sub-grants, pharmaceutical, training and technical assistance components in their respective areas.
f. Maintaining permanent relations with private entities which work with the project and with other public and/or private entities in the region.
g. Monitor progress indicators and prepare project reports and budget revisions as required.

h. Providing technical assistance and support to the NGOs particularly in preparing proposals.
i. Supervising the application of the information system in each region.
j. The Regional Coordinator is responsible for the project in his/her region.
k. He/she is accountable to the project Coordinator.

3.- In addition, there will be one technical support post, a (local hire) PHC Technical Advisor, with headquarters in Arequipa. The main duties of the Advisor will be:

a. Develop training programs with regional coordinators.
b. Design permanent technical assistance system in the health projects (sub-grants) to be implemented.
c. Provide technical expertise for PHC programs of the NGOs.
d. Use information systems to analyze NGO and MOH coverage for vaccination, CDD, ARI, Nutrition, Family Planning, Maternal care, and deliveries. Provide technical feedback to regional coordinators and NGOs.
e. Monitor quality of primary health services provided.
f. Designing the annual work plan, in such a way that his/her time is equally divided between both regions.
g. Writing reports for both Regional Coordinators, as required.
h. He/she will report to the Project Coordinator.

4.- Staff:

The project will have the following personnel:

In Lima:

Project Coordinator.....1
Bilingual Secretary.....1

In Arequipa and Puno:

Regional Coordinator.....2
PHC Technical Advisor.....1
Accountant.....2
Secretary(1).....2
Driver/messenger.....2
Watchman(2).....4
==========
TOTAL.....15

(1) Should have data entry capabilities.
(2) There are four watchmen to take round-the-clock shifts.

The Project Coordinator will be identified and selected by CARE Peru management in coordination with CARE USA, with USAID approval. The Regional Coordinators and PHC Technical Advisor will be selected by CARE Peru management, with appropriate USAID approvals.

CARE\Peru will also select the bilingual secretary. TheAccountants will be pre-selected by the Regional Coordinators and approved by the CARE Finance Department. All other support personnel will be selected by the Regional Coordinators. The auditors required for technical assistance to the NGOs will be contracted under technical assistance packages, and are not considered permanent project staff.

Insert Organigram

Insert Cuadro 1

NOTE: Cuadro 2

VI. PROJECT IMPLEMENTATION PLAN:

The implementation plan has two different stages and periods: Start-up and Expansion and Consolidation. The Start-up period will last for 10 to 12 months and the Expansion and Consolidation period for four years.

1.-Start-up Period

The following are the most important activities in this project stage:

1.- Opening offices in Arequipa and Puno.
2.- Hiring personnel.
3.- Hire technical assistance in HIS.
4.- Finalize HIS and hold workshop.
5.- Develop initial Technical Assistance plan
6.- Preparing the Project Introduction Workshop.
7.- Holding the Project Introduction Workshop.
8.- USAID approval on measures\outcomes by which increased coverage and quality of services will be evaluated.
9.- Hiring a consultant for the initial study of the NGOs, their capacities and needs.
10.- Carrying out this NGO study.
11.- Develop Training Plan
12.- Signing agreements with the Regional Governments and the Regional Health Authorities.
13.- Designing the sub-grant mechanism.
14.- Signing agreements with the NGOs.
15.- Preparing the Sub-grant Workshop.
16.- Holding the sub-grant Workshop.
17.- Finalize Technical Assistance Plan.
18.- USAID contracts for technical assistance in Pharmaceutical Distribution System
19.- Putting Technical Assistance Plan into effect.
20.- Writing a guide for creating the NGO Committees.
21.- Establishing the NGO committees.
22.- Establishing the Technical Advisory Committees.
23.- Buying and distributing the first lot of pharmaceuticals.
24.- Starting up the sub-grant mechanisms with 6 NGOs.
25.- Preparing the Programming Workshop.
26.- Holding the Programming Workshop.
27.- Internal evaluation.

2.-Expansion and Consolidation Period:

This is to be divided into two stages, each one of two years' length. During the first two years the existing NGO programs will

be consolidated in the communities where they are working. The following will thus be critical to project success:

- Training for NGO and MOH personnel in project sustainability, handling the information system, techniques in PHC, rational use of pharmaceuticals, and health program administration.
- Technical assistance in programming, monitoring, and evaluation; and sub-grant management.
- The extension of pharmaceutical distribution with all interested and qualified NGOs.
- Extension of the sub-grants to the NGOs of both regions which are willing to fulfill the requirements and are able to do so.

During the two last years of the project, with the experience gained in the previous years by the project and the NGOs, these programs will be extended to other committees, trying to increase coverage, according to the projections of the NGOs.

Please refer to the detailed flow chart for the first year of the project and a more general flow chart for the four following years, on pages 39-40.

VII. PROJECT REPORTING REQUIREMENTS AND EVALUATIONS:

1. Evaluation Responsibilities

.1- External Evaluations:

An external evaluation will be conducted half-way through the project and another at its closure. These evaluations will be contracted by USAID from funds obligated to that component under the cooperative agreement. The selection, approval, and contracting of the project evaluation firms will be done by USAID/Peru. USAID will use these evaluations, in addition to on-going monitoring, to determine overall component progress with CARE, and the progress to meeting overall SHIP goals.

1.2- Internal Evaluations:

Every year there will be internal evaluations of the sub-grants given to each NGO, which will review the goals proposed, their scope and the methodologies used. At the same time, the necessary adjustments will be made to both the activities and the goals.

Each NGO will make these annual evaluations under CARE supervision. At a later date, the NGO Committee will devote two days to discuss

the evaluations and to make the program for the next year. Community organization representatives will participate in these workshops.

2. Auditing of the Project and the NGOs:

2.1- Project audits:

An A133 annual financial and compliance audit is to be conducted by CARE. Under this Cooperative Agreement, the project will pay for those additional costs required to include the project in the terms of reference of the standard annual audit. A Peruvian firm with an affiliation with a U.S. accounting firm will be acceptable. USAID/Peru Controller's Office will make available the draft scopes of work, review the draft reports, and track efforts to address all material recommendations. The audits will be performed in accordance with GAO standards, with copies provided to USAID/Peru and the RIG/A/T.

The approximate cost will be US$10,000 each, totalling US$20,000.

2.2- NGO Audits:

These will be completed at the end of the first year for each NGO and at the end of each NGO's sub-grant. CARE will hire an auditor, since there will be 18 NGOs, and this will require one person full-time. The annual cost will be US$11,000, a total sum of US$55,000.

3. Project Reporting Requirements

As the cooperative agreement method of financing will be direct payment under the CARE Letter of Credit, CARE/Peru has special responsibilities to ensure effective and up-to-date reporting for efficient project monitoring. Each financial transaction or activity recorded under the component agreement will be reported to USAID under the LOC on a quarterly basis, according to the approved AID project elements. Project disbursements will cover the cost of project operational expenses, technical assistance, training and sub-grant activities. Sub-grant activity under MAXSERV will be reported on a quarterly basis by CARE. Detailed program reports will be provided to USAID on project progress on a semi-annual basis, supplemented by trimester progress updates. Project counterpart contributions of CARE or other regional entities will be monitored and reported to USAID on a semi-annual basis.

VIII. PROJECT BUDGET

All major budget items are explained in this section. Throughout the budget, annual increases of 10% are included to cover inflation projections. CARE expects to have 15% tolerance on budgetary line items.

1. 4 Budget Detail

1.1- Salaries:

The MAXSERV Coordinator will be international staff. The salary budgeted represents the mid-range of the Project Coordinator salary scale. The difference in benefits between the first and second year is because of the payment of his/her trip to and installation in Peru. Annual salary increases of 7% are budgeted, as average projections programmed by CARE USA. The benefits include housing, social security, R&R, home leave (every two years), school fees, personal and vehicle insurance, and moving expenses. For budgeting purposes it has been assumed that the Coordinator supports 3 dependents (spouse and 2 children).

The national salaries represent top salary ranges within CARE Peru's staff structure for all positions. This provision must be made given the level of technical experience to be required for this project. The salaries have been calculated per CARE Peru policy, and include 14 monthly payments per year. The social benefits are calculated at 40% of the salary. Annual 10% salary increases are budgeted based on CARE\Peru projections.

1.2- Vehicles:

Four vehicles and two motorcycles will be indispensable for the project. The vehicles will be used for the work of the MAXSERV Coordinator, the Regional Coordinators, and the PHC Technical Advisor. It is CARE USA policy to assign a vehicle to every international staff member.

1.3- Computers:

Seven computers will be bought for the project programming, administrative and accounting registers, and for project coordination/administration in the regions and in Lima.

The Coordinator and PHC Technical Advisor will be provided with laptops to facilitate their work in the field. The Lima-based secretary will utilize a desk-top computer. Two desk-top computers for each regional office will be used by the Regional Coordinators, Accountants, and Secretaries. These will be critical for ensuring timely programmatic and financial reporting to USAID, particularly

since the latter will be required on a quarterly basis.

1.4- Office Costs:

The rent and maintenance of offices in Arequipa and Puno are included here, as well as furniture (desk, etc.) for each project employee. Communication and material costs, calculated with a monthly average, are also included. All of the above have been calculated based on similar expenses made in existing CARE regional offices.

Two modems for the Arequipa and Puno offices will facilitate the transmission of programmatic coverage to MOH and CARE headquarters, and financial information to CARE headquarters to ensure timely reporting.

1.5- Travel:

The Coordinator and PHC Technical Advisor will travel to supervise the project, and the Regional Coordinators and PHC Technical Advisor will periodically travel to Lima for required meetings. CARE per diem expenses are determined by CARE\Peru policy.

1.6- Technical Assistance:

A detailed description of the technical assistance plan will be completed during the pre-implementation stage of the project.

As explained in section 2.1, the NGO study is expected to take 3 months and will necessitate extensive travel in the project areas. The cost estimate is based on preliminary discussions held with IDDSA in Puno, as this institution has expressed interest in undertaking such a study.

The proposed 9-month information system consultancy is explained in detail in Appendix 1, with budget detail for year one. The year 2two allocation will be utilized for readjustment of the system as necessary.

The pharmaceutical distribution consultancy, the only among the group to the procured by AID, will take 60 days. The training plan design is programmed for 3 months, and will include trips to each region.

The project has budgeted 2 trips each for visits by CARE's Regional Advisors for Health and Training during the life of the project. The costs of their services is determined by CARE USA.

1.7- Sub-grants:

The sub-grant budget is distributed in the four first years. No sub-grants will be made in the fifth year.

1.8- Pharmaceuticals:

This budget is distributed over the first three years, since in the fourth and fifth years the system must be consolidated.

1.9- Training:

A detailed description of training is provided due to the high cost involved. It must be recognized that this component is a key element in the project's sustainability strategy. With the exception of the pharmaceutical use workshops, all events will be conducted by national facilitators. Budget detail is included in the attached worksheets.

1.10- Auditing and Evaluation:

The external evaluations of the project program will be conducted in the third and fifth years, directly by USAID. Under this Cooperative Agreement, the project will support the additional costs of including the project in the annual A133 audit, to ensure full compliance with Federal regulations.

1.11- CARE\Peru Fixed Mission Costs (FMC) and Indirect Costs:

The project will support 12% of the administrative expenses, or FMC, of CARE Peru. This cost is distributed among all mission projects, based on their proportion of the overall portfolio. CARE estimates that its FY 1992 budget, with MAXSERV, will total close to $11 million. Thus, MAXSERV's year one cost of $1.3 million constitutes 12% of the mission's portfolio. Given that it is not possible to project mission budgets over the next five years, a lump sum of $192,000 per year (i.e., 12% of AID FY 1992 FMC) will support these costs. This represents 17.4% overhead on the project budget. There is also an 7.6% charge on CARE-USA Indirect Costs. It is CARE policy to include this in all project proposals.