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

HONDURAS

PROJECT PAPER

HEALTH SECTOR II
AMENDMENT NUMBER 2

AID/LAC/P-937
CR- 426, 898

PROJECT NUMBER: 522-0216

UNCLASSIFIED

A

AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT DATA SHEET		1. TRANSACTION CODE <input type="checkbox"/> A = ADD <input checked="" type="checkbox"/> C = CHANGE <input type="checkbox"/> D = DELETE	AMENDMENT NUMBER <u>2</u>	DOCUMENT CODE 3
2. COUNTRY/ENTITY Honduras		3. PROJECT NUMBER 522-0216		
4. BUREAU/OFFICE LAC		5. PROJECT TITLE (maximum 40 characters) Health Sector II		
6. PROJECT ASSISTANCE COMPLETION DATE (PACD) 09/30/99		7. ESTIMATED DATE OF OBLIGATION (Under 'B', below, enter 1, 2, 3, or 4) A. Initial FY 88 B. Quarter 4th C. Final FY 98		

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

A. FUNDING SOURCE	FIRST FY 88			LIFE OF PROJECT		
	B. FX	C. L/C	D. TOTAL	E. FX	F. L/C	G. TOTAL
AID Appropriated Total			0	41,301	25,609	66,910
(Grant)	(3,610)	(3,500)	(7,110)	(41,301)	(25,609)	(66,910)
(Loan)			0			0
Other U.S.	1.		0			0
	2.		0			0
Host Country			0	6,329	24,805	31,134
Other Donor(s)			0			0
TOTALS	3,610	3,500	7,110	47,630	50,414	98,044

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATION TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1 Grant	2 Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) PN				3,130		3,472		6,602	
(2) HE				17,072				17,072	
(3) CS				33,900		5,735		39,635	
(4) AIDS				2,558		1,043		3,601	
TOTALS				56,660	0	10,250	0	66,910	0

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

13. PROJECT PURPOSE (maximum 480 characters)

To insure a sustainable and effective public primary health care system in Honduras by improving the quality, accessibility, and sustainability of effective child survival, family planning and reproductive health, and STD/AIDS prevention services.

14. SCHEDULED EVALUATIONS	15. SOURCE/ORIGIN OF GOODS AND SERVICES
Interim <input type="checkbox"/> Final <input type="checkbox"/>	<input checked="" type="checkbox"/> 000 <input type="checkbox"/> 941 <input checked="" type="checkbox"/> Local <input type="checkbox"/> Other (specify)

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

This amendment extends the PACD by three years, increases the planned USAID contribution by \$10.25 million, and redefines the results expected from the project.

17. APPROVED BY	Signature <i>Wayne R. Nilsestuen</i> Wayne R. Nilsestuen	18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
	Title Acting Mission Director	

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I. PROBLEM STATEMENT

A. Progress to Date

Over the past fifteen years, Honduras has had one of the most rapid declines in infant mortality of any country in Latin America. This achievement was largely due to the Government of Honduras (GOH) commitment to primary health care and to its close and long-term working relationship with USAID under the Health Sector I (HS I) and II (HS II) and Rural Water and Sanitation Projects.

USAID project assistance has been instrumental in enabling the GOH's Ministry of Health (MOH) to adopt effective child survival technologies and in providing important administrative, management and logistic support to the MOH, beginning first with primarily central level support under HS I (1980-87) and then under HS II (1988-96) with management and administrative support for decentralization of health systems to the regions. Among the many notable achievements under the HS II Project have been the advances made in cholera and diarrheal disease control, the nationwide expansion and maintenance of near universal Expanded Program of Immunizations (EPI) coverage, and the construction and maintenance of community-managed water and sanitation systems in rural areas.

Oral rehydration therapy (ORT) for combating diarrheal disease is now widely practiced. Over 40 percent of children with diarrhea are routinely treated by mothers¹ resulting in a dramatic reduction over the project period in the percent of outpatient clinic visits due to diarrhea. The percent of children under one vaccinated for common childhood diseases -- Diphtheria-Pertussis-Tetanus (DPT), measles, polio and tuberculosis -- and through their mothers for neonatal tetanus, has increased to more than 90 percent, and now ranks highest in Latin America. Significantly, there have been no cases of polio reported since 1989 and Honduras continues to make excellent progress toward the year 2000 goals of eliminating measles, tetanus and whooping cough. Access to latrines and to water has also improved with USAID assistance. Approximately 746,000 rural Hondurans have benefited under earlier USAID projects and through the construction of 783 water systems and 93,715 latrines under HS II, far exceeding the original life of project targets. Now approximately 70% of the rural population has access to potable water, compared to only 48% at the start of HS II. The operation and maintenance of these systems is conducted by village water boards (*Juntas de Agua*) and supervised by a core of Operation and Maintenance Technicians (TOMs) through successful replication by the National Water and Sewer Authority (SANAA) of a USAID pilot activity.

¹ Honduras was one of the first countries in Latin America to adopt a strategy of community based distribution of ORS in the early 1980s, largely as a consequence of the USAID funded Mass Media and Health Practices Project which introduced litrosol and supported a sophisticated communication/education strategy.

In the area of administrative reform, the HS II midterm evaluation (May 1995) also found positive, if less immediate results. Several elements of the DOFUPS system² (which includes administrative systems aimed at strengthening supervision, health information, supplies, logistics, and facility maintenance in rural health centers) have been developed and introduced, and the implementation of DOFUPS has been an important dimension of the MOH's efforts to improve the supervision of CESAMO (health centers with physicians) and CESAR (rural health center) staff by Area and Regional level supervisors.

The HS II Project has also been effective in strengthening regional administrative capabilities. Regional budgets were developed, effectively programmed and accounted for (in consultation with the Areas) in all the health regions of the country (except for the sparsely populated La Mosquitia region), and sound regional level financial tracking and information systems were developed and maintained. As a consequence, GOH plans to decentralize budget functions and begin allotting health funds directly to the regions have been appreciably advanced. In addition, another potentially far-reaching and durable reform of the HS II Project was presaged in the bilateral Project Grant Agreement which, for the first time, allowed UPSs (service production units, i.e., all MOH health centers, clinics and hospitals) to collect and retain fees for certain types of services. As a consequence, there has been greater public appreciation of the value of these services, and a significant increase in local cost recovery and in the percent locally retained by CESARes and CESAMOs. These facilities have applied these revenues (often through local voluntary community health committees) to urgent and high priority local procurement.

B. Remaining Challenges

Notwithstanding these project achievements, several of the specific covenants, project objectives and benchmarks established in the 1994 Project Grant Agreement Amendment No. 19 are still to be fully achieved. Key remaining challenges are summarized below.

The achievement of STD/AIDS prevention and STD treatment objectives, i.e., arresting the growing incidence of HIV/AIDS infections in the nation by focussing on high-risk populations, will require considerably more time and resources. This is not unexpected. The 1994 HS II amendment and logical framework recognized that the AIDSCAP activity would need to continue beyond HS II's September 1996 Project Assistance Completion Date (PACD), and AIDSCAP's July 1994 "Detailed Implementation Plan of Assistance for the National STD/AIDS Prevention and Control Program in Honduras" was developed with a four-year time horizon (1994-98), with plans for a mid-term program evaluation in 1996. The current FHI/AIDSCAP contract terminates August 1997, and the Strategic Objective Three (SO-3) team is considering cost-saving alternatives for continuation of STD/AIDS efforts

² DOFUPS (the Organizational and Functional Development of the UPS -- rural health centers).

under a follow-on contract.³ Specifically, the SO-3 team has agreed to carry out the planned mid-term evaluation this year to look at progress to date and the institutional arrangements most appropriate to insuring project results during the extended life of project.

With respect to integrated child care services, the MOH has made progress in implementing integrated child care (known by its Spanish acronym, AIN) as part of its basic package ("*paquete basico*") of primary health care services. Project support through the G/PHN/HN BASICS contract (which includes a resident representative, Dr. Barry Smith, in La Ceiba) has been instrumental in developing and implementing AIN in selected communities of Health Regions 2,3,4 and 5. Based on this experience, USAID through BASICS will continue to assist the MOH to develop its strategy to maximize the sustainability and impact of AIN, and to plan the expansion of this community model to the entire nation. Key indicators of project success include the increased percentage of children under one attending health clinics for the first time and receiving AIN services during the preceding month (see Annex 2, indicator IR 3.1e) and the expansion of this model to all 41 health areas by 1999 (IR 2.1d).

With respect to strengthening management/administrative support systems, it is also clear that a number of original project objectives are unlikely to be achieved without additional resources and time, and, most importantly, a clear signal from the MOH that it is committed (and that in turn other donors will also be committed) to these objectives. As part of this amendment planning process, the MOH established three special working groups to develop strategies and multi-year workplans in the areas of Supervision; MIS/Finance/Administration (MIS/F/A); and Health Information -- which will better insure MOH ability to deliver timely and high quality primary health care, sustained and supported by MOH management systems.

Several of the project objectives related to improved supervision, monitoring and evaluation appear to have been achieved. For example, the project implementation benchmark (as set forth in Project Agreement Amendment 19, Annex 1) that 80 percent of the UPS, Areas and Regions would have received at least three supervisory visits per year from the next higher level, was achieved in all Health Regions. Similarly, 80 percent of auxiliary nurses from CESARes and CESAMOs in all Regions supervised the health volunteers under their program responsibility at least four times per year. However, supervisory visits still tend to be more fault finding than supportive and generally fail to provide assistance in problem identification, problem solving, counseling and motivation. The entire supervisory process needs to be strengthened and systematized (in terms of the staff levels, calendar of visits and the instruments being employed).

³ The Mission has noted with concern the high "fully loaded" headquarters and regional office costs and overhead associated with this contract, our frequent delays in receiving financial information, and the lack of G/PHN/HN core funds to support AIDSCAP/Honduras activities under the new approach to Global Field Support.

Moreover, while USAID cannot support the full range of training and human resource development activities the MOH needs, project resources will finance an assessment of possible interventions to strengthen the National University (UNAH) Masters in Public Health and Nursing programs to make them more relevant to MOH human resource development needs -- possibly through a linkage with a U.S. university. In addition to increasing access to quality education in public health administration, a strengthened UNAH program would also reduce the need for costly public health training abroad. In addition, a Covenant in the Project Grant Agreement Amendment will help ameliorate the problem caused by turnover of key Regional and Area personnel because of the political nature of their appointments by establishing minimum qualifications and selection procedures for their replacements (Section V below). This turnover continues to undermine the cost-effectiveness of human resource development (HRD) and the continuity of MOH and project-supported activities.

Deficiencies in the MIS/F/A system (i.e., the financial and administrative information systems of the MOH) exacerbated by the turnover of politically appointed regional administrators, constrain the ability of the MOH to decentralize budget execution to individual health regions as envisioned. For MOH staff to further decentralize administrative and financial decision-making to the Area level -- with increased community participation in planning and priority setting accompanied by the development and execution of area-level workplans and budgets -- new financial management instruments, procedures and training are required. The MIS/F/A working group, with technical assistance from USAID,⁴ plans to strengthen the financial information system at all levels -- the key activities of which include developing, legalizing and implementing simplified instruments and procedures, followed by effective system training and evaluation.

There has also been some progress in developing health information systems at the Central and Regional levels, but the maintenance and use of these systems often does not take place at the Area and rural health center levels. These systems are often perceived to be burdensome and irrelevant to service providers, and information is now collected in more than 70 forms, many of which are simultaneously sent to the Regions and the Center for repetitive data entry. In all, it takes one to two years for information to surface in the Ministry's "*Boletín Estadístico*". This health information system is thus of little relevance to local programming. Because a "culture of data analysis" does not exist, local staff and community members have little appreciation of or training in the utility of information for planning, evaluation, and decision-making. Under the project, the use of the data will be systematized, especially at the local, Area, and Regional levels, for an optimal decision-making process.

The May 1995 mid-term evaluation also found the implementation of other important administrative reforms to be uneven. The procurement and logistics system, for example, still suffers from centralization, under-funding and the absence of community participation.

⁴ See E.A. Associates: "*Area Administrativo Financiera -- Diagnostico Tecnico Organizacional*" (March 1995) and "*Estudio Diagnostico de Los Procedimientos Operacionales*" (March 1995).

However, the MOH has taken important steps in creating the Special Procurement Office (SPO), which is now empowered to procure for the MOH where before a GOH-wide office had to be used. The next steps in the role of the SPO will be to involve the Regional, Area, and local levels in the procurement process and to institutionalize the changes made to assure their sustainability. Two especially critical problem areas are the need for improved vehicle maintenance and repair, and the need to better ensure the local availability of essential drugs (including oral contraceptives).⁵

Transportation is critical to achieving MOH objectives, but a relatively large proportion of the MOH vehicular fleet is old and non-functional. Budgets for vehicle maintenance and spare parts are inadequate and consequently the Ministry's staff mechanics are often under-utilized. Nor is there any incentive for MOH drivers to properly maintain their vehicles. The MOH has made important advances in the creation and operation of the SPO, but the challenges of supplying basic pharmaceuticals and supplies at the UPS on a continual basis and the need to involve the Regions and possibly the Areas in the procurement process⁶, while maintaining important economies of scale, and to introduce innovative community-based initiatives including local procurement (using retained fees) and the creation of rotating drug funds (*botequins*) still remain. In addition, practical measures including giving Area directors more responsibility over transferring drugs (and other supplies) between UPSs to avoid shortages and excesses will also help resolve this major problem (see Section V below).

Additionally, the mid-term evaluation pointed to the high maternal mortality and total fertility rates (especially in rural areas), a high incidence of malnutrition in children under five, and rising diarrheal and acute respiratory infection (ARI) case fatality rates in hospitals and clinics which are accompanying improved community management (as only the more severe and advanced cases begin arriving at these facilities). There is also a need for better case management of acute respiratory infections, especially pneumonia, which have replaced diarrheal disease as the leading cause of death among children under five. Accordingly, USAID and the MOH plan to obtain technical assistance to develop new or improved approaches and protocols for effectively introducing proven maternal and child health technologies that will address childhood malnutrition, ARI, obstetric emergencies, micronutrient deficiencies and suboptimal breastfeeding practices within nine focus Health Areas. If shown to be effective, the MOH will expand these approaches nationally. In addition, there is also a need to continue efforts to improve the quality and increase the access

⁵ According to the mid-term evaluation, a major complaint of the rural population about the MOH appears to be unavailability of medicines.

⁶ Under the current system, Regions submit annual supply requests in consultation with the Areas, and forward these to the Pharmacy and Finance Divisions of the MOH. The requests are in turn sent to the Purchase and Supply Division which in coordination with the Ministry of Finance selects a single vendor. Budget constraints generally mean that Regions and Areas do not receive their full requests, and supply of basic drugs is generally based on prior year levels rather than epidemiological or demographic factors.

to well established child survival (CS) and maternal health technologies at the community level, including family planning services⁷, pre- and post-natal checkups, ORS, immunizations, and potable water and sanitation.

Finally, it is clear that more emphasis on health education and communication will be needed at the community level to accompany these important public health interventions. Health education and communication is implemented deficiently throughout the country. Technically appropriate, state-of-the-art communication plans which have been developed by the Division of Health Education (DHE) have not been funded or implemented, and there is a lack of a clear national policy regarding the role of DHE vis-a-vis other divisions of the MOH in developing information, education and communication (IEC) materials. As a consequence, there is an absence of effective health communication in areas of child survival and reproductive health and no focused health education efforts directed at the community.

⁷ The MOH has a tacit policy towards family planning which is implicit in its "*Manual de Normas Y Procedimientos de la Atencion Integral de la Mujer*" (April 1995). The norms and procedures discussed in this manual relate to (1) obstetrical risk -- which involves appropriate care for high risk pregnancies (including a referral system, transportation, well-trained personnel, equipped facilities for obstetric emergencies, postpartum family planning counseling, etc) and (2) non-obstetrical risk -- which includes family planning services (surgical and non-surgical contraception, counselling, well-trained personnel, health education, etc.) in order to space and prevent unintended pregnancies.

II. RESULTS FRAMEWORK⁸

A. Development Hypothesis and General Approach (see Figure 1)

As shown in Figure 1, this project extension is designed to further USAID's and the Ministry of Health's long-term effort to establish a "Sustainable and Effective Public Primary Health Care (PHC) System nationally (IR 2 level result) by focusing TA and resources on the most salient supply-side problems -- both administrative and technical -- which hinder further progress in reducing maternal and infant mortality in rural areas. The development hypothesis underlying what (with this three-year extension)⁹ will be ten-plus years of HS II Project assistance is that "a sustainable and effective public primary health care system" will contribute directly to the three highest IR 1 people-level results under the SO-3 strategy through actual behavioral changes (namely, the increased use of selected child survival interventions, of reproductive health and family planning services, and of STD/AIDS prevention practices). Use of these essential interventions in turn will result in "improved family health."

This project focuses on strengthening the public sector. It will contribute both to "a Sustainable and Effective Public Primary Health Care (PHC) System", through its work with the MOH, as well as to the parallel IR 2 level result, "a Sustainable and Effective Private Sector Family Planning and Reproductive Health Care System", through its AIDS/STD prevention activities through local governments and NGOs, in collaboration with the Private Sector Population III Project. The STD/AIDS project component, a project element which began in early 1995 with a four year time horizon, works both with the MOH and local NGOs and is also slated to continue under this extension.

Administrative, financial and technical constraints to improving the public primary health care system have been well documented in several USAID, development partner and MOH studies and reports, including, most recently, in the mid-term project evaluation.¹⁰ Given the limited resources and short time available under this amendment to address these constraints, it is clear that a substantial new program in this sector, currently planned to coincide with a new World Bank sector loan and begin in FY 1999, will be required. In this three-year interim,

⁸ The convention throughout this document will be to label all results below the "SO-3" Improved Family Health strategic objective as intermediate results (IR), with the highest level IR labelled "IR 1" corresponding to what was previously termed the "program outcome" level; the next highest intermediate result level labelled "IR 2" and corresponding to the previously termed project goal; followed by "IR 3" which corresponds to previously termed project purpose. Below the IR 3 level in Figure 1 and Annex 2 are IR 3 level group indicators.

⁹ For budgetary purposes, however, there are four project years defined as follows: project year one is from June to December 1996; project year two is January to December 1997; project year three is January to December 1998; and project year four is January to September 1999.

¹⁰ Mid-Term Evaluation of Health Sector II Project, May 1995.

HEALTH SECTOR - II

Strategic Objective

Improved Family Health

IR-1

Increased Use of Selected Child Survival Interventions

Increased Use of Reproductive Health Services including Family Planning

Increased Use of STD/AIDS Prevention Practices

IR-2

Sustainable and Effective Public Sector Primary Health Care System

Sustainable and Effective Private Sector FP and Reproductive Health Care system

IR-3

Improved Delivery of Child Survival Services

Improved Delivery of Reproductive Health and Family Planning Services

Improved Delivery of STD/AIDS Prevention and STD Treatment Programs

National Systems & Policies Strengthened

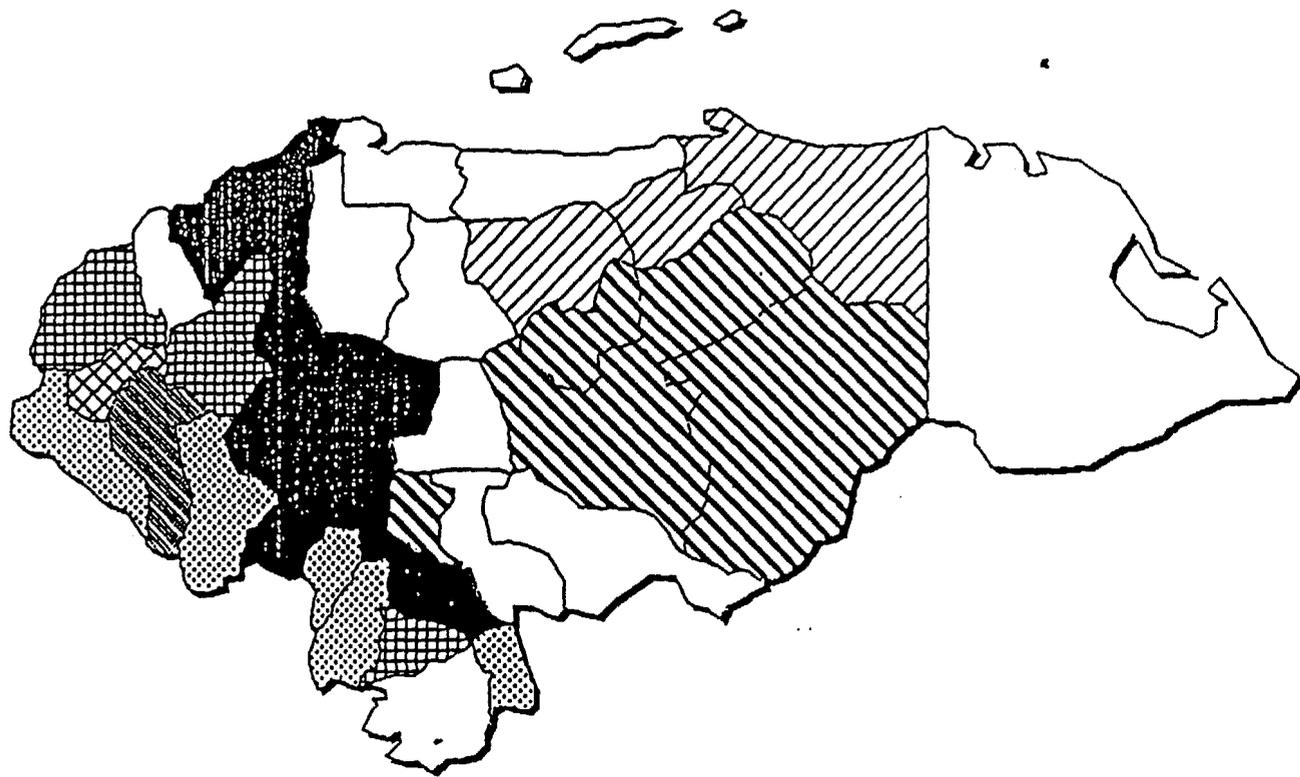
- Improved or New Approaches
- Improved Quality

- Improved or New Approaches
- Improved Quality
- Improved Referral System
- Increased CYPs provided by MOH
- Increased Purchase of Contraceptives by MOH

- Increased Purchase of Condoms by MOH
- Improved Knowledge of STD/AIDS Prevention Practices

- "Acceso" Implemented
- Environmental Health Strategy Implemented
- Improved Supervision
- Improved Financial Administration
- Improved Health Information System (HIS)
- Improved Human Resources Development
- Effective IEC

Areas de Salud
por Agencia Cooperante
Honduras
6 de Nov. de 1995



Agencia

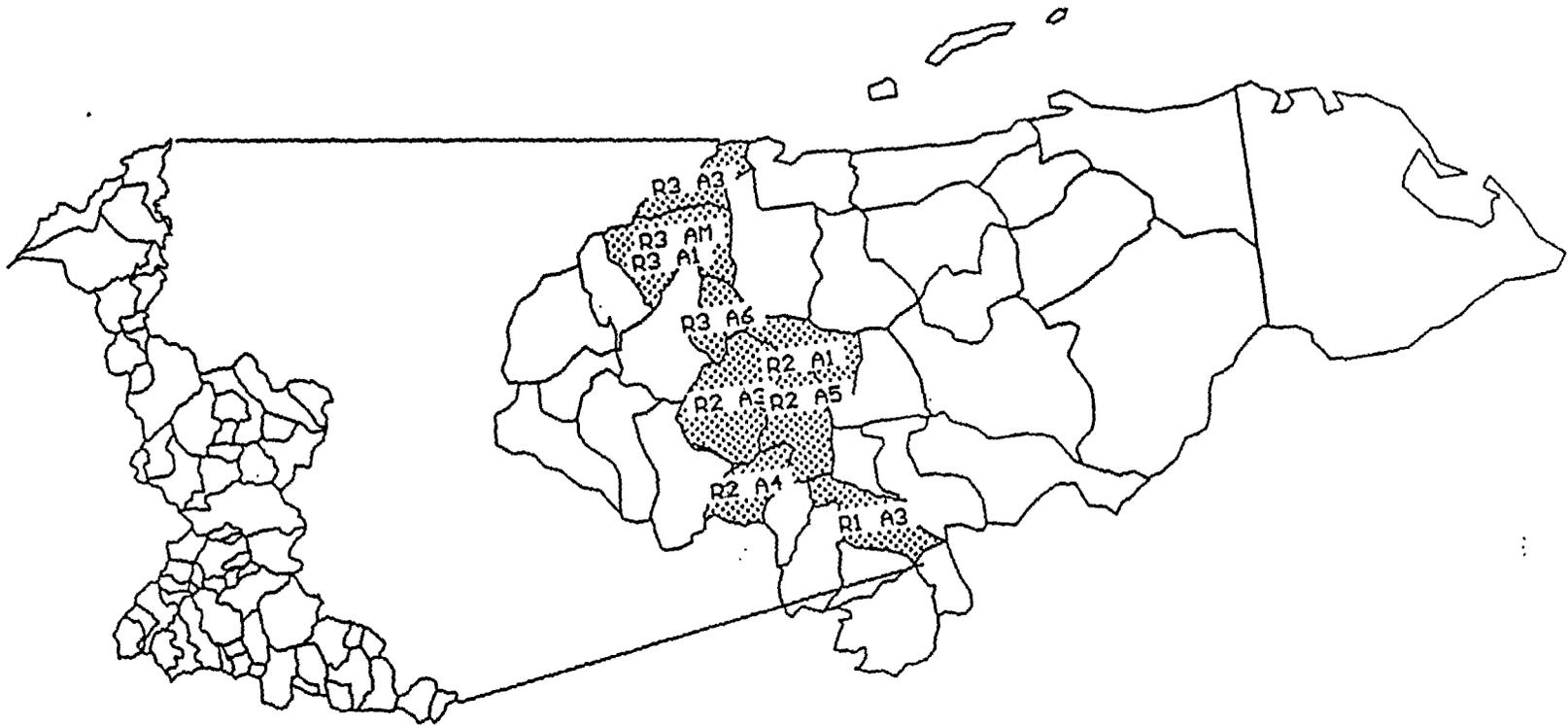
-  Un. Europeo
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-  DESAPER
-  UNFPA
-  USAID
-  Suecos
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Municipios y Areas de Salud

Extension del Proyecto
Sector Salud II

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however, the mid-term evaluation and other studies point to the need for a four-pronged strategy that will focus on the following intermediate results described by geographic level of implementation:

(1) Improved delivery of child survival, reproductive health and family planning services in nine health focus Areas which have approximately 226 clinics and hospitals and serve approximately 25% of the nation's population. In these focus Health Areas (see maps) project resources will help support and strengthen the UPSs to better provide rational, integrated and responsive primary health care to the community. Support will include both USAID-funded technical assistance (mostly programmed with the Division of Maternal Child Health) and direct budgetary support to each of the nine Areas for the implementation of individual Area workplans.¹¹ The strategy will entail developing, testing and implementing in these Areas new or improved approaches to reducing infant and maternal mortality, malnutrition and fertility. The nine Areas include Health Region 3 (Honduras' largest Region which includes Metro-San Pedro Sula, San Pedro Sula, Puerto Cortes and Santa Cruz de Yojoa), Region 2 (Comayagua, Siguatepeque, La Paz and Marcala), and Region 1 (Sabana Grande).¹² In family planning, USAID will also support provision of contraceptives nationally, the formation of reproductive health committees at the central MOH level, and a pilot activity on the provision of family planning services by auxiliary nurses in CESARes in Health Areas selected from all nine Health Regions.

(2) National systems and policies strengthened in 15 Health Areas to improve decentralized financial management and local cost recovery, and to improve supervision, management and health information systems, health education and the vehicle and equipment supply and maintenance systems. The MOH goal is to implement these reforms nationally, but a number of these reforms will need to be first introduced and tested on a more modest scale. The 15

¹¹ Approval for the nine Area plans and budgets (i.e., \$215,000 in HS II grant funds), GOH counterpart contributions, and the rotating fund mechanism for reimbursement were mutually agreed to by the MOH and USAID through Project Implementation Letter (PIL) 56 effective from April 1, 1996 through September 30, 1996. These Area workplans and budgets will support per diem, training and limited local procurement of equipment and supplies for these Areas. Workplans and budgets are still being developed for the local hospitals and for the regional level of the three health regions in which USAID will be working. In addition, ACCESO and MOH personnel in the nine focus Health Areas are working with municipalities to develop Area workplans and budgets, which USAID and the MOH will need to approve, for funding Area plans under this project extension (See Section V).

¹² There are eight Health Regions in Honduras (which do not correspond with any other political or administration boundaries) plus Tegucigalpa which makes nine. The population of the eight Regions varies from 320,000 to 1.35 million. Each regional headquarters is staffed by a Regional Director, under whom are the various departments which generally correspond to the organizational divisions of the central MOH. In Region 3, the country's largest, the regional headquarters is organized into ten departments employing 52 persons. Additionally, each region has a regional nurse who is key to area-level supervision and evaluation. Below the eight health regions are 41 Health Areas headed by area chiefs, physicians who are appointed by the regional directors.

Areas selected for demonstrating these administrative reforms include all of the above nine Areas (representing three health regions), plus one area selected from each of the six remaining health regions in the country.¹³ USAID assistance will take the form of policy dialogue with the MOH that is linked to a mutually agreeable set of end of project indicators and covenants, and limited regional and Area-level technical assistance (programmed in coordination with the three specialized administrative working groups) that is aimed at strengthening decentralized administrative and financial decision-making to provide practical solutions to pressing administrative problems.¹⁴

(3) Improved delivery of STD/AIDS prevention and STD treatment programs among high-risk target groups in San Pedro Sula, Tegucigalpa, La Ceiba and Comayagua.

(4) Maintenance of highly effective national programs by providing limited support to such activities as the expanded program of immunization, oral rehydration therapy and environmental health.

The success in fully achieving the results envisioned for the first and second "prongs" of this project strategy, and of truly having a national impact will depend on MOH commitment and coordination, and through the MOH coordination with other donors, to insure that improved technologies and administrative practices are adequately supported and implemented in all nine health Regions and 41 Health Areas of the country. In introducing new or improved approaches to implementing child survival, family planning and maternal health technologies, this coordination will be facilitated by technical assistance working with central MOH authorities, and through MOH involvement in special national technical committees (such as the Reproductive Health Technical Committee). In introducing new and/or improved administrative practices, donor coordination through the MOH and USAID's support in at least one demonstration Area in each of the nine health regions of the country will help insure that appropriate administrative changes are recognized and adopted nationally.

The MOH will provide the baseline data and the annual and end-of-project targets associated with the intermediate project results in Annex 2 by December 1996, in accordance with a condition precedent to be included in the Project Grant Agreement Amendment that will formally extend this project. As seen in this Annex, some of the project indicators at the IR 4 level will be measurable at the sub-national level since USAID will concentrate project

¹³ Specifically, the 15 include the nine focus Areas plus six additional Areas: San Lorenzo, Choluteca (Region 4); Gracias, Lempira (Region 5); Tela, Atlantida (Region 6); Juticalpa, Olancho (Region 7); Cauquira, Gracias a Dios (Region 8) where Swedish International Development Agency is working and supporting local costs; and Comayaguela, MDC (Region Metro).

¹⁴ Many of the existing administrative systems in place (i.e., DOFUPS) are useful (i.e., they provide information) but are not empowering. They focus on how to follow standard operating procedures but fail to provide the skills for analyzing new problems and developing appropriate solutions.

resources on the nine focus and 15 demonstration Areas. All SO and IR 1 level indicators, however (except those focussing on HIV/AIDS transmission), measure *national* level project impact, as do key IR 2 level indicators of a sustainable and effective national public primary health care system, e.g., progress in expanding proven administrative systems (SME, HIS and ACCESO), in expanding new or improved approaches to implementing proven health technologies (family planning, obstetric emergency care, pneumonia case management, breastfeeding and nutrition) to all 41 Health Areas, and in increasing the percentage of rural water systems that operate at an "A" level.

B. Customer Definition and Projected Impact

Under this project, USAID and our principal "partners" (most notably the Ministry of Health) will deliver key technical and administrative services through appropriate "intermediate customers", establishing and communicating high standards and putting into place mechanisms for obtaining customer feedback. USAID will provide technical assistance through the Quality Assurance Project (of the University Research Corporation/Center for Human Services) to support the development of this See the "Customer Service Plan" provided in Annex 4.

III. PLAN OF ACTION FOR ACHIEVING RESULTS

The following is a summary of the key interventions (i.e., the tools and tactics) that will be needed to achieve the four level three intermediate results (IR 3) along with the identification and designation of responsibilities. This discussion is based on the workplans developed by ACCESO and the three MOH working groups in Supervision, MIS/Finance/Administration, and Health Information, on the workplans of the nine focus Health Areas (approved in Project Implementation Letter 56), and on the proposed conditions precedent and covenants presented in Section V below. The definitions of success for each of these intermediate results including both the indicators table and the first year key activities, are provided in Annex 2 and Annex 3 respectively.

ACCESO is a process initiated by the MOH and under the responsibility of the "*Grupo de Asistencia Técnica*" (GAT) task force. ACCESO works with communities in a process of local programming which will involve the local levels intimately in the identification and the resolution of their own health problems, especially in environmental health, cost recovery, the referral system, and the "basic package" (*paquete básico*) of health services. The process involves the decision-makers and persons of influence in the communities, including the municipalities, under the guidance of one or more members of GAT and of the Health Area and/or Region. Once the process is underway, the GAT will play an advisory role, with a greater share of the process being assumed by the Health Area. One of the goals of ACCESO is to improve the access and utilization of health care services by involving the communities in supporting their local UPS to improve and sustain the quality of health care.

Improving the quality and availability of locally available primary health care services (including child survival, reproductive health and family planning services) while simultaneously meeting the long-range challenge of sustainable health care financing will be key to achieving the intermediate results USAID and the MOH expect from the extended Health Sector II Project. This will entail providing technical assistance to the MOH for operations research, and focussing USAID resources on supporting the Area workplans, procuring supplies for, and providing technical assistance to nine target Health Areas, which together represent approximately 25% of Honduras' total population. This assistance will result in the development and introduction of cost-effective new approaches and procedures that focus on the principal remaining causes of preventable child mortality. In addition, improving the cost-effectiveness of national administrative, financial and health information systems is another key element of this strategy. A Covenant to be included in the Project Grant Agreement Amendment (see Section V) will require the MOH to undertake a study of the costs and savings associated with the new technologies and administrative systems introduced and supported under this project, and of the ACCESO model and establishment of decentralized Area level budgets.

The nine project-supported focus Health Areas encompass approximately 226 health facilities, including 62 CESAMOs and 155 CESARes (see Figure 2). The two urban public hospitals (Leonardo Martinez and Mario Catarino Rivas) in San Pedro Sula and three area hospitals (in

La Paz, Comayagua and Puerto Cortes), and four mother-child clinics are included in this total.

FIGURE 2

REGION	AREA	HOSPITALS	CLINICS M-I	CESAMOs	CESARes	TOTAL UPS
2	1	1	2	6	31	40
2	3	0	1	5	20	26
2	4	1	0	11	20	32
2	5	0	1	5	20	26 ¹⁵
3	M	2	0	10	5	17
3	1	0	0	7	15	22
3	3	1	0	4	10	15
3	6	0	0	5	14	19
1	3	0	0	9	20	29
TOTAL	9	5	4	62	155	226

The CESARes, CESAMOs, clinics, and area hospitals will be the primary focus for the development of sustainable programs. USAID will provide limited assistance to the five hospitals and four Maternal-Infant (M-I) Clinics to improve customer service and quality. Through this assistance, these facilities will be MOH accredited as "Baby Friendly Hospitals/Clinics" (Annex 2, IR 3.1(d)(1)). Project support to the two urban hospitals will focus on the effective referral and treatment of pneumonia and obstetrical emergencies while avoiding involving the project in the host of supply and labor problems currently found there. Although there are risks associated with involvement with hospitals, the large patient pool treated in these two institutions is a compelling argument for strengthening this last stage of the referral system for severe pneumonia and obstetric emergency cases that cannot be treated at lower levels. This is a feasible number of sites for the limited interventions proposed.

Staff from USAID, the Project Coordination Unit (PCU), MOH (central, regional and area levels, as well as the ACCESO task force) and local representatives of USAID (G/PHN) cooperating agencies, MotherCare, Wellstart and BASICS, have participated in a working group to oversee the development of area-based workplans for achieving the desired results in

¹⁵ Apart from the 26 UPSs in Marcala (Region 2, Area 5) there are also four community birthing centers (*casa comunitaria de parto*).

reproductive health and child survival. Each of the nine focus Health Areas under the project extension, with local community participation, then developed its own specific annual workplan and budget, which USAID and the MOH reviewed and approved through Project Implementation Letter (PIL) 56. Under this PIL, the GOH will establish a rotating fund in the Areas to reimburse activities set forth in the workplans and budgets, and will use the PCU to monitor and support the execution of these Area plans.

An important intermediate result of this project (see Annex 2, IR 2.1(a)) is for the Ministry of Health (and in particular, the "ACCESO" Task Force) to demonstrate progress in increasing the percentage of CESARes and CESAMOs in the nine focus Areas maintained at the "A" level -- a composite measure to be developed by the MOH which will measure quality and availability of basic MCH services. To achieve this, the MOH will need to insure that local communities served by the CESARes and CESAMOs become more fully involved in the provision of health services (through community volunteers and health groups), in the management of the health centers, and in the determination of priorities (through the creation and/or support of local committees). With local currency support and technical assistance to the MOH through select G/PHN cooperating agencies such as Quality Assurance, BASICS, and Data for Decision Making, local committees will be better able to assess the health problems in the health center coverage area and work with health personnel in finding appropriate solutions.

The MOH, through ACCESO, and with USAID support, will continue to promote community involvement in the monitoring of its health condition through the expansion of simple basic information systems, including for example, the community lists of coverage of pregnant women and young children ("*listados*") with essential child survival and reproductive health services. Specifically, USAID assistance will enable the MOH to involve local communities so they will be better prepared to develop and assume authority over the management of the fees collected and retained at the health centers, and over community pharmacies which can contribute to the financial sustainability of project-supported activities while improving access to essential drugs. Local community groups will also be involved in the direct delivery of certain health interventions (see the following sections). The chief of the GAT will be MOH counterpart for this set of activities.

Intermediate Result 3.1: Improved Delivery of Child Survival Services in Nine Focus Areas

(a) New approaches introduced and used for combatting pneumonia in children under 5 five years, and (b) improved quality of pneumonia case management

USAID will procure supplies, program local currency support (in CY 96) and provide technical assistance (TA) to assist the MOH to reduce pneumonia-related mortality in the communities and health centers assisted by the project. USAID will obtain the bulk of this TA through the MotherCare Project (particularly for the "Situational Analysis") and the BASICS Project. At the community level, the MOH will seek to increase awareness and

improve early detection, effective local treatment and timely referrals through the equipping and training of community volunteers in the diagnosis, management, and referral of serious cases of ARI. At the hospital level, mortality will be reduced through improved equipment, logistics, training of key personnel, and supervision for effective case management of pneumonia. Both levels of intervention will benefit from a new focus on quality of care, which in turn will be supported by improvements to supervision and logistics. BASICS will provide technical assistance to the MOH both in developing and updating an ARI communication plan and in monitoring and evaluating the ARI community treatment program. The counterpart to USAID for these activities will be the Director of the Maternal-Child Health Division (MCH).

(c) New approaches introduced and used for promoting exclusive breastfeeding for children under six months of age, and (d) improved quality of exclusive breastfeeding promotion

USAID and the MOH will continue to provide technical assistance and support to increase exclusive breastfeeding among children 0-6 months. This will involve the integration of optimal breastfeeding practices with other child survival interventions (e.g., the effective management of diarrhea and ARI, maternity care, and growth monitoring) and the further extension of the community counselor program supported by the Liga de La Lactancia Materna with technical assistance from Wellstart (or the follow-on G/PHN project). With technical assistance from MotherCare, a final evaluation of the community counselor program in El Progreso and Puerto Cortes will be completed by the MOH during the first year of the project to inform the MOH on how best to expand this intervention into the nine focus Areas.

Additionally, in collaboration with the WHO/UNICEF Baby Friendly Hospital Initiative (BFHI) all five hospitals and four MCH clinics in the nine focus areas will be MOH accredited as "Baby Friendly" in terms of sound lactation management practices. Another cost effective intervention related to this will be the upgrading of the UNAH General Medicine and Nursing training curricula also with technical assistance from Wellstart. The counterpart to USAID for breastfeeding activities will be the Director of the Maternal-Child Health Division.

(e) New approaches introduced and used for monitoring growth and integrated child health care among children under one year of age, and (f) improved quality of integrated child care

The community-based integrated child care program, widely known by its Spanish acronym "AIN", seeks to increase the percentage of children attending a health clinic for the first time. It also seeks to increase the percentage of children under one who receive integrated child care services on a monthly basis, including growth monitoring and nutrition and health education for mothers. Under the extended Health Sector II Project, USAID assistance will help AIN focus on the most needy communities. USAID will help the MOH identify such priority communities within the nine focus Areas and increase the percentage of those communities with operating and effective AIN programs. The project will promote community participation and the use of trained community volunteers. BASICS will assist the

MOH in an extensive evaluation of the costs and impact of the AIN model, expected to be completed in CY 96. The results of this evaluation will be used to refine and implement the program throughout the nine focus Health Areas. The Director of MCH will be the MOH counterpart to USAID for these activities.

Additionally, while the focus of the project's strategy in child survival will concentrate on these new or improved technologies in the nine focus areas and beyond, the project will continue to provide limited support to ensure sustainable national delivery of highly successful child survival interventions -- namely immunizations and oral rehydration therapy at the national level monitored by the indicators of maintained coverage (use) at the first intermediate results level (Annex 2, IR 1.1a,b,d & e). Although these project interventions are very important, these mature components of primary health care do not require major investment or additional technical assistance. Therefore, instead of creating a separate IR 3 level result under the framework, or grouping these interventions as indicators of another IR 3 level result (e.g., under IR 3(a), child survival or under IR 3(d), national systems support) it appears more appropriate to describe these limited interventions in a footnote.¹⁶

¹⁶ Increased use of selected child survival interventions nationally (i.e., delivery systems for highly successful immunizations and oral rehydration therapy sustained throughout the nation).

(Annex 2, I.R.1.1(a) Immunization coverage for children under one (DPT, Measles, Polio, Tuberculosis, and (IR 1.1(b) Tetanus Toxoid immunization coverage of women aged 12-49 maintained at 90% or higher.

Maintenance of the cold chain for vaccines is critical to the continued success of the immunization program, and the MOH and USAID are committed to ensuring that the cold chain remains operational. USAID grant funds will finance national cold chain audits and project counterpart funds will, on a limited basis, be used to support the cold chain through the purchase of spare parts and kerosene. Another element in sustaining the 90%-plus immunization coverage rates will be the project's focus through ACCESO and with the Area budgets on increasing the percentage of municipalities and UPSs with local health organizations/committees functioning (Annex 2, IR 3.4(a)(3)). Increasing the use of the "Listados" of children under two years of age as a community-based management tool is another key element. The Director of MCH and the chief of the Expanded Program of Immunization (PAI) unit under MCH will be the MOH counterparts to USAID for these activities.

(I.R.1.1(d) Percentage of total outpatient visits to health centers of children under five due to diarrhea not exceeding 10%; and (IR 1.1(e) Percentage of children under five with diarrhea in the last 15 days treated with oral rehydration therapy (ORT) increased from 31.7% to 40%.

HS II will continue to assist the MOH in its efforts to increase the percentage of children under five years with diarrhea who receive community-based oral rehydration therapy and to hold the percentage of cases requiring clinical referral to no more than 10% of total outpatient visits of children under five to health centers (Annex 2, IR 1.1 d & e). To accomplish this, HS II will assist the MOH in the development of a plan to strengthen ORT at the community level based on an evaluation by BASICS of the community-based ORT program. An important element of BASICS' technical assistance will

Intermediate Result 3.2: Improved Delivery of Reproductive Health and Family Planning Services in the Selected Areas

a. Improved or New Approaches to Family Planning Introduced, and (b) Increased MOH Purchase of Contraceptives Nationally.

Enhanced family planning (FP) services need to be provided by the MOH throughout its health care system in order to achieve both maternal and child survival objectives. This is especially critical in rural areas where ASHONPLAFA is unable to provide full and adequate coverage, even though it is in rural areas where maternal mortality and total fertility rates are highest. MOH interventions will therefore complement the activities supported under the USAID-assisted Private Sector Population III Project (PSP III).¹⁷

More active involvement in turn requires a commitment on behalf of the MOH to actively promote reproductive health services, especially family planning. Under the project, the MOH will strive to increase the number of couple-years-of-protection (CYP) it provides nationally with USAID supported contraceptives, and the GOH will establish a budget line item for the MOH's direct procurement of contraceptives per a Covenant to this agreement. The MOH will set targets for significantly increasing CYPs in the nine focus Areas (Annex 2, IR 3.2(a)(2)), and for ensuring that a growing percentage of women in these nine Areas receive postpartum family planning methods in UPSs (IR 3.2(a)(3)).

Additionally, an innovative pilot project will be implemented by the MOH in one Area of every health Region of the country to provide family planning counseling, the distribution of oral contraceptives, and IUD insertion by auxiliary nurses in CESARes (IR 3.2(a)(1)). The Population Council (INOPAL) will assist this initiative by providing technical assistance in the design and analysis of findings. Similarly the Association for Voluntary Surgical

be the development and pretesting of a manual for community volunteers. USAID will monitor the PAHO program review of the Expanded Program for Cholera and Diarrheas (PACED) for the purpose of applying the lessons learned to ORT project interventions. As with other health interventions, two keystones to improving clinical- and community-based interventions are improved supervision at the local level and the institution of quality assurance procedures. The Director of MCH will be the MOH counterpart to USAID for these activities.

¹⁷ Under PSP III, the Mission will provide assistance both to ASHONPLAFA and to a number of PVOs working primarily in the nine focus Health Areas to promote family planning, to counsel clients on both publicly and privately available FP services, and, to a lesser extent, to directly provide family planning services. USAID expects that these activities will increase demand for FP services at the UPS level. Because MOH participation is key to sustainability and national impact, PSP III will support three private-public reproductive health technical committees, chaired by the MOH, on training, IEC, and services, to strengthen the communication between ASHONPLAFA, PVOs and the MOH. The Population Council will provide technical assistance to the committees, and Population Communications Services will provide technical assistance in the design of an IEC strategy for reproductive health which includes adolescents and men.

Contraception (AVSC) will assist this initiative by providing training for auxiliary nurses in clinical family planning methods. If successful, the lessons learned by the MOH will be used to guide policy changes to make family planning services more accessible to rural populations throughout the country.

Operations research by the Faculty of Public Health of the National Autonomous University of Honduras (UNAH) on support of reproductive health/family planning innovation in the MOH program will also be financed by USAID with technical assistance from The Population Council.

Contraceptives as well as medical and educational equipment and supplies will be provided to the Honduran Social Security Institute (IHSS) by USAID under HS II to upgrade its capacity to continue to perform voluntary surgical sterilizations, IUD insertions, condom distribution, and counseling to men, women and adolescents in family planning and STD/AIDS prevention. IHSS has been an active partner in reproductive health, mainly in Tegucigalpa and San Pedro Sula, with IHSS coverage extending to approximately 24% of the total population of Honduras. IHSS outputs in terms of voluntary surgical sterilizations, IUD insertions, and condom distribution have been critical in meeting MOH targets to increase contraceptive prevalence attributable to modern methods (IR 1.2(a)).

Project resources will also support training and effective supervision to enhance FP/RH services at the UPS level. The physicians, professional nurses, and auxiliary nurses who counsel male and female customers will provide family planning counseling and services proactively. The supervisors, too, will receive training in order to effectively supervise this area. These innovations are departures from current operations, but are essential to improve the health of rural women of reproductive age and their children. The MCH Division will be responsible for the technical training of personnel at all levels. Training in counseling skills will also be needed; the training provider will be determined jointly by the MOH and USAID.

c. Improved or New Approaches to Reproductive Health (RH), (d) Improved Quality of RH Services, and (e) Improved RH Referrals

In addition to enhancing family planning counselling and services, UPS and hospital services (including the referral system) in the nine focus Areas will be strengthened to improve the quality of RH services (i.e., to increase prenatal visits and postpartum checkups, and reduce maternal and neonatal mortality -- I.R.3.2d), and for managing high risk pregnancies and obstetric emergencies more effectively (IR 3.2e). To this end, the project will finance and provide technical assistance to the MOH for a diagnostic survey/inventory (situational analysis) of health facilities equipment and service needs and, based on the results of the survey, USAID will procure basic equipment for the UPS, including clinics and hospitals.

Another key activity to be funded by USAID will be a qualitative community diagnosis on delivery and postpartum (perinatal) practices by MotherCare. This diagnosis will be key to improving maternal and neo-natal care. The MOH will then design specific interventions that

address the identified problems, including plans for an IEC campaign and efforts to increase the number of births attended by health personnel other than TBAs (I.R.3.2c(2)). Technical assistance from MotherCare will be provided for the qualitative research and subsequent design of interventions for MOH use. Another planned activity with technical assistance from MotherCare will be the development of obstetric and perinatal case management protocols for use at health centers and hospitals and training in their use.

The interventions proposed here also recognize that the entire period spanning pregnancy, childbirth and the first weeks of life is a continuum, and consequently the need to provide a range of services for the mother/child dyad is compelling. Improved maternal nutrition (including a maternal anemia strategy), prenatal care, improved birthing environments with enhanced hygiene, transportation for women with obstetric emergencies to facilities capable of handling these events, care for low birth weight babies, successful initiation of breathing and exclusive breastfeeding, and the protection and monitoring of the newborn are all among the expected results of these interventions.

The Director of MCH will be the MOH counterpart to USAID for these activities.

Intermediate Result 3.3: Improved Delivery of STD/AIDS Prevention and STD Treatment Programs

The primary objective of this project component, which supports the MOH National STD/AIDS Prevention and Control Program (NACP), is to provide technical, administrative and financial assistance to institutions in both the public and private sectors in order to maintain at a constant level the HIV seroprevalence rate among target populations. USAID supports the MOH's National AIDS Prevention Program with a three-pronged strategy of: (1) detection, treatment, and prevention of STDs; (2) education in responsible sexual behavior; and (3) promotion of the use of condoms, all directed at high-risk populations, namely, commercial sex workers and their clients, men who have sex with men, people who work in factories in industrial processing zones, and the Garifuna ethnic group, in the most affected areas -- San Pedro Sula, Tegucigalpa, La Ceiba, and Comayagua. This work has been initiated and is being carried out through the AIDSCAP program. The AIDSCAP project agreement and detailed implementation plan (DIP) describe USAID-funded interventions, which will continue to be supported under HS II through August, 1997. An external mid-term evaluation of this component will be conducted in August-September 1996 by an evaluation team led by an Health Technology Services consultant.¹⁸ One of the principal purposes of this exercise will be to revise the intermediate results and benchmarks for the continuation of the component after the local AIDSCAP technical assistance contract ends in August 1996, and to recommend the most appropriate mechanism for continuing support

¹⁸ In addition to the Health Technologies consultant (team leader) the team will include an STD specialist, NGO specialist, and surveillance specialist as well as a representative from the MOH.

during the September 1996 through August 1997 interim period, and from the end of the AIDSCAP central contract in August 1997 until the September 1999 PACD.

The local AIDSCAP technical assistance contract ends August 1996, and can only be extended for one year until the AIDSCAP central contract terminates in August 1997. In light of this and the high overhead, regional and headquarters costs associated with the current institutional contractors, the MOH and USAID will explore, as part of the evaluation exercise, alternative mechanisms for continued program support. These may include the registration of the local AIDSCAP office in Honduras as an NGO -- a process which could take approximately ten months -- followed by a direct USAID-managed contract or cooperative agreement, or to encourage AIDSCAP/Honduras to form a grantee relationship with an established NGO. Under either arrangement, necessary short-term technical assistance could be procured separately, through, for example, the Centers for Disease Control, the G-CAP Regional AIDS Prevention Program, or the G/PHN follow-on to the AIDSCAP contract.

The Director of the NACP will be the MOH counterpart to USAID for the activities falling under this intermediate result.

Intermediate Result 3.4: National Systems and Policies Strengthened

Another major set of objectives of HS II is to: (1) assist the MOH to implement its ACCESO multi-year workplan in 15 demonstration Areas and achieve key results with respect to effective decentralization; (2) implement an environmental health strategy at the national level which focuses on decentralization of SANAA, the training of environmental health technicians, and developing and using an evaluative instrument to increase the percentage of "A" rural water systems operating in the country; and (3) strengthening the managerial/administrative capability of the MOH with respect to (a) MIS/Finance and administration; (b) supervision, monitoring and evaluation; (c) the Health Information System (HIS); (d) improving the MOH's capacity to develop its human resources, possibly by working to strengthen the general medicine, nursing and public health programs and curricula at UNAH; and (e) implementing an effective IEC policy.

(a) ACCESO multi-year workplan developed and implemented in 15 demonstration Areas

ACCESO is an MOH initiative established for the purpose of promoting broad community participation in the health sector. It has developed a multi-year plan and budget for further decentralizing the administration of health services starting in 15 demonstration Areas of the country (see footnote 13 for list), and plans to expand this effort nationally. Key objectives of ACCESO include the identification of underserved and needy communities; increasing the percentage of UPSs and municipalities with functioning local health committees; working with Health Area and UPS officials and with local municipalities to develop and implement Area workplans and budgets, and through the ACCESO Technical Assistance Group (GAT), developing the policies and instruments needed to insure a growing percentage of high quality "A" level CESARes and CESAMOs (Annex 2, IR 3.4(a) and IR 2.1(a)).

The ACCESO Technical Assistance Group (GAT) meets monthly and includes representatives of all the major MOH divisions (*Unidades Normativas*). It is chaired by the Director of Planning in the MOH. Over the GAT is a ten-person Technical Working Group (GT) chaired by the Director of ACCESO (Vice Minister) with the participation of USAID, the PCU, Swedish International Development Agency (SIDA) and PAHO. The GT meets regularly for technical coordination, assuring implementation of the ACCESO workplan (including the USAID HS II Project component), and for briefing the GAT. The ACCESO process will support, and in turn will be supported by, project activities designed to strengthen the MOH managerial and administrative systems discussed in paragraphs c, d and e below.

(b) Environmental Health Strategy Implemented Nationally

Under this project USAID will provide technical and financial assistance to complete the construction (by December 1996) of high quality water and sanitation systems and insure that all 700-plus rural water and sanitation systems that will have been built with project funding, as well as the more than 3,000 rural water systems constructed with financial support from USAID or other donor assistance in the past, are maintained at an optimal level. In addition, USAID will continue its policy dialogue to promote a more effective, decentralized National Water and Sewer Authority (SANAA).

To help achieve the higher level intermediate result of "increasing the percentage of rural water systems in the nation that operate at an "A" level" (Annex 2, IR 2.1(b)), USAID will provide technical assistance to support SANAA's development of an evaluation and monitoring instrument (IR 3.4(b)(2)) and will fund the training and equipping of approximately 48 additional technicians in operations and maintenance (TOMs). The responsibilities of these TOMs include providing assistance to local communities in the maintenance and operation of their systems and in the collection and utilization of fees by the local water boards (*juntas de agua*).

The MOH will create a new level of employee called the "*Técnico de Salud Ambiental*" (Environmental Health Technician or TSA) who will oversee all environmental health activities at the local level. At the Area level, the MOH will create a position of a "*Jefe de Salud Ambiental*" (JSA), who will manage environmental health programs. USAID will support the MOH in its efforts to train and deploy new TSAs and JSAs by financing the development of curricula and training for these new technicians (IR 3.4(b)(3,4)).

USAID will also provide the MOH with technical assistance for the restructuring of its environmental health program. Specifically, the MOH has a variety of environmental health activities (including, for example, the control of malaria and other vector-borne diseases, control of zoonoses (rabies), improving quality of water and sanitation, and maintaining food and phytosanitary standards), but the organizational structure of these programs within the MOH has impeded adequate implementation. The MOH is now consolidating these activities into a single office, headed by a director with "Director General" status.

Additionally, USAID will continue to coordinate with other donors and provide technical assistance and a limited amount of equipment to bring about a further decentralization of SANAA's structure and operations to the regional level. The longer-term objective (one that will not be achieved during the extended life of this project) is to have every urban water system in the country transferred from SANAA control to municipal ownership. USAID policy dialogue, consistent with the World Bank agenda for the sector, will focus on SANAA reorganization to further increase the number of decentralized regional offices to seven (IR 3.4(b)(1)), and to separate SANAA's programmatic and support functions from its more routine operational functions.

(c) MIS/Finance/Administration (MIS/F/A) reforms developed and in use

Three working groups focussing on MOH managerial/administrative reforms for MIS/F/A, supervision, monitoring and evaluation (SME), and health information systems (HIS) have been established by the MOH and have prepared and submitted three-year workplans. All the plans contemplate the implementation of administrative changes initially in 15 demonstration Health Areas followed by national expansion. USAID will provide limited (but essential) local budget assistance to the MOH to implement these administrative reforms in the demonstration Areas. USAID and the MOH will also agree on several specific covenants to disbursement (Section V) which focus on key administrative and management support system improvements.

The development and implementation of an effective financial management and information system (*MIS/F/A*) for timely decision making at all levels of the MOH will be a major intermediate result of the extended HS II Project. In the process of designing and implementing this MIS over the project period, administrative processes will be simplified, decentralized, and transparently controlled and reported on - thereby becoming more responsive to the customer service requirements of the primary health care delivery system.

The MOH and USAID envision two sets of activities leading to these results. One derives from the management of project grant funds disbursed in support of the technical and community participation activities of the nine focus Health Areas selected from Regions 1, 2 and 3. In year 1 of the project extension (June to December 1996), annual work plans and operating budgets will be developed and implemented by the nine focus Areas, with project funded technical assistance. The MOH, through the Project Coordination Unit (PCU), will establish rotating funds in each of these Health Areas to enable Health Area to staff execute their annual work plans and operating budgets. Personnel from the PCU will visit each Health Area twice per month, providing training and supervision services for the utilization of the funds. These PCU staff members will work in close coordination with administrative personnel from the corresponding health Regions. PCU staff will gather sufficient data during their visits to prepare monthly project activity completion and budget execution reports for distribution to the health Regions and the MOH policy level. In year 2 of the project extension (1997), the PCU personnel visiting the Health Areas will be tasked with turning over the training, supervision and monitoring report preparation duties to a counterpart in the

corresponding Health Regions. In year 3 (1998) of the project extension, the Health Regions will be responsible for the training, supervision and monitoring report preparation duties. The successful assumption of these duties will constitute the end result of this vanguard effort to decentralize resource utilization and accountability to the Health Area level.

The other set of activities derives from the financial administration reform initiated in conjunction with HS II ProAg Amendment No. 19 dated August 26, 1994. These reform activities have been delayed in order to be responsive to changes in GOH public administration expected to result from the passage of "Modernization of the State" legislation currently being reviewed by the Honduran National Congress. It is anticipated that this legislation will allow for the decentralization of budget execution to health Regions 1 and 5 beginning in 1996.

The MIS/F/A working group will coordinate the simplification of MOH administrative procedures and instruments, including recovered costs. All levels of the MOH (central, Regional, and Area) will participate in this process. An implementation unit, composed of a USAID-funded Director and two counterpart funded analysts, will be responsible for designing an information system that incorporates these simplified processes, preparing an operations manual, training personnel in its use, and installing the system on a pilot basis at the central level of the MOH and in health Regions 1 and 5. The MIS at the central level will aggregate regional information and handle any administrative processes not decentralized to the health Regions. Subsequently the system will be installed in the remaining health Regions and adjusted in accordance with the evaluation. Successful implementation by the Regions of these simplified administrative procedures and instruments will constitute the end result of this aspect of the process of administrative decentralization.¹⁹

The MOH counterpart to USAID for these activities will be the Director of Administration.

(d) Supervision, Monitoring and Evaluation (SME) working group multi-year plan developed and implemented

During 1996 the SME working group, together with representatives of the Central, Regional, Area, and local levels, will review current MOH supervisory procedures and instruments. As

¹⁹ Another important element of the MIS/F/A reforms envisioned under this project extension is the continued implementation of a usage control and preventative maintenance vehicle and supply system. The MOH Division of Transportation and the PCU will conduct a transportation resources analysis in the nine focus Areas that could lead to USAID procurement of spare parts and/or vehicles (maximum of 12 vehicles) and/or other innovative solutions to the Health Areas' transportation problems. The MOH Division of Transportation will also conduct vehicle usage control and preventative maintenance inspections in the Regions. The project will also continue funding the Center-to-Region inspections initiated in 1995, and Region-to-Area inspections in the nine focus Areas beginning in 1996. Finally, the MOH and USAID will explore the possibility of publicly auctioning vehicles, including USAID-procured vehicles which cannot be economically repaired.

the result of this review, SME protocols will be refined, appropriate personnel will be trained in their use, and these will be tested and validated by the MOH in each of the 15 demonstration Health Areas. The MOH will adjust the protocols in accordance with the field experience of the demonstration Areas.

USAID will finance travel and per diem to enable the MOH to develop and implement a system of supportive supervision, monitoring and evaluation at all levels of the MOH -- with each supervising level providing support, problem solving skills, counseling, and in service education to the supervised level. Over the course of the project extension, as agreed upon through the budgetary process, the MOH will assume an increasing share of these recurrent costs.

HS II resources will support the participation of personnel from the selected Areas of Regions 4, 5, 6, and 7 by funding the travel and per diem costs to enable them to travel from their respective Areas to Tegucigalpa for training and meetings, and of MOH personnel to the Areas for monitoring and validation purposes. The movement of Area supervisory personnel within their respective Areas will be supported by the Swedish International Development Agency, a notable example of donor coordination.

In years 1997-98 the MOH will evaluate the experience of the 15 demonstration Areas and make appropriate adjustments to the system. Based on this assessment and relevant findings from the health care financing study on the cost-effectiveness of these reforms (see Covenant 9 below), an additional 14 Areas will be incorporated into the system (in 1997), and the balance of the Areas by the end of 1998. The Director of Planning will be the MOH counterpart to USAID for the SME system.

(e) Health Information System (HIS) working group multi-year plan developed and implemented

The development and institutionalization of an efficient and effective HIS will serve as a basis for strengthening local decision making and for insuring a more rational (i.e., epidemiologically based) and therefore more cost-effective allocation of scarce MOH resources. At the same time, this information will be also be useful in early warning/health surveillance, in monitoring progress in achieving MOH targets, and in providing data on the general health condition of the population.

During year 1 (June to December 1996) the HIS working group, with appropriate technical assistance funded from HS II, will analyze the current state of health information; examine and define health information needs and the data collection instruments by level; test, validate, and modify the system simultaneously in each of the 15 demonstration Areas; and develop the first draft of a system operations manual. In years 2 and 3 (CY 1997 and CY 1998) the MOH and USAID will review and evaluate the experience of the 15 demonstration Areas; the MOH will make appropriate adjustments to the system; train personnel in the use of the operations manual; take into account relevant findings from the health care financing

study (see Covenant 9 below) including an assessment of recurrent costs, and, if cost-effective, implement and institutionalize the HIS reforms in the remaining Health Areas.

As with the SME system, HS II funds will support the participation of Area personnel from Regions 4, 5, 6, and 7 with travel and per diem expenses between their Areas and Tegucigalpa. Project resources will also fund MOH personnel to enable them to monitor and validate the HIS process in the Areas. Travel and per diem costs for Area personnel working within their respective Areas will be supported by the Swedish. Over the course of the project extension, the MOH will assume an increasing share of the recurrent costs of the HIS. The Director of Planning will be the MOH counterpart to USAID for the HIS.

(f) Improved MOH Human Resources Development

Under this project extension, USAID and the MOH will explore specific, well targeted opportunities that could improve human resource development within the MOH (see IR 3.4(f)). In particular, USAID will carry out an assessment of opportunities to improve the Nursing and Masters in Public Health programs at the Honduras National Autonomous University (UNAH). Specifically, this assessment will look at the feasibility and appropriateness of modifying and upgrading the curriculum in these programs (and in the curriculum that governs pre-service training in the areas of reproductive health/family planning and breastfeeding counseling). The possibility of supporting other nurse training programs outside UNAH and introducing certificate courses for MOH personnel that would help meet MOH human resource development needs will also be explored, as will the feasibility of using the USAID/W University Development Linkages Program to achieve professional academic ties with UNAH.

(g) Effective Information, Education and Communication (IEC) policy implemented

The Health Area focus and its intensive community-based programming will require new approaches to health communication. MOH communication programs have been independently developed in many separate programs instead of being channeled through the DHE. This has led to a duplication of efforts throughout the Ministry and a failure to take advantage of an established resource. In accordance with a Covenant to the planned Project Agreement Amendment (see Chapter five), HS- 2 will encourage the MOH to define and approve a policy on health education. The essential characteristic of this policy will be its stipulation that the DHE must be involved in the design of all IEC campaigns. In this spirit, the communications component of the MCH workplan will be developed in collaboration with the DHE and financed by the project. Health education program design, development and implementation will emphasize greater community participation.

USAID will support IEC nationwide through policy dialogue (see Section V, Covenant 10) and funding of the development, reproduction, and use of IEC materials in specific technical areas, including IRA, ORT, and Reproductive Health. The Directors of MCH and of the Health Education Division (DHE) will be MOH counterparts to USAID for these activities.

IV. PRINCIPAL ASSUMPTIONS AND RISKS

The success of the extended project will depend on several budgetary and political assumptions which could affect the ability of the MOH to effectively carry out the program and policy reform agenda. These assumptions are operative at both the IR 2 and IR 3 levels. Assumptions will be reviewed and monitored by USAID at least once a year, both to insure they remain valid and to insure that they are adequately addressed by USAID and the GOH during the project period.

A. Assumptions at the IR 2 Level: *"Sustainable and Effective Public Sector PHC System":*

1. *GOH budgetary commitment to public health.* In authorizing the extension of this project, USAID assumes that the GOH will remain committed to spending approximately 13% of its total central budget on public health programs, and that within this budget, the portion dedicated to primary health care (including STD/AIDS prevention and STD treatment programs) will not decline. USAID assumes that in order to move towards sustainability the MOH will continue to finance a growing proportion of fixed budgetary recurrent costs associated with this project, including, most notably, costs for contraceptive procurement, costs associated with on-going use of the new child survival approaches the project will introduce, and the costs of carrying out the national-level policies and administrative reforms the project will support.

Given the completion of ESF assistance to Honduras, the GOH will no longer be able to provide host country-owned local currency from this source to finance its counterpart contribution to HS II at the same levels as in prior years. The GOH will therefore need to increase its contribution from other sources, notably from National funds. Through a Covenant in the planned Project Grant Agreement Amendment, the GOH will pledge to provide counterpart funding in amounts adequate to meet its commitments to HS II. A major assumption underlying this entire project extension is that the GOH will honor this pledge. USAID staff will monitor the GOH's provision of its planned counterpart contribution through the Mission's established procedures for such monitoring, and will alert Mission management on a timely basis should the GOH begin to fall short

2. *GOH commitment to health sector reform.* In addition to maintaining adequate funding levels, the project's success also hinges on the ability of the MOH to effectively follow through on its commitment to health sector reform. This will require a certain degree of continuity in personnel and policies over time, and a political commitment by both parties to avoid a wholesale replacement of qualified MOH personnel with the 1997 elections. Even assuming a proliferation of new political appointments with the 1997 elections, however, the establishment of profiles and standards for officials (per Covenant 4) should help mitigate the deleterious impact of such turnover.

In addition, the MOH will also need to maintain its commitment to strengthen national systems and mechanisms for donor coordination to ensure that a common, integrated approach

is taken in all 41 Health Areas and that "best practices" are recognized and implemented on a national scale. The MOH assessment of the full costs and savings associated with the new technologies and administrative systems (including ACCESO) that are introduced and supported under this project, and their convening annual seminars to present the most salient findings (per Covenant 9) will help solidify this commitment to reform.

B. Assumptions at the IR 3 Level: *Improved delivery of CS services; FP/RH services, STD/AIDS prevention services and STD treatment; and strengthened national systems and policies.*

1. *The present GOH and its post-1997 successor are, and will be committed to fully implement DOFUPS and other key administrative reforms. In particular, this includes a commitment and plan of action to implement such reforms as: permanent legalization of fee collection and retention, reduction in the appointment of non-qualified and poorly qualified persons to key MOH professional positions after the 1997 elections; simplifying the financial/management information and the health information systems; improving local access to essential drugs, and exploring options for improving the maintenance of MOH vehicles. Once again, the health financing studies and seminars associated with the new technologies and administrative systems (including ACCESO) introduced and supported under this project (per Covenant 9) will help solidify commitment to cost-effective reforms.*

2. *Public opposition to the use of modern contraceptives will continue to be effectively addressed through public dialogue and support of natural FP methods, and that the MOH will implement its RH/FP norms, which entails increased availability of modern contraceptives and FP counselling in the UPS. Section VII.C below describes how USAID and its partners will seek to assure that this assumption remains valid.*

V. CONDITIONS PRECEDENT AND COVENANTS

To assure that project resources and interventions contribute to the desired and expected results, the Government of Honduras and USAID/Honduras will agree to the following Conditions Precedent and Covenants, including: (1) those Covenants previously established in the Project Grant Agreement, as amended, that will be retained under the Project Grant Agreement Amendment that will extend HS II; (2) Conditions Precedent to disbursement of funds during the extended life of this project that will be included in the upcoming ProAg Amendment; and (3) new Covenants that will be included in this ProAg Amendment.

A. Retained Prior Covenants

Retention of Fees and Costs at Operational Level

The Cooperating Country agrees that all fees and costs recovered as part of any activity described in this Agreement shall be retained by the collecting unit and shall be in addition to any amounts budgeted by the Cooperating Country for that Unit. Furthermore, the Cooperating Country agrees to make whatever provisions are necessary, including and not limited to the passage of national legislation, to allow the retention of fees and costs at the operating level after the end of the activities described in this Agreement.

Bonding Requirements

The Coordinator of the Project Coordination Unit and the designated manager of the rotating fund established in SANAA will post fidelity bonds satisfactory in form and substance to the Ministry of Finance and Public Credit. The Area revolving funds will be derived from the rotating fund established in the Project Coordination Unit. Accordingly, the designated managers of these funds will not be required to post such bonds.

Issuance of Multi-year Personnel Contracts

The Cooperating Country agrees to the issuance of multi-year contracts, for up to the life of the Project, for Project-funded personnel in the MOH Project Coordination Unit (PCU).

Annual Liquidation Requirement

The Cooperating Country agrees that the Project's Coordination Unit will present annual financial status reports at the close of each calendar year (Cooperating Country fiscal year) and, on the basis of these reports, the Ministry of Finance and Public Credit will authorize the replenishment of the fund in the Central Bank for its original amount. The liquidation requirement for the previous year will be carried out during the first quarter of the following year.

Establishment and use of Regional Management Control Systems

The Cooperating Country agrees that:

- a. The MOH Division of Transportation will provide training and certification services for installing and maintaining inventory control systems for pick up and motorcycle spare parts in each of the MOH Health Regions before releasing spare parts to them, and
- b. The MOH Division of Transportation in coordination with the HS II Project Coordination Unit will monitor the MOH Health Regions use of the management control systems recommended in USAID/FARS Report No. 92-03. The MOH Division of Transportation shall prepare biannual reports certifying the adequacy of the MOH Sanitary Regions' use of these management control systems.

B. Conditions Precedent

1. *The MOH shall provide baseline data and establish annual and end-of- project targets for all result indicators by December 31, 1996 that are mutually agreeable to USAID. The mutual agreement by USAID and the MOH to these targets is a Condition Precedent to the commitment of USAID grant funds after January 1, 1997 for MOH-incurred local costs.*
2. *Prior to any disbursement of USAID grant funds for MOH incurred local costs after September 30, 1996, the MOH shall name one Health Area in every Health Region of the country in which the demonstration program on provision of family planning services by auxiliary nurses at CESARes will be conducted.*
3. *Prior to any disbursement of USAID grant funds into any of the nine Area funds after December 31, 1996 the MOH shall carry out an evaluation of Area and community activities. This will include a consideration of the use, impact and sustainability of the activities supported by the Area budgets and their effect on the mobilization (or displacement) of resources from other sources.*

This Condition Precedent along with Covenant 8 below, allow USAID and the MOH to disburse USAID grant funds for Area-level plans only until December 31, 1996, on the basis of workplans and budgets that mutually acceptable to both parties. Disbursements of USAID grant funds after this date will be contingent on the completion of an MOH evaluation of the Area and community activities, and the incorporation of the conclusions and recommendations of this evaluation into the Area workplans of 1997. The health financing studies discussed in Covenant 9 below will include an analysis of the Area level funds, and the MOH will incorporate the results of this analysis into the Area workplans of 1998 and 1999.

C. New Covenants

1. The MOH agrees to monitor the agreed-on performance results for the nine Areas and report to USAID semi-annually commencing January 31, 1997. These reports will be provided to USAID on January 31 and July 31 each year.

The project indicators (Annex 2) developed jointly by the MOH and USAID and the annual targets (to be mutually agreed upon by USAID and the MOH) are critical to assessing project impact. However, the data must be collected and analyzed in order for the degree of impact to be measured. The MOH, with USAID assistance, will be responsible for collecting the data and reporting on a semi-annual basis (in January and July) to the Mission.

2. In addition to the financing of contraceptives per Covenant 5 below, the GOH commits to provide adequate counterpart funding in the amounts agreed upon through the budgetary process to support project activities. Furthermore, the GOH commits to utilizing a rotating fund mechanism to disburse the counterpart.

FY 1996 is the last year that GOH counterpart contributions financed with Economic Support Funds (ESF) will be available as project counterpart. For FY 1997, the MOH will be responsible for supplying counterpart from its own resources. The MOH has been informed of this eventuality and has indicated its intention of honoring its commitment to providing these funds and to the use of rotating funds as the disbursement mechanism.

3. The MOH agrees that through the supervisory and information systems, Area directors will be responsible for the transfer of supplies of medicines and other supplies among UPS in order to assure that all UPS are continually stocked.

According to the 1995 evaluation, the lack of supplies (i.e., medicines) at the UPS is "the major complaint the population has against the UPS." A visit to a random selection of health centers showed that medicines are available only about 50% of the time that they attend patients. On the other hand, local health situations being unique, monitoring visits have revealed that one UPS may experience a shortage of a given medicine, while a neighboring UPS may have that particular medicine in abundance. Transferring these scarce resources among UPS should be a relatively easy process, using the cardex system of each UPS developed under POSSS for control. Area supervisors are in the best position to make these transfers, since their visits to UPS reveal these relative shortages and excesses. The Area director should be responsible for making sure that resources are moved among his/her UPS to avoid either shortages or excesses, and thereby alleviate this major complaint of the users.

4. The MOH agrees to establish the profile, including academic preparation and minimal experience, and the procedure for selection of the positions of Regional and Area Administrative Officers.

The 1995 evaluation stated that while Regional directors report an improvement in financial management at all levels, the political appointments of regional administrators is disruptive. The delays due to a new person following the learning curve can be lessened if s/he brings a minimum level of academic preparation and experience. Profiles exist for the selection of Regional and Area Directors; they should be developed, along with selection procedures, for the key positions of Regional and Area administrators. These positions are responsible for budget execution and control, key functions in a decentralized system. Candidates for the Regional administrator position should be university trained and have appropriate public health program administration or similar experience. Area administrators should hold the title of "*perito mercantil*" (accountant) and also have public health program administration or similar experience. Establishing profiles for these key positions will reduce the negative impact of personnel changes, as well as the recurrent costs of training unprepared personnel.

5. The GOH agrees to finance the procurement of contraceptives for both Family Planning and AIDS prevention activities beginning in 1997 and increasing thereafter. Under this Covenant, the GOH agrees to open a line item in its 1997 budget for the lempira equivalent of at least \$20,000 (3% of the projected total costs of contraceptives), increasing it to at least \$70,000 in 1998 (10 percent) and to at least \$140,000 in 1999 (20 percent). The exchange rate used to estimate the dollar value of these Lempira costs will be the highest rate not unlawful in Honduras as of the first working day of the calendar/GOH fiscal year in which these contributions are to be made.

As the MOH continues to implement its program of reproductive health, it will become increasingly critical for UPS at all levels to maintain an adequate supply and mix of contraceptives. Given budgetary realities, it is unclear whether USAID funding will be available in the future to continue to provide contraceptives to the MOH for HIV/AIDS prevention and family planning activities.

6. The MOH agrees that the three working groups established to design the workplans for the support systems in MIS/Finance/Administration, Health Information, and for Supervision, Monitoring and Evaluation will continue to function actively under the supervision and guidance of the designated MOH counterpart officer.

The mid-term evaluation recommends that the MOH focus on maintaining national-level systems for sustainable support to the provision of health care services. Specifically, the evaluation recommends that working groups be established in the areas of financial management/cost recovery, supervision, and health/management information systems. The MOH has already organized these three working groups. These have developed three-year workplans which will function with project support.

The MOH commits to maintaining and strengthening these committees and giving them the responsibility and authority to monitor the implementation of their plans. This will assure that implementation issues will be dealt with by a cross-section of the MOH and that ownership and commitment to the success of these systems will be shared across the MOH.

7. SANAA will seek the support of other donors in the water and sanitation sector as USAID intends to discontinue assistance for constructing new water and sanitation systems after December 31, 1996. At the same time, all USAID funding for other sectoral activities will be done in accordance with the model for community participation developed under the project. This includes the establishment of local community water boards, the active involvement of TASes (Water and Sanitation Technicians) and TOMs (Operations and Maintenance Technicians) in the process, and a strong water and sanitation education component.

The mid-term evaluation observes that the rural water and sanitation component of the project has been "very successful," noting especially that "a remarkable achievement is the continuous maintenance of constructed systems. This is due to the project's insistence on the organization and training of local water boards and health education." In the water sector, the project activities have already demonstrated the widespread success of the community participation model. With assistance from the TASes and TOMs from SANAA, it is a sustainable approach to the problem of potable water in rural areas. The MOH should insist that this highly successful model be replicated by other donors. Given that the USAID support for the sector and for the construction of new water and sanitation systems in particular will be ending in CY 1996, SANAA will need to seek the support of other donors.

8. Prior to approving the funding for Area-level plans, the MOH shall submit Area workplans and budgets for review and approval by USAID. In developing these Area workplans and budgets, priority shall be given to using project funds to support primary health investments and those activities which will mobilize local resources for community health.

PIL 56 approved the use of \$215,000 in existing HS II grant funds through September 1996 to finance nine Area-level workplans. It also approved the use of GOH counterpart funds to support other local costs of these plans for the full calendar/GOH fiscal year. These funds will be used primarily to cover local costs of training and per diem and limited local procurement of equipment and supplies. At the same time, ACCESO and MOH personnel in the nine focus Health Areas are continuing to work with municipalities, Regional Health authorities, hospitals, etc. to develop Area workplans and budgets for other activities. These local Area funds are intended to promote greater community involvement and responsibility in primary health care management and are therefore experimental. USAID will review and approve Area workplans and budgets in CY 1997 and beyond prior to the commitment of grant funding for them. USAID will provide this approval by issuance of a PIL.

9. The MOH agrees to assess the full costs and savings associated with the new technologies and administrative systems introduced and supported under this project, including ACCESO and the establishment of Area level budgets. This assessment shall look at travel, supplies, and other

recurrent costs as well as the impact on personnel time associated with sustaining these initiatives. The assessment shall also include a general review of MOH resource allocation, use and management and options for assuring an adequate GOH budget allocation for rural primary health care services. The MOH shall present the results of this assessment to a broad audience in a series of annual seminars convened in 1997, 1998 and 1999 specifically for this purpose.

In the face of declining donor agency budgets, the MOH faces the long-range challenge of financing the health sector on a sustainable basis. To this end, the MOH will commit itself to carrying out an assessment of primary health care financing and sustainability issues early in the life of the project extension. The assessment will focus on such issues as resource allocation, use and management, as well as financing, costing and expenditure monitoring. The project will provide technical assistance for the assessment, but the bulk of the task will be the responsibility of the MOH. The GOH will present the results of the assessment during a series of seminars with broad representation by other donor agencies, PVOs and national interest groups, such as the press, political leaders, and key members of the private sector. The assessment will provide an agenda for financing health services into the 21st century.

10. Prior to USAID's funding of new initiatives in information, education, and communication, the MOH shall: (1) elaborate and approve a policy on Health Education which defines the role of the Division of Health Education (DHE); (2) hold a seminar to discuss and publicize the policy within the Ministry; and (3) agree not to use USAID or project counterpart funds for any IEC materials which do not conform to the policy.

The DHE was established with HS II funds to provide MOH in-house expertise in health communications. Currently, however, the normative divisions of the MOH manage their own health education communication programs and funding. This results in a highly inefficient use of scarce MOH resources for health communications. A draft policy on health education is currently under review, but is yet to be approved and implemented by the Ministry. The purpose of this Covenant is to ensure that such a policy is adopted in a timely manner.

11. The Ministry of Health shall institute a medical waste management system that insures proper disposal in all UPSs where amounts of waste accumulate (i.e., CESAR, CESAMO, Maternal-Infantile Clinic, and Hospitals). Project activities in the nine focus Areas will result in the production of certain amounts of medical waste (syringes, bandages, etc.) which, if not properly disposed, could constitute a public health risk. In order to reduce to the maximum extent possible such risk, the Ministry of Health agrees to institute and implement a medical waste management system mutually agreeable to USAID and the MOH (as set forth in a PIL). This system shall include procedures appropriate to each UPS level for medical waste management (including training of personnel) and shall specify monitoring and enforcement of these procedures. Additionally, the MOH shall insure that disposal containers, incinerators and/or other appropriate means of handling wastes are available and in use. The MOH further agrees not to use USAID or project counterpart funds for procuring medical supplies and equipment that lead to the production of medical wastes for any UPS until such a system is implemented.

VI. MONITORING, EVALUATION, AND AUDIT PLAN

A. Monitoring and Evaluation

1. Monitoring

The MOH will monitor the achievement of the key activities and annual targets developed for the project results indicators, as set forth in Annexes 2 and 3 and discussed in Covenant 1 above, and to report to the Mission semi-annually (by January 31 and July 31 of every year), progress made in reaching these targets. To the extent possible, data will be disaggregated by gender.

As shown in Annexes 2 and 3, several different data sources will be utilized by the MOH and USAID in carrying out this monitoring function. These sources will include a situational analysis conducted in the nine focus Areas, the 1996 Epidemiology and Family Health Survey (EFHS), a limited version of the EFHS in 1998 in the nine focus Areas, service statistics from reporting UPS, and other MOH reports.

As the MOH Health Information System is developed, it will provide data on progress toward meeting planned results. The supervision system will perform an important data-gathering function for the monitoring function: supervisors will complete a simple data collection instrument describing the status of UPS service provision, inventory, operations, and physical condition. This information will be used to measure the availability and provision of services at each UPS and in the aggregate. During the first 12 months of the project extension, the MOH will also carry out a monitoring visit to each of the nine focus Areas and 15 demonstration Areas. Both USAID and MOH (including the PCU) will participate in these visits.

2. Evaluation

USAID and the MOH will carry out an evaluation in early 1998 to analyze project achievements, based on indicators of project results (Annex 2). The MOH and USAID shall jointly agree on the scope of work for this evaluation and on the selection of the evaluation team. The MOH shall also designate a counterpart representative to the team. USAID will be responsible for either contracting directly or using Global Field Support Funds to procure the services of a GAPHN cooperating agency to carry out the evaluation. The evaluation is to begin in early 1998 in order to allow time for adjustments during the final year of the project and to assist in the design of a possible follow-on program beginning in FY 1999.

B. Annual Audit Requirement

The Ministry of Finance and Public Credit (Grantee) shall have annual financial audits made of all funds disbursed to the Ministry of Health (covering funds disbursed directly to the Central, Regional and Health Area levels), to SANAA, and to any other public or private

sector institution or ministry carrying out activities funded under this project agreement extension (except where the total direct annual disbursement does not exceed \$100,000).

The audits shall be carried out in accordance with the following terms:

The audits shall determine whether the receipt and expenditure of the funds provided under the Agreement are presented in accordance with generally accepted accounting principles and USAID standard provisions and whether the recipient has complied with the terms of the Agreement. Each audit shall be completed no later than one year after the close of the calendar year (i.e., GOH fiscal year) in which the funds were disbursed.

The Ministry of Finance shall select an independent auditor eligible to USAID under the "Guidelines for Financial Audits contracted by Foreign Recipients" issued by the USAID Inspector General ("Guidelines"), and the audits shall be performed in accordance with the "Guidelines".

USAID may, at its discretion, also conduct financial reviews of the funds provided under the Agreement. The recipient shall afford authorized representatives of USAID/Honduras CONT/FARS Office the opportunity at all reasonable times to conduct these reviews.

VII. SUMMARY ANALYSIS OF FEASIBILITY²⁰

A. Technical: *Why does USAID believe this strategy or approach will get the desired results?*

USAID and the MOH believe this project extension is technically feasible and likely to lead to the achievement of the mutually expected results. The tools and tactics to be employed are technically sound. They are based on the May 1995 comprehensive mid-term evaluation of the present HS-2 project which assessed both: (1) the constraints to fully achieving specific project results that continue to be elusive and require new or improved approaches and technologies, and (2) the extent to which national support systems are in place that can sustain the tested approaches as part of an effective public primary health care system.

Honduras has experienced one of the most rapid declines in infant and child mortality of any country in Latin America, with infant mortality (under 1) declining 37.5% and child mortality (under 5) declining 42% during the 1983-90 period. Largely explaining this decline has been the MOH's successful implementation of diarrheal disease control and immunization programs at the UPS and community levels. This project amendment focuses on the need to improve and maintain public access to primary health care interventions such as these. It posits that improved administration and policies are key to doing so, particularly in the high-priority areas of local financial management, management information systems, cost recovery, supervision to improve the quality of services, and health information systems.

At the same time, this approach (i.e., the tools and tactics employed) takes into account the fact that rural Honduras has one of the highest total fertility rates in Latin America and, not coincidentally, one of its highest maternal mortality ratios. To significantly reduce these will require the implementation of the MOH's women's reproductive health norms -- involving both safer deliveries and fewer, better-spaced pregnancies.²¹ Similarly, this approach also recognizes that any further drop in infant and child mortality rates will require the effective implementation of relatively new health technologies (for Honduras) aimed at reducing perinatal, infant and child mortality due to acute respiratory infections, malnutrition, sepsis and unsafe delivery practices, short birth intervals and sub-optimal breastfeeding practices.

The introduction of selected management support systems in 15 demonstration Areas is also a technically feasible and appropriate strategy. The need for these systemic improvements is well documented in the mid-term evaluation and in other MOH and project documents. The permanent establishment of the MOH working groups (which developed four multi-year workplans to implement and expand key management support systems) will bolster the MOH and

²⁰ See the August 1994 HS II Project Paper Supplement for a discussion of the technical, political, financial, social, and institutional feasibility for the AIDS/STD prevention and STD treatment component of the project, including the "Detailed Implementation Plan" (Attachment 8).

²¹ The "*Tarjeta del Nino*" which the UPS gives to new mothers recommends that they wait at least two years before their next pregnancy to better insure the good health of their newborn.

donor commitment to the strengthening of these systems, and the geographic selection of the project's 15 demonstration Areas in every Health Region of the country will facilitate and better insure effective national expansion.

Accordingly, the Strategic Objective team believes that the case for introducing these administrative and technological interventions at this time is persuasive. It is consistent with the Agency's strategies for Sustainable Development and Implementation Guidelines for Population, Health and Nutrition programs.

B. Social Soundness: *How do these approaches meet our customers' needs and desires?*

The approaches described herein reflect the Ministry's commitment to "ACCESO", i.e., to providing our customers (especially high risk mothers and children in rural Honduras) with integrated, accessible, high quality and appropriate services at the UPS/community level. The ACCESO program ensures MOH responsiveness to the needs and desires of our ultimate customers by promoting community involvement in local programming, e.g., in the high degree of community participation in the development of the nine focus Area workplans. This has never before been done by the Ministry of Health in Honduras.

Moreover, the development of a customer service plan in the nine focus Areas (with technical assistance from the Quality Assurance Project) will further strengthen the MOH's customer service orientation. This plan will entail working in teams, obtaining information on client expectations and needs (via baseline surveys, exit interviews, microsurveys, etc); establishing norms and standards for service delivery; developing a training plan; monitoring quality; and defining an incentive and communication plan.

C. Political: *How will we and our partners address the interest or opposition of local stakeholders to planned approaches?*

Opposition to the Ministry of Health's active role in promoting use of modern contraceptives (OCs, condoms and IUDs) as part of its reproductive health strategy exists in Honduras, and could, unless adroitly handled, distract attention from the agenda agreed upon and undermine achievement of key project results.

USAID and the MOH will address this opposition by pursuing a culturally and religiously sensitive and sensible strategy that includes the following:

- Articulation of family planning need solely in terms of improved maternal and child health;
- The availability of an array of modern contraceptive methods;
- Involvement of churches and religious groups in the development of the nine focus Area workplans;

- Encouraging local support for family planning services by introducing effective new approaches including the distribution of oral contraceptives and IUD insertion by nurse auxiliaries in CESARes as a pilot demonstration project in selected Health Areas;
- Close coordination between the MOH and PVOs financed under PSP III (through the reproductive health working group, chaired by the MOH, for training, services and IEC) to insure consistent and culturally sensitive/appropriate family planning services; and,
- A policy dialogue that focuses on GOH procurement of increasing amounts of contraceptives and the delivery of family planning counseling and services at all levels of UPS.

D. Institutional: *Are our partners committed to and capable of using planned approaches and resources to achieve planned results? How can we be sure this commitment to ACCESO will continue after the 1997 elections with a new administration?*

USAID believes that the GOH is committed to supporting the approaches to be carried out under this extension. This conclusion is based on a number of factors. First, the GOH is committed at the policy level to leave a functioning, viable health delivery system when the current Honduran government relinquishes control in early 1998. Second, there has been virtual linear development of the public health system over the past 10-15 years. No new administration during this period has thrown out the work of the previous to begin anew, and the current MOH does not believe that this will happen in the new administration. Third, the GOH has accepted the Covenant regarding the profile of minimum required professional qualifications for Regional and Area administrative officers and the commitment to reduce the effect of turnover in these key positions. Finally, the MOH is coordinating donor assistance through the ACCESO Technical Assistance Group (GAT), the ACCESO Technical Working Group (GT), and the Interagency Coordinating Health Committee, and assuring that most Health Areas of the country have the assistance of external donors -- a process further strengthened by IDB (and World Bank) sector policies that encourage decentralization.

ACCESO has generated an energy at the Area and local levels that will be difficult to ignore in the future. Area and community personnel for the first time have been intimately involved in the development of Area-level workplans. It is expected that the experiences of the nine focus and the 15 demonstration Areas during the three year HS II extension will lead to the institutionalization of more responsive, effective, and decentralized health care services for the country as a whole.

The lack of resources is a constant problem for the MOH and will not be resolved by HS II. Within the obvious budgetary and personnel constraints, the MOH is determined to move forward with both ACCESO and the approaches that prove to be successful in the nine focus and 15 demonstration Areas.

E. Financial: *Are these the most cost effective means of getting these results, and do these approaches maximize the impact of our scarce development resources?*

This project will seek to maximize the impact of scarce USAID and GOH resources by: (1) mobilizing local personnel and resources to more effectively engage communities in the health seeking and disease prevention process; and (2) providing comprehensive and cost-effective primary health care services and technologies at the UPS/community level. Locally collected fees for service will help to offset the cost of providing these services.

Decentralized management, decision-making and budgetary administration are critical to establishing a sustainable and effective primary health care system in Honduras. Strengthened administration/management support systems will enable the MOH to evaluate the cost-effectiveness of various administrative changes and reforms and to adopt those which prove to be the most cost-effective and implement them nationwide.

The comprehensive primary health care services supported under this project are a mix of the most cost effective technologies known. Combined, these interventions should lead to reductions in maternal and child mortality, malnutrition and fertility.

F. Sustainability: *What progress will our partners have made toward self-financing by the time USAID support ends?*

During this project extension from June 1996 to September 1999, the MOH will assume a substantial share of the recurrent costs associated with the implementation and expansion of administrative and technological innovations which this project supports. The total recurrent costs (including contraceptives) for the extended project are approximately 67.6 million lempiras (33.6 million lempira excluding contraceptives) of which the GOH will provide 30 million lempiras (see the recurrent cost analysis, Annex 1f). As shown in the recurrent cost analysis, the GOH will continue to use ESF generated funds to finance its counterpart contribution in year 1 (June to December 1996) but not in the subsequent project years. Instead, the growing GOH budgetary commitment to this project will be manifest in the GOH commitment to provide its own funds to compensate for the decline of ESF counterpart funds. In particular, the GOH will increasingly use National Funds to support those recurrent expenditures formerly financed with ESF local currency or USAID grant funds, including (but not limited to) costs associated with maintenance and operations of vehicles and equipment including the cold chain, staff per diem and travel, and contraceptive procurement. As shown in Annex 1f, the percentage of recurrent costs financed by the GOH is projected to increase during the life of the project extension. By the final (nine month) year of the project, the GOH will provide over 10 million lempira in National Funds, representing over 50% of the total recurrent costs that year, and over 90% if contraceptives are excluded (see also Section VIII.C below).

VIII. FINANCIAL, HUMAN RESOURCE, AND MANAGEMENT PLAN

A. Resource Requirements - USAID and Counterparts

1. Life of Project Budget (see Annex 1a)
2. Detailed First Year Budget (see Annex 1b)
3. Human Resources Requirements (see Annex 1c)

Within USAID: USAID project management responsibility will rest with members of the Mission's Strategic Objective Three team. Technical leadership will be provided by the Director of the Office of Human Resources Development (who is also the SO Three Team Leader), and the Chief of the Health Population and Nutrition Division (HRD/HPN). The HRD/HPN US Direct Hire Officer will provide general technical and administrative oversight and will manage the project for results with assistance from a project-funded Technical Advisor in AIDS and Child Survival (TAACS) under a PASA with CDC, a FSN Public Health Advisor, a FSN Population Advisor, a USPSC Rural Water and Sanitation Advisor,²² a non-PSC FSN Child Survival Technical Assistance Coordinator, a USPSC Financial Advisor (for the final year of the project) a USPSC Administrative Officer, and a FSN Direct Hire Administrative Assistant. This group of professionals will work with the Ministry of Health (MOH) to facilitate project implementation, identify and resolve problems, and monitor progress toward achievement of planned results and the use of resources to that end.

Within MOH Project Coordination Unit: Project implementation coordination will be facilitated by the MOH's Project Coordination Unit (PCU). The PCU will coordinate project implementation activities with administrative, budgetary and oversight offices of the MOH, the Ministry of Finance and the Controller General. The PCU will also be responsible for establishing, monitoring and reporting on the local cost disbursement mechanisms (rotating funds) of the project. The PCU will be staffed by a Project Coordinator, a Project Administrator (Deputy Coordinator), a Controller, a Monitoring Officer, and support staff for facilitating and accounting for disbursements.

Within Cooperating Agencies: Virtually all technical assistance will be provided by the Global Bureau's PHN Cooperating Agencies. All technical advisors will be short-term with specific scopes of work. There will be no resident technical advisors contracted except for AIDSCAP and the Population Council (INOPAL).

²² The USPSC Rural Water and Sanitation Advisor will serve only through September 1996.

B. Planned Obligation Actions and Instruments

1. Funds Obligated by the Mission (see Annex 1d)
2. Funds Obligated by the Global Bureau (see Annex 1e)

Project funds scheduled for obligation by the Mission will be obligated by amending the Health Sector II Project Grant Agreement. Mission approval for project funds scheduled for obligation by the Global Bureau for Global Field Support will be provided via cable on an annual basis.

C. Recurrent Costs of Project Interventions to Participant Organizations

The recurrent cost analysis of this project is composed of two elements: a budgetary estimate of the project recurrent costs during the CY 1996-1999 project period, tied to an agreement with the GOH on the amount and proportion of those recurrent costs which will be assumed by the GOH (see Annex 1f for a breakdown of these costs); and a commitment by the MOH to fully assess the costs and savings associated with new technologies and administrative systems (including ACCESO) that are introduced and supported under this project (per Covenant 9).

The annual project recurrent costs are estimated as follows: (1) All local costs in the first year budget are classified as either investment or recurrent, and estimates are projected to years two, three and four; (2) fixed recurrent costs of 4% per annum are associated with all project procured equipment maintenance and repair; and (3) an increasing share of contraceptive procurement will be born by the GOH (per Covenant 5). Based on this formula, the percentage of non-contraceptive recurrent costs covered by the GOH during each of the four project years will be 62%, 70%, 85% and 91%, respectively, while the percentage of contraceptive recurrent costs paid by the GOH will increase from 1.6% to 20% over the period of the extended project. The overall percentage of all recurrent costs borne by the GOH over the four years is: 31%, 41%, 53% and 57%. In interpreting these recurrent cost data, it should also be noted that for CY 1996 recurrent costs will be covered by ESF, and that National Funds will be used thereafter.

**ANNEX 1a to the HEALTH SECTOR II PP SUPPLEMENT
ILLUSTRATIVE SUMMARY LOP COST ESTIMATE (US\$ 000)**

3

PROJECT ACTIVITIES	LC	FX	SUBTOTAL MISSION	USAID/W: GFS	TOTAL USAID	GOH COUNTERPART	PROJECT TOTAL
I. REENGINEERED PROJECT ACTIVITIES 6/96-9/99	7,267	5,044	12,311	7,151	19,462	2,623	22,085
Result 1: Improved Delivery of Selected Child Survival Services	2,416	576	2,992	844	3,836	1,509	5,345
Result 2: Improved Delivery of Reproductive Health and Family Planning Service	868	1,891	2,759	2,500	5,259	207	5,466
Result 3: Improved Delivery of STD/AIDS Prevention and STD Treatment	1,090	176	1,266	2,233	3,499	534	4,033
Result 4: National Systems and Policies Strengthened	2,293	1,029	3,322	1,349	4,671	312	4,983
Result 5: Effective Project Administration and TA Coordination (includes audits, mini-survey and the final evaluation)	600	1,372	1,972	225	2,197	62	2,259
II. PRE-REENGINEERING PROJECT ACTIVITIES 10/88-10/96	18,342	36,257	54,599	3,140	57,739	28,511	86,250
SUSTAINABLE SUPPORT SYSTEMS	6,540	10,896	17,436		17,436		
HEALTH TECHNOLOGIES (SEE NOTE NO. 1)	445	7,506	7,951	2,990	10,941		
RURAL WATER AND SANITATION	4,106	12,846	16,952		16,952		
PRIVATE SECTOR	6,195	1,745	7,940		7,940		
PROJECT ADMINISTRATION	1,056	3,264	4,320	150	4,470		
III. PROJECT TOTALS 10/88-9/99	25,609	41,301	66,910	10,291	77,201	31,134	108,335

1. AN OYB TRANSFER TO USAID/W FOR \$640,000 IS LISTED IN THIS CHART AS GFS UNDER HEALTH TECHNOLOGIES.

THE 640,000 OYB TRANSFER WAS DESCRIBED AS AN IN KIND CONTRIBUTION TO THE \$57.3 MILLION USAID TOTAL IN PROAG AMENDMENT NO. 21.

2. THE DISTRIBUTION OF OBLIGATIONS SHOWN ABOVE IN SECTION NO. II DOES NOT MATCH THE DISTRIBUTION SHOWN IN PROAG AMENDMENT NO. 21

BECAUSE \$2.06 MILLION OF OBLIGATIONS WHICH HAVE NOT BEEN EXPENDED/ENCUMBERED ARE BEING REPROGRAMMED HEREIN IN SECTION NO. 1 ABOVE.

ANNEX 1b to the HEALTH SECTOR II PP SUPPLEMENT
HEALTH SECTOR II EXTENSION: MISSION OBLIGATED BUDGET BY RESULT

	DETAILED 1ST YEAR BUDGET			2ND YEAR BUDGET			3RD YEAR BUDGET			4TH YEAR BUDGET			TOTAL PROJECT EXTENSION		
	USAID	GOH	TOTAL	USAID	GOH	TOTAL	USAID	GOH	TOTAL	USAID	GOH	TOTAL	USAID	GOH	TOTAL
Result 1: Improved Delivery of Selected Child Survival Services	884,151	82,004	966,154	858,422	372,048	1,230,470	720,000	580,361	1,300,361	529,000	474,273	1,003,273	2,991,573	1,508,685	4,500,258
A. New Or Improved Approaches	771,088	17,316	788,404	713,288	227,882	941,171	600,000	388,487	988,487	409,000	327,523	736,523	2,493,377	961,018	3,454,395
1. Strengthened UPS with Local Community Involvement	361,008	17,316	378,324												
a. Local Costs	361,008	17,316	378,324												
i. Programmed jointly by the 9 MOH focus health areas and their respective municipalities	213,850	17,316	231,166												
ii. Programmed by the 9 MOH focus health areas (see note no. 4)	139,212		139,212												
iii. Programmed by the MOH Division of Maternal Child Health	7,916		7,916												
2. Improved Treatment of Pneumonia	206,387	0	206,387												
a. Local Costs	3,687	0	3,687												
i. Programmed by the 9 MOH focus health areas (see note 4 below)	1,163		1,163												
ii. Programmed by the MOH Division of Maternal Child Health	2,524		2,524												
b. Mission-procured Equipment (respiratory equipment)	202,700		202,700												
3. Improved Breastfeeding Practices	200,000	0	200,000												
a. Local Costs	0	0	0												
i. Programmed by the 9 MOH focus health areas (see note 4 below)															
b. Technical Assistance (Mission, La Liga)	200,000		200,000												
4. Increased Access to Integrated Child Care (ICC)	3,693	0	3,693												
a. Local Costs	3,693	0	3,693												
i. Programmed by the 9 MOH focus health areas (see note 4 below)	1,202		1,202												
ii. Programmed by the MOH Division of Maternal Child Health	2,491		2,491												
B. Sustained Availability of Proven Interventions	113,062	64,688	177,750	145,133	144,366	289,499	120,000	191,864	311,864	120,000	146,750	266,750	498,185	547,687	1,045,873
1. Sustained Immunization Coverage	113,062	64,688	177,750												
a. Local Costs	13,062	64,688	77,750												
i. Programmed by the 9 MOH focus health areas (see note 4 below)			0												
ii. Programmed by the MOH Division of Maternal Child Health	13,062	64,688	77,750												
b. Mission-procured equipment (cold chain equipment)	100,000		100,000												
2. Sustained Oral Rehydration Therapy	0	0	0												
a. Local Costs	0	0	0												
i. Programmed by the 9 MOH focus health areas (see note 4 below)			0												
ii. Programmed by the MOH Division of Maternal Child Health			0												
Result 2: Improved Delivery of Reproductive Health and Family Planning Services	305,357	0	305,357	813,024	20,949	833,973	913,000	58,778	971,778	728,100	126,982	855,082	2,759,481	206,709	2,966,190
a. Local Costs	6,357	0	6,357												
i. Programmed by the 9 MOH focus health areas (see note 4 below)	4,032		4,032												
ii. Programmed by the MOH Division of Maternal Child Health	2,325		2,325												
b. Mission-procured Equipment (1st year includes \$185,000 for IHSS)	254,000	0	254,000												
c. Mission-procured IEC Materials (1st year includes \$45,000 for IHSS)	45,000	0	45,000												

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ANNEX 1b to the HEALTH SECTOR II PP SUPPLEMENT
HEALTH SECTOR II EXTENSION: MISSION OBLIGATED BUDGET BY RESULT

	DETAILED 1ST YEAR BUDGET			2ND YEAR BUDGET			3RD YEAR BUDGET			4TH YEAR BUDGET			TOTAL PROJECT EXTENSION		
	USAID	GOH	TOTAL	USAID	GOH	TOTAL	USAID	GOH	TOTAL	USAID	GOH	TOTAL	USAID	GOH	TOTAL
Result 3: Improved Delivery of STD/AIDS Prevention and STD Treatment	160,000	79,717	239,717	382,000	116,289	498,289	379,000	167,861	546,861	345,000	169,646	514,646	1,266,000	533,512	1,799,512
a. Local Costs		79,717	79,717												
b. Participant Training	160,000		160,000												
c. Laboratory Reagents		70,859	70,859												
d. Condoms		8,857	8,857												
Result 4: National Systems and Policies Strengthened	1,017,643	67,560	1,085,203	949,527	60,134	1,009,661	746,730	100,942	847,672	608,000	83,399	691,399	3,321,900	312,036	3,633,936
A. Financial and Administrative Information System	88,275	14,172	100,447												
1. Local Costs	18,275	14,172	30,447												
2. Technical Assistance (Mission)	50,000		50,000												
3. Mission-procured Equipment (computers and accessories)	20,000		20,000												
B. Supervision, Monitoring and Evaluation	34,667	0	34,667												
1. Local Costs	34,667		34,667												
C. Health Information System	53,665	0	53,665												
1. Local Costs	38,665		38,665												
2. Mission-procured Equipment (computers and accessories)	15,000		15,000												
D. Human Resources Development	15,611	0	15,611												
1. Local Costs	15,611		15,611												
E. Sustaining Access to Water and Sanitation	420,000	0	420,000												
1. Local Costs (training TSAs, 50,000; training Area Env. Health Chiefs, 5,000)	55,000		55,000												
2. Mission-procured Equipment (35 motorcycles, 7 vehicles and office equipment)	265,000		265,000												
3. Technical Assistance	100,000		100,000												
a. SANAA (Mission)	50,000		50,000												
b. MOH (Mission)	50,000		50,000												
F. Rationalization of Transportation Resources	302,214	49,527	351,741												
1. Local Costs	2,214	49,527	51,741												
2. Equipment (12 vehicles)	300,000		300,000												
G. IEC	83,646	319	83,965												
1. Local Costs	83,646	319	83,965												
H. Grupo de Asistencia Técnica ("GAT"): Coordinación de Acceso	21,563	3,543	25,106												
1. Local Costs	21,563	3,543	25,106												
Result 5: Effective Project Administration and TA Coordination	452,047	52,374	504,422	570,000	3,000	573,000	820,000	3,200	823,200	130,000	3,000	133,000	1,972,047	61,574	2,033,622
A. Project Coordination Unit (see note no. 5 below)	52,047	2,755	54,802												
B. USAID (administrative personnel, technical advisors, audits, mini-survey, final evaluation, and medical waste disposal)	400,000		400,000												
C. Additional Rotating Fund Capital		49,620													
TOTAL	2,819,197	281,655	3,100,853	3,572,973	672,420	4,145,393	3,578,730	911,141	4,489,871	2,340,100	857,300	3,197,400	12,311,000	2,622,516	14,933,517

NOTES:

1. THE ABOVE BUDGET ASSUMES R4 SCENARIO 1 FUNDING LEVELS FY 96-98
2. THE ABOVE BUDGET INCORPORATES \$2.06 MILLION OF UN earmarked FUNDS WHICH HAVE ALREADY BEEN OBLIGATED BY THE MISSION TO THE HS II PROJECT.
3. THE ABOVE BUDGET ASSUMES THAT THE MISSION WILL OBLIGATE IN JUNE OF EACH YEAR.
4. \$215,440 WERE PREVIOUSLY COMMITTED FOR THIS ACTIVITY UNDER P/L NO. 56
5. THE PROJECT COORDINATION UNIT WAS FUNDED THROUGH BGD/06 UNDER P/L NOs. 53 AND 56.
6. L1,431,110 (EQUIVALENT TO US\$128,759 @ 11.29 TO 1) WAS PROGRAMMED UNDER P/L 56 AS A GOH COUNTERPART CONTRIBUTION FOR THE NINE FOCUS AREAS.
7. PROJECT YEARS AND EXCHANGE RATES:
 - A. PROJECT YEAR ONE IS JUNE TO DECEMBER 1996, 11.29 TO 1
 - B. PROJECT YEAR TWO IS JANUARY TO DECEMBER 1997, 12.5 TO 1
 - C. PROJECT YEAR THREE IS JANUARY TO DECEMBER 1998, 14 TO 1
 - D. PROJECT YEAR FOUR IS JANUARY TO SEPTEMBER 1999, 15.5 TO 1
8. RECONCILIATION OF GOH YEAR ONE LOCAL COST AND RECURRENT BUDGETS:

	LOCAL COST	RECURRENT
1. UNADJUSTED TOTALS FROM ANNEXES 1b AND 1f	\$281,655	\$330,355
2. PLUS P/L 56	\$126,739	
3. LESS NON-RECURRENT COSTS*	(\$178,059)	
ADJUSTED TOTALS	\$330,355	\$330,355

*NON-RECURRENT COSTS: L125,500 COMMUNITY PLANS; L124,800 AREA PLANS; L40,000 LEGAL ADVISOR (RETAINED REVENUE ISSUES); L31,110 PCU UTILITIES; AND L560,208 FOR INCREASING ROTATING FUND CAPITALIZATION LEVEL.

9. THE DIFFERENCES BETWEEN THE GOH RECURRENT AND LOCAL COST BUDGETS IN ALL OTHER YEARS IS DUE TO NON-RECURRENT COSTS IN THE GOH LOCAL COST BUDGET FOR COMMUNITY ACTIVITIES AND UTILITIES FOR THE PCU.

ANNEX 1c to the HEALTH SECTOR II PP SUPPLEMENT

USAID MANAGEMENT COSTS (in terms of money and people for the period 10/96 through 9/99)

POSITION	DURATION	SOURCE OF FUNDING	% HS II	COST LOP (US\$)
SO3 TEAM LEADER (US DIRECT HIRE/OFFICE DIRECTOR)	10/1/96 - 9/30/99	OE FUNDS	30%	180,000
HPN OFFICER (US DIRECT HIRE)	10/1/96 - 9/30/99	OE FUNDS	45%	270,000
TAACS ADVISOR (US/PASA)	10/1/96 - 9/30/99	GLOBAL FIELD SUPPORT FUNDS	50%	225,000
WATER & SANITATION ADVISOR (USPSC)	10/1/96 - 9/30/98	PROGRAM FUNDS	100%	270,000
PUBLIC HEALTH ADVISOR (FSNPSC)	10/1/96 - 9/30/99	PROGRAM FUNDS	100%	180,000
POPULATION ADVISOR (FSNPSC)	10/1/96 - 9/30/99	PROGRAM FUNDS	50%	73,500
CHILD SURVIVAL TA COORDINATOR (FSN NON-PSC)	10/1/96 - 9/30/99	PROGRAM FUNDS	100%	108,000
PROJECT ADMINISTRATIVE OFFICER (USPSC)	10/1/96 - 9/30/99	PROGRAM FUNDS	75%	247,500
PROJECT ADMINISTRATIVE ASSISTANT (FSN DIRECT HIRE)	10/1/96 - 9/30/99	OE FUNDS	100%	42,000
SECRETARY (FSNPSC)	10/1/96 - 9/30/99	PROGRAM FUNDS	100%	36,000
HEALTH FINANCE ADVISOR (USPSC)	10/1/98-9/30/99	PROGRAM FUNDS	100%	135,000
TOTAL				1,767,000

Note: Mission overhead expenses (USAID building rent, for example) are embedded in the above figures.

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**ANNEX 1d to the HEALTH SECTOR II PP SUPPLEMENT
ESTIMATED USAID LOP OBLIGATIONS BY FISCAL YEAR**

	FY88-95	FY96	FY97	FY98	FY96-98	FY88-98
I. MISSION						
A. CHILD SURVIVAL	33,900	1,823	2,231	1,681	5,735	39,635
B. POPULATION	3,130	1,631	1,113	728	3,472	6,602
C. HEALTH	17,072					17,072
D. AIDS (SEE NOTE NO. 2)	3,198	100	876	67	1,043	4,241
SUBTOTAL	57,300	3,554	4,220	2,476	10,250	67,550
II. GLOBAL						
A. CHILD SURVIVAL	1,300	393	1,065	1,050	2,508	3,808
B. POPULATION		925	730	755	2,410	2,410
C. AIDS	800	1,138	573	522	2,233	3,033
D. MICRONUTRIENTS	400				0	400
SUBTOTAL	2,500	2,456	2,368	2,327	7,151	9,651
TOTALS	59,800	6,010	6,588	4,803	17,401	77,201

NOTES:

1. FY96-98 FIGURES ASSUME OBLIGATION LEVELS PROJECTED ON 4/29/96 FOR SO3.
2. MISSION OBLIGATED AIDS, FY88-95, INCLUDES AN OYB TRANSFER OF \$640,000.

**ANNEX 1e to the HEALTH SECTOR II PP SUPPLEMENT
LOP GLOBAL FIELD SUPPORT BY PROJECT RESULT**

	PRE-FY96*	FY96	FY97	FY98	FY96-FY98	TOTALS
RESULT/COOPERATING AGENCY						
Result 1: Improved Delivery of Selected Child Survival Services	950,000	394,000	225,000	225,000	844,000	1,794,000
1. BASICS	750,000	226,000	200,000	200,000	626,000	1,376,000
2. WELLSTART	200,000	118,000			118,000	318,000
3. WELLSTART FOLLOW ON		50,000	25,000	25,000	100,000	100,000
Result 2: Improved Delivery of Reproductive Health and Family Planning Services	300,000	700,000	895,000	905,000	2,500,000	2,800,000
1. MOTHERCARE	250,000	250,000	150,000	150,000	550,000	800,000
2. INOPAL		270,000	300,000	300,000	870,000	870,000
3. PCS		60,000	40,000	40,000	140,000	140,000
4. AVSC		100,000	40,000	40,000	180,000	180,000
5. FPLM ("CDC")	50,000		15,000		15,000	65,000
6. FPLM ("JSI")		20,000	20,000	10,000	50,000	50,000
7. CENTRAL CONTRACEPTIVE PROCUREMENT	0		330,000	365,000	695,000	695,000
Result 3: Improved Delivery of STD/AIDS Prevention and STD Treatment	1,440,000	1,138,000	573,000	522,000	2,233,000	3,673,000
1. AIDSCAP	1,240,000	904,700			904,700	2,144,700
2. POST-AIDSCAP AIDS TA			343,000	257,000	600,000	600,000
3. CENTRAL CONTRACEPTIVE PROCUREMENT	200,000	233,300	230,000	265,000	728,300	928,300
Result 4: National Systems and Policies Strengthened	0	149,000	600,000	600,000	1,349,000	1,349,000
1. HEALTH FINANCING & SUSTAINABILITY		99,000	300,000	300,000	699,000	699,000
2. TAACS ("CDC"; SHORT TERM CONSULTANCIES FOR HEALTH INFORMATION SYSTEM)		50,000			50,000	50,000
3. QA II		0	100,000	100,000	200,000	200,000
4. UNIVERSITY LINKAGES			100,000	100,000	200,000	200,000
5. DATA FOR DECISION MAKING (CDC)			100,000	100,000	200,000	200,000
Result 5: Effective Project Administration and TA Coordination	150,000	75,000	75,000	75,000	225,000	375,000
1. TAACS ("CDC"; RESIDENT ADVISOR)	150,000	75,000	75,000	75,000	225,000	375,000
TOTALS	2,840,000	2,456,000	2,368,000	2,327,000	7,151,000	9,991,000

NOTES:

* THE PRE FY96 FIGURES INCLUDE THE FY95 OYB TRANSFER OF \$640,000 TO AIDSCAP.

** THE ABOVE FIGURES ASSUME OBLIGATION LEVELS PROJECTED ON 4/29/96, AND AS MODIFIED FOR THE "POLIO TAX".

ANNEX 1f to the HEALTH SECTOR II PP SUPPLEMENT
RECURRENT COSTS OF THE PROJECT EXTENSION (IN LEMPIRAS)

	YEAR ONE			YEAR TWO			YEAR THREE			YEAR FOUR			TOTALS		
	USAID	GOH	TOTAL	USAID	GOH	TOTAL	USAID	GOH	TOTAL	USAID	GOH	TOTAL	USAID	GOH	TOTAL
Result 1: Improved Delivery of Selected Child Survival Services	1,866,126	2,042,350	3,928,476	2,121,892	3,907,172	6,029,064	1,326,182	6,210,148	7,536,331	663,091	5,159,037	5,822,128	5,997,291	17,318,707	23,315,998
A. New Or Improved Approaches	1,702,961	1,001,559	2,704,511	1,915,831	2,277,285	4,193,117	1,197,394	4,044,002	5,241,396	598,697	3,502,230	4,100,927	5,414,884	10,825,067	16,239,951
1. Strengthened UPS with Local Community Involvement	1,685,780	913,580	2,579,360	1,874,003	2,030,038	3,904,040	1,171,252	3,708,798	4,880,050	585,626	3,074,412	3,660,038	5,296,660	9,726,828	15,023,488
a. Supervision Travel expenses	505,810		505,810	569,036	189,679	758,715	355,648	592,746	948,394	177,824	533,471	711,295	1,608,318	1,315,896	2,924,214
b. Monthly meetings/Updating of CEFASA	301,094		301,094	338,731	112,910	451,641	211,707	352,845	564,551	105,853	317,560	423,413	957,385	783,315	1,740,700
c. Delivery of "Paqueta Basico"	427,144		427,144	480,537	160,179	640,716	300,336	500,559	800,895	150,168	450,503	600,671	1,358,184	1,111,242	2,469,426
d. Supplies for DOFUPS	149,732		149,732	168,449	56,150	224,598	105,280	175,467	280,748	52,640	157,920	210,561	476,101	389,537	865,638
e. Materials for repair of UPS	240,000		240,000	270,000	90,000	360,000	168,750	281,250	450,000	84,375	253,125	337,500	763,125	624,375	1,387,500
f. Office supplies for Health Area Offices	36,000		36,000	40,500	13,500	54,000	25,313	42,188	67,500	12,656	37,969	50,625	114,469	93,656	208,125
g. Vehicle maintenance		370,000	370,000	0	555,000	555,000	0	693,750	693,750	0	520,313	520,313	0	2,139,063	2,139,063
h. Fuel (transportation)		543,580	543,580	0	815,370	815,370	0	1,019,213	1,019,213	0	764,409	764,409	0	3,142,572	3,142,572
i. Office equipment maintenance			0		15,000	15,000		18,750	18,750		14,063	14,063		47,813	47,813
j. Computer equipment supplies	6,000		6,000	6,750	2,250	9,000	4,219	7,031	11,250	2,109	6,328	8,438	19,078	15,609	34,688
k. Computer equipment maintenance			0		20,000	20,000		25,000	25,000		18,750	18,750		63,750	63,750
2. Improved Treatment of Pneumonia	28,981	36,375	65,356	32,604	166,780	199,384	20,377	228,853	249,231	10,189	346,614	356,803	92,151	778,623	870,773
a. Implementation of norms for ARIs	28,981		28,981	32,604	10,868	43,472	20,377	33,962	54,339	10,189	30,566	40,755			
b. Fuel (transportation)		15,375	15,375	0	23,063	23,063	0	28,828	28,828	0	21,621	21,621	0	88,887	88,887
c. Salbutamol		21,000	21,000	0	31,500	31,500	0	39,375	39,375	0	29,531	29,531	0	121,406	121,406
d. Maintenance of project procured equipment (4% of equipment budget/year)			0		101,350	101,350	0	126,688	126,688	0	264,896	264,896	0	492,934	492,934
3. Improved Breastfeeding Practices (none identified)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4. Increased Access to Integrated Child Care (ICC)	8,200	51,595	59,795	9,225	80,468	89,693	5,766	106,350	112,116	2,883	81,204	84,087	26,073	319,616	345,690
a. Printed materials	8,200	51,595	59,795	9,225	80,468	89,693	5,766	106,350	112,116	2,883	81,204	84,087	26,073	319,616	345,690
B. Sustained Availability of Proven Interventions	183,165	1,040,800	1,223,965	206,061	1,629,887	1,835,948	128,788	2,166,146	2,294,934	64,394	1,656,807	1,721,201	582,407	6,493,640	7,076,048
1. Sustained Immunization Coverage	183,165	1,040,800	1,223,965	206,061	1,629,887	1,835,948	128,788	2,166,146	2,294,934	64,394	1,656,807	1,721,201	582,407	6,493,640	7,076,048
a. Repair of ice chests	52,000		52,000	58,500	19,500	78,000	36,563	60,938	97,500	18,281	54,844	73,125	165,344	135,281	300,625
b. Repair of cold storage facilities	37,800		37,800	42,525	14,175	56,700	26,578	44,297	70,675	13,289	39,867	53,156	120,192	86,339	216,531
c. Cold chain audits	39,375		39,375	44,297	14,766	59,063	27,688	46,143	73,628	13,843	41,528	55,371	125,200	102,437	227,637
d. Mini-operatives	17,590		17,590	19,789	6,596	26,385	12,368	20,613	32,981	6,184	18,552	24,736			
e. Theometers	36,400		36,400	40,950	13,650	54,600	25,594	42,656	68,250	12,797	38,391	51,188	115,741	94,697	210,438
f. Repair of refrigerated trucks		35,800	35,800	0	53,700	53,700	0	67,125	67,125	0	50,344	50,344	0	206,969	206,969
g. Refrigerator spare parts		370,000	370,000	0	555,000	555,000	0	693,750	693,750	0	520,313	520,313	0	2,139,063	2,139,063
h. Fuel (kerosene)		635,000	635,000	0	952,500	952,500	0	1,190,625	1,190,625	0	892,969	892,969	0	3,671,094	3,671,094
2. Sustained Oral Rehydration Therapy (none identified)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Result 2: Improved Delivery of Reproductive Health and Family Planning Services	71,246	64,596	135,842	80,152	123,611	203,763	50,095	268,449	318,544	25,047	643,330	668,378	226,540	1,099,987	1,326,527
a. Printed materials	57,351	49,596	106,947	64,520	95,901	160,421	40,325	160,201	200,526	20,162	130,232	150,394	182,358	435,929	618,287
b. Fuel (transportation)		15,000	15,000	0	22,500	22,500	0	28,125	28,125	0	21,094	21,094	0	86,719	86,719
c. Contraceptives (see below)															
d. Cytology supplies	13,895	0	13,895	15,632	5,211	20,843	9,770	16,283	26,053	4,885	14,655	19,540	44,182	38,149	80,330
e. Maintenance of project procured equipment (4% of equipment budget/year)								63,840	63,840		477,350	477,350		541,190	541,190

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ANNEX 1f to the HEALTH SECTOR II PP SUPPLEMENT
RECURRENT COSTS OF THE PROJECT EXTENSION (IN LEMPIRAS)

	YEAR ONE			YEAR TWO			YEAR THREE			YEAR FOUR			TOTALS		
	USAID	GOH	TOTAL	USAID	GOH	TOTAL									
Result 3: Improved Delivery of STD/AIDS Prevention and STD Treatment	0	800,000	800,000	0	1,200,000	1,200,000	0	1,500,000	1,500,000	0	1,125,000	1,125,000	0	4,625,000	4,625,000
a. Condoms (see below)															
b. Laboratory reagents		800,000	800,000	0	1,200,000	1,200,000	0	1,500,000	1,500,000	0	1,125,000	1,125,000	0	4,625,000	4,625,000
Result 4: National Systems and Policies Strengthened	282,442	722,758	1,005,200	317,747	678,916	996,663	198,592	1,139,637	1,338,229	99,296	941,576	1,040,872	898,077	3,060,542	3,958,620
A. Financial and Administrative Information System															
1. Office supplies	30,000	120,000	150,000	33,750	207,250	241,000	21,094	347,356	368,450	10,547	302,991	313,538	85,391	977,597	1,072,898
2. Systems analysis (2)	30,000	30,000	30,000	33,750	11,250	45,000	21,094	35,156	56,250	10,547	31,641	42,188	95,391	78,047	173,438
3. Fuel (transportation)		100,000	100,000	0	150,000	150,000	0	187,500	187,500	0	140,625	140,625	0	578,125	578,125
2. Computer supplies		20,000	20,000	0	30,000	30,000	0	37,500	37,500	0	28,125	28,125	0	115,625	115,625
3. Computer spare parts & maintenance		0	0	0	6,000	6,000	0	7,500	7,500	0	5,625	5,625	0	19,125	19,125
		0	0	0	10,000	10,000	0	79,700	79,700	0	96,975	96,975	0	186,675	186,675
B. Supervision, Monitoring and Evaluation															
1. Office supplies	500	0	500	563	188	750	352	588	938	178	527	703	1,590	1,301	2,891
	500		500	563	188	750	352	586	938	176	527	703	1,590	1,301	2,891
C. Health Information System															
1. Office supplies	13,492	0	13,492	15,179	18,560	33,738	9,487	57,888	67,373	4,743	45,786	50,528	42,900	122,232	185,132
2. Computer supplies	13,492		13,492	15,179	20,238	20,238	9,487	15,811	25,298	4,743	14,230	18,973	42,900	35,100	78,001
3. Computer spare parts & maintenance		0	0	0	6,000	6,000	0	7,500	7,500	0	5,625	5,625	0	19,125	19,125
		0	0	0	7,500	7,500	0	34,575	34,575	0	25,931	25,931	0	68,006	68,006
D. Human Resources Development (none identified)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
E. Sustaining Access to Water and Sanitation	0	0	0	0	132,500	132,500	0	165,625	165,625	0	124,219	124,219	0	0	0
1. Vehicle maintenance					132,500	132,500		165,625	165,625		124,219	124,219			
F. Rationalization of Transportation Resources															
1. Vehicle maintenance	25,000	558,158	584,158	28,125	174,875	203,000	17,578	236,287	251,875	8,788	181,817	190,408	79,492	1,152,047	1,231,539
2. Supervision travel expenses	25,000	10,400	35,400	28,125	24,975	53,100	17,578	48,797	66,375	8,789	40,992	49,781	79,492	125,164	204,656
G. IEC															
1. Fuel (transportation)	0	3,800	3,800	0	5,400	5,400	0	6,750	6,750	0	5,063	5,063	0	20,813	20,813
		3,600	3,600	0	5,400	5,400	0	6,750	6,750	0	5,063	5,063	0	20,813	20,813
H. Grupo de Asistencia Técnica ("GAT"): Coordinación de Acceso															
1. Office equipment maintenance	213,450	40,000	253,450	240,131	140,044	380,175	150,082	325,137	475,219	75,041	281,373	356,414	678,704	788,554	1,465,258
2. Travel expenses	11,250	20,000	31,250	12,656	4,219	16,875	7,910	13,184	21,094	3,955	11,865	15,820	35,771	29,268	65,039
3. Office supplies	179,700	20,000	199,700	202,163	97,388	299,550	126,352	248,086	374,438	63,176	217,652	280,828	571,390	583,126	1,154,516
4. Vehicle maintenance	22,500	20,000	42,500	25,313	8,438	33,750	15,820	26,367	42,188	7,910	23,730	31,641	71,543	58,535	130,078
		20,000	20,000	0	30,000	30,000	0	37,500	37,500	0	28,125	28,125	0	115,625	115,625
TOTAL NON-CONTRACEPTIVE RECURRENT COSTS: LEMPIRAS	2,239,814	3,629,704	5,869,518	2,519,791	5,909,699	8,429,490	1,574,869	9,118,234	10,693,103	787,435	7,868,943	8,656,377	7,121,909	26,104,236	33,226,145
TOTAL NON-CONTRACEPTIVE RECURRENT COSTS: US\$	\$198,389	\$321,497	\$519,886	\$223,188	\$623,446	\$746,633	\$139,492	\$807,638	\$947,130	\$69,746	\$696,983	\$766,730	\$630,816	\$2,349,564	\$2,980,380
CONTRACEPTIVE RECURRENT COSTS : LEMPIRAS	6,040,150	100,000	6,140,150	6,322,400	225,800	6,548,200	7,112,700	790,300	7,903,000	6,322,400	1,580,600	7,903,000	25,797,650	2,696,700	28,494,350
CONTRACEPTIVE RECURRENT COSTS : US\$	\$535,000	\$8,857	\$543,857	\$560,000	\$20,000	\$580,000	\$630,000	\$70,000	\$700,000	\$560,000	\$140,000	\$700,000	\$2,285,000	\$238,857	\$2,523,857
TOTAL RECURRENT COSTS: LEMPIRAS	8,279,964	3,729,704	12,009,668	8,842,191	6,135,499	14,977,690	8,687,569	9,908,534	18,596,103	7,109,835	9,449,543	16,559,377	32,919,559	28,800,936	61,720,495
TOTAL RECURRENT COSTS: US\$	\$733,389	\$330,355	\$1,063,744	\$783,188	\$543,446	\$1,326,633	\$769,492	\$877,638	\$1,647,130	\$629,746	\$838,983	\$1,466,730	\$2,916,816	\$2,588,422	\$5,504,237
GOH SHARE OF NON-CONTRACEPTIVE RECURRENT COSTS		61.84%			70.11%			85.27%			20.00%			78.57%	
GOH SHARE OF CONTRACEPTIVE RECURRENT COSTS		1.63%			3.45%			10.00%			20.00%			3.46%	
GOH SHARE OF TOTAL RECURRENT COSTS		31.06%			40.96%			53.28%			57.06%			46.66%	

- NOTES:
1. PROJECT YEARS ARE DEFINED AS FOLLOWS:
A. PROJECT YEAR ONE IS JUNE TO DECEMBER 1996
B. PROJECT YEAR TWO IS JANUARY TO DECEMBER 1997
C. PROJECT YEAR THREE IS JANUARY TO DECEMBER 1998
D. PROJECT YEAR FOUR IS JANUARY TO SEPTEMBER 1999

2. BASIS OF FUTURE PROJECTIONS (YEARS 2-4):
YEAR 2 IS INCREASED BY A FACTOR OF 50% (LENGTH OF YEAR AND INFLATION)
YEAR 3 IS INCREASED BY A FACTOR OF 25% (INFLATION)
YEAR 4 IS DECREASED BY A FACTOR OF 25% (DURATION)
MAINTENANCE COSTS FOR EQUIPMENT WERE CALCULATED AT 4% PER YEAR OF THE BUDGETED COST OF THE EQUIPMENT, THE YEAR AFTER THE EQUIPMENT IS EXPECTED TO BE DELIVERED.

3. EXCHANGE RATE: 11.29 LEMPIRAS = 1 US DOLLAR

4. CONTRACEPTIVES MAY BE AN IN-KIND CONTRIBUTION

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ANNEX 2:

HEALTH SECTOR II PROJECT RESULTS INDICATORS

Strategic Objective 3: Improved Family Health	Means of Verification
<p>S.O. Improved Family Health</p> <p>a. Under 1 infant mortality rate reduced nationally from 50 (1989 baseline) to 40 (1999).¹</p> <p>b. Reduced level of malnutrition nationally among children 12-23 months of age (2 S.D. below mean wt/age) from 24.1% (1994 baseline) to 22% (1999).</p> <p>c. Reduced maternal mortality ratio (maternal deaths per 100,000 live births) nationally from 221 (1989 baseline) to 175 (1999).</p> <p>d. Reduced total fertility rate in women 15-44 years from 5.1 (1991 baseline) to 4.5 (1999) nationally.</p> <p>e. Maintained HIV seroprevalence rate among CSWs and women attending prenatal clinic in San Pedro Sula at 13% and 4% respectively (to 1999).</p>	<p>a. Epidemiology and Family Health Survey²</p> <p>b. EFHS and/or Title III Household Social Economic Survey/</p> <p>c. EFHS ("sisterhood" method in 1996 EFHS)</p> <p>d. EFHS</p> <p>e. Sentinel surveillance sites (San Pedro Sula)</p>

¹ The 1999 target date refers to the September 1999 PACD, but is the same target as shown in the R-4 for 1998.

² EFHS data for 1996 will be available by August 1996 and may alter the targets now being set on the basis of the 1991 EFHS. It should be noted that given the timing for the next EFHS, progress will not be reported during the three year project extension for national level HS II project indicators -- including infant mortality rate, malnutrition in children, maternal mortality ratio, total fertility rate, breastfeeding, ORT use, and contraceptive prevalence -- all of which rely on the EFHS. Nevertheless, in the nine project focus areas a limited version of the EFHS will be done in 1998 at the midpoint between the 4-year national EFHS. This will provide data for the survey-based indicators for the nine focus areas, and although not nationally representative, it will give an indication of trends.

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INTERMEDIATE RESULTS 1 LEVEL	
<p>I.R.-1.1 Increased Use of Selected Child Survival Interventions Nationally</p> <p>a. Immunization coverage of children under 1 maintained at 90% or higher (for DPT, Measles, Polio, Tuberculosis).</p> <p>b. Tetanus toxoid immunization coverage of women 12-49 years maintained at 90% or higher (second dose within last 3 years).</p> <p>c. Increased percentage of children 2-3.99 months exclusively breastfed during the previous 24 hours increasing from 23% (1991) to 33% (1999).</p> <p>d. Percentage of total outpatient visits to health centers of children under 5 years due to diarrhea not exceeding 10% (1995 baseline).</p> <p>e. Percentage of children under 5 years with diarrhea in the last 15 days treated with ORS increased from 31.7% (1991) to 40% (1999).</p>	<p>a. MOH annual reports</p> <p>b. MOH annual reports</p> <p>c. EFHS (1996, 2000)</p> <p>d. MOH annual reports</p> <p>e. EFHS (1996, 2000)</p>
<p>I.R.-1.2 Increased Use of Reproductive Health Services including Family Planning Services Nationally</p> <p>a. Contraceptive prevalence rate in women 15-44 years in union increased from 47% (1991) to 53% (1999), of which modern methods increases from 35% (1991) to 41% (1999).</p> <p>b. Percent of rural women who gave birth in last 5 years who had a prenatal visit at a health facility during last pregnancy increased from 67% (1991) to 82.5% (1999).</p>	<p>a. EFHS (1996, 2000)</p> <p>b. MOH annual reports (and EFHS)</p>

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I.R.-1.3 Increased Use of STD/AIDS Prevention Practices and STD Treatment Services among target populations in San Pedro Sula, Tegucigalpa, Comayagua and La Ceiba

- | | |
|---|---|
| <p>a. Rate of reported condom use among target populations -- Commercial Sex Workers- (CSW), CSW clients, Garifuna males and females, people in the workplace (PWP) males and females, and men who have sex with men (MWM) -- during most recent sexual intercourse of risk increased from 1996 (baseline) to 1999 (end of project) as follows: CSW - 87 to 92; CSW client - 65 to 75; Garifuna male - 69 to 80; Garifuna female - 28 to 40; PWP male - 37 to 43; PWP female - 25 to 31; MWM 80 to 90.</p> <p>b. Decreased rate of reported non-regular sexual partners among target populations from 1996 (baseline) to 1999 (end of project) as follows: CSW client - 76 to 70; Garifuna male - 40 to 35; Garifuna female - 12 to 9; PWP male - 45 to 41; PWP female - 30 to 28; MWM 75 to 70.</p> <p>c. Increased percentage of individuals presenting with STDs in health facilities assessed and treated per national standard case management protocols increasing from 21% (1992 baseline) to 60% (1999).</p> | <p>a. Periodic Knowledge, attitude and behavioral change (KAB) Studies</p> <p>b. Periodic KAB Studies</p> <p>c. Periodic AIDS Technical Assistance Contractor facility surveys.</p> |
|---|---|

INTERMEDIATE RESULTS 2 LEVEL	
<p>I.R.-2.1 Sustainable and Effective National Public Primary Health Care System</p> <p>a. Increased percentage of all CESARs and CESAMOs in the nine focus areas maintained at the "A" level (illustrative measure could include: days/month open, hours of operation, staffing, availability of essential drugs and equipment, quality of counselling, physical condition of facility and service delivery measures such as immunizations and rural prenatal care coverage).</p> <p>b. Increased percentage of rural water systems in the nation that operate at the "A" level. (A rural water system functioning at the "A" level is defined as one having the following characteristics: (a) water is disinfected, (b) there is a water board that meets periodically, (c) there is a water fee that is paid by users, (d) there is a maintenance employee, and (e) water is available from the system on a daily basis).</p> <p>c. Expansion of proven administrative systems (SME; HIS; and ACCESO) introduced in 15 demonstration areas to 41 health areas by 1999.</p> <p>d. Expansion of new or improved approaches to implementing proven health technologies (family planning, reproductive health, pneumonia case management, exclusive breastfeeding, and integrated child care) introduced in the nine focus areas to all 41 health areas by 1999.</p> <p>e. Simplified MIS/F/A administrative procedures and instruments in place and being used at the regional and central levels.</p> <p>f. Within the nine focus Areas, at least 90% of UPS receiving at least three supervision/training visits/year from the Area/Sector; all Areas receiving at least two supervision/training visits/year from the Region, and all three Regions receiving at least one visit from the central MOH per year.</p> <p>g. In 100% of the UPSs within the nine focus areas: (a) recuperated funds managed according to the MOH operations manual; and (b) increased number of alternative (community based) sources of financing available to the UPSs.</p> <p>g. Increased percentage of referrals that are received and treated (for: obstetric emergencies, family planning services, pneumonia, diarrhea, etc.) at higher level health centers or hospitals in the nine focus Areas.</p> <p>i. Increased number of referrals (for obstetric emergencies, family planning services, pneumonia, diarrhea, etc.) in the nine focus Areas.</p>	<p>a. The evaluative instrument will be defined prior to the signing of the Agreement.</p> <p>b. Baseline data and targets for 1997, 1998 and 1999 to be established in CY 1996 with SANAA</p> <p>c. Baseline data and targets to be established per condition precedent.</p> <p>d. MOH and USAID reports</p> <p>e-i Baseline data, and targets to be established per condition precedent</p>
<p>I.R.-2.2 Sustainable and Effective National Private Sector Family Planning and Reproductive Health Care System</p>	<p>See PSP III Project Paper</p>

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INTERMEDIATE RESULTS 3 LEVEL	
<p>I.R.-3.1 Improved delivery of child survival services within the nine focus areas.</p> <p><i>a. New approaches introduced and used for combatting pneumonia in children under five years.</i></p> <ol style="list-style-type: none"> 1. Increased percentage of pneumonia cases among children under five years treated by community volunteers in target communities. <p><i>b. Improved quality of pneumonia case management.</i></p> <ol style="list-style-type: none"> 1. Pneumonia mortality rate of children under five years reduced in the five hospitals. 2. The number of deaths from pneumonia in children under five years reduced in targeted communities. 3. Increased percentage of pneumonia cases in children under five years treated in UPS. <p><i>c. New approaches introduced and used for promoting exclusive breastfeeding for children under six months.</i></p> <ol style="list-style-type: none"> 1. Increased percentage of communities with a trained, community counselor promoting breastfeeding. 2. Increased percentage of children at 2, 4, and 6 months of age who are exclusively breastfed. <p><i>d. Improved quality of exclusive breastfeeding promotion.</i></p> <ol style="list-style-type: none"> 1. Five hospitals and four maternal-child clinics accredited as "Baby Friendly Hospitals/Clinics by the MOH. <p><i>e. New approaches introduced and used for monitoring and improving integrated child health care among children under one year of age.</i></p> <ol style="list-style-type: none"> 1. Increased percentage of children under one year attending a health clinic for the first time. 2. Increased percentage of children under one year who have received integrated child care services in the preceding month. 	<p>a.1. Baseline data and targets to be established per condition precedent.</p> <p>b.1-3 . Baseline data and targets to be established per condition precedent.</p> <p>c.1-2. Baseline data and targets to be established per condition precedent.</p> <p>d.1. MOH reports</p> <p>e.1-2. Baseline data and targets to be established per condition precedent.</p>

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<p><i>f. Improved quality of integrated child health care.</i></p> <ol style="list-style-type: none"> 1. Increased average number of health clinic visits per year among children under one (as measured by: total number of visits of children under one year/total number of children under one year who attended a health clinic for the first time). 2. Increased percentage of most needy (postergada) communities in which integrated child health care services for children under one are available (including growth monitoring, and nutrition and health education for mothers). <p>I.R.-3.2 Improved Delivery of Reproductive Health Services and Family Planning Services in the Nine Focus Areas</p> <p><i>a. Improved or new approaches to FP introduced</i></p> <ol style="list-style-type: none"> 1. Pilot project implemented (beginning in one Area in every health Region in the country) for family planning counseling, the distribution of oral contraceptives, and IUD insertions by auxiliary nurses in CESARs. 2. Increased number of Couple Years Protection (CYP) disaggregated by family planning method and UPS level. 3. Increased percentage of women receiving family planning methods postpartum (first 42 days) in UPSs. 4. Increased number of family planning users registered by community personnel. <p><i>b. Increased MOH purchase of contraceptives nationally</i></p> <p><i>c. Improved or new approaches to reproductive health</i></p> <ol style="list-style-type: none"> 1. Increased percentage of pregnant women (per national micronutrient survey baseline) who received iron supplements in the previous month. 2. Increased percentage of births attended by health personnel (excluding TBAs). <p><i>d. Improved quality of RH services</i></p> <ol style="list-style-type: none"> 1. Increased percentage of pregnant women having prenatal visits during the first 20 weeks of pregnancy in a UPS. 2. Increased percentage of new mothers attending a UPS for a postpartum checkup within the first 42 days (six weeks) of delivery. 3. Reduced numbers of maternal deaths in the five hospitals. 4. Reduced neonatal mortality rate in the five hospitals. 	<p>f.1-2. Baseline data and targets to be established per condition precedent.</p> <p>a.1. Pilot project site selection, TA and monitoring plans to be jointly established per condition precedent.</p> <p>a.2-4. Baseline data and targets to be established per condition precedent.</p> <p>b. Per Covenant #5</p> <p>c. 1-2 Baseline data and targets to be established per condition precedent.</p> <p>d. 1-4. Baseline data and targets to be established per condition precedent.</p>
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<p><i>e. Improved RH referrals</i></p> <ol style="list-style-type: none"> 1. Increased number of high risk pregnancies referred to UPS by TBAs. 2. Increased number of obstetric emergencies referred to UPS by TBAs. <p>I.R.-3.3 Improved Delivery of STD/AIDS Prevention and STD Treatment Programs</p> <ol style="list-style-type: none"> a. Increased percentage of target population knowledgeable of STD/AIDS prevention practices (i.e., Commercial Sex Workers -(CSW), CSW clients, Garifuna males and females, people in the workplace (PWP) males and females, and men who have sex with men (MWM) in San Pedro Sula, Comayagua, Tegucigalpa and La Ceiba). b. Increased MOH purchase of condoms nationally <p>I.R.-3.4 National Health Systems and Policies Strengthened</p> <p><i>a. ACCESO multi-year workplan to decentralize the administration of health services developed and implemented in 15 demonstration Areas.</i></p> <ol style="list-style-type: none"> 1. All municipalities and UPSs classified with respect to socio-economic status nationally. 2. Increased percentage of municipalities, UPSs and areas with action plans and budgets developed and executed. 3. Increased percentage of municipalities and UPSs with local health organizations/committees functioning. 4. Evaluative instrument for grading UPSs developed and in use within nine focus areas. 5. Adequate financial and human resources available to carry out reforms. <p><i>b. Environmental Health Strategy implemented at a national level</i></p> <ol style="list-style-type: none"> 1. Number of decentralized regional offices increased from three to seven by 1997. 2. Evaluative instrument for grading water systems in use nationally by SANAA. 3. Curricula developed by MOH for the training of the Environmental Health Technician (TSA) and the area-level Environmental Health Area Supervisor. 4. First group of 50 Environmental Health Technicians (TSA) and 5 Environmental Health Area Supervisors trained and in place in five of the nine focus areas. 5. Adequate financial and human resources available to carry out reforms. 	<p>e. 1-2. Baseline data and targets to be established per condition precedent.</p> <p>a.1 Baseline and plan for KABC studies to monitor progress established with AIDSCAP during year 1.</p> <p>b. Per covenant #5</p> <p>a.1. NBI, CEFASA surveys.</p> <p>a.2-3 Baseline data and targets to be established per condition precedent.</p> <p>a.4 MOH Reports</p> <p>b.1-2 SANAA reports</p> <p>b.3-4 MOH Reports</p>
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ANNEX 3:

Key First Year Activities

Result	Intermediate Result	Year 1: 1996-97 Activities
<p>IR 3.1 Improved Delivery of Child Survival Services in Nine Focus Areas</p>	<p>a-b. New approaches introduced and used for combatting pneumonia in children under five years, and improved quality of pneumonia case management</p> <p>c-d. New approaches introduced and used for promoting exclusive breastfeeding for children under six months, and improved quality of program</p> <p>e-f. New approaches introduced and used for monitoring and improving integrated child health care among children under one, and improved quality of integrated child health care program</p>	<ul style="list-style-type: none"> • Complete UPS facility survey/situational analysis. • Pilot test Ministry community-based protocols • Modify protocols and implement in selected communities in each Health Area • Conduct operational research on community-based treatment and referral • Develop training materials and initiate training on referral system initiated in selected communities in each Health Area. • Implement counselor program and mothers' groups in selected communities in each Health Area • Review and implement appropriate Baby Friendly Hospital (BFH) practices in all five hospitals and four maternal-child clinics situated within the focus areas • Refine and implement AIN model in selected communities in each Health Area. • Write AIN program manual and distribute in training program for UPS staff in selected communities in each Health Area.

Result	Intermediate Result	Year I: 1996-97 Activities
<p>IR 3.2 Improved Delivery of Reproductive Health and Family Planning Services in the Selected Areas</p>	<p>a. Improved or new approaches to family planning introduced</p> <p>b. Increased CYPs by method and UPS level</p> <p>c. Increased percentage of women receiving post partum family planning</p> <p>d. Increased number of family planning users registered by community personnel.</p> <p>e. Increased percentage of pregnant women who received iron supplements in previous month.</p> <p>f. Improved quality of Reproductive Health Services (increased prenatal and postpartum checkups; and reduced maternal and neonatal deaths)</p> <p>g. Increase MOH purchase of contraceptives</p> <p>h. Improved Reproductive Health referrals.</p>	<ul style="list-style-type: none"> • Initiate family planning service delivery by auxiliary nurses at CESARes in one designated Health Area of each Health Region. • Train institutional personnel in postpartum IUD insertion • Train community personnel to use LISMEF (Listado de Mujeres de Edad Fertil, 15-49) and counsel men and women. • Complete micronutrient survey and qualitative study on use of iron supplements in pregnancy and initiate corrective interventions, including a monitoring system (LISEM-- Listada de Embarazadas) • Develop obstetric and perinatal protocols with UPS personnel in selected Health Areas. • Complete community diagnosis of perinatal and postpartum practices. • Train personnel from UPSs (including hospitals) in referral procedures • Form functional perinatal committees in hospitals • Complete equipment inventory assessment • Establish MOH budget line item • Conclude training of TBAs in identification of reproductive risk/obstetric emergency factors and when to refer. • Initiate experimental improvements to referral system

Result	Intermediate Result	Year 1: 1996-97 Activities
<p>IR 3.3 Improved Delivery of STD/AIDS Prevention and STD Treatment Programs</p>	<p>a. Increased percentage of target population knowledgeable of STD/AIDS prevention practices</p> <p>b. Increased MOH purchase of condoms</p>	<ul style="list-style-type: none"> • Implement STD/AIDS prevention programs by ten implementing organizations working with target populations. • Complete mid-term evaluation of STD/AIDS prevention component. • Complete data collection and analysis for "male questionnaire" for EFHS • Select MOH "Peace Scholars" and train them in HIV/AIDS prevention in the United States. • Establish MOH budget line item for condoms

Result	Intermediate Result	Year I: 1996-97 Activities
<p>IR 3.4 National Systems and Policies Strengthened</p>	<p>a. Acceso multi-year workplan to decentralize the administration of health services developed and implemented in 15 demonstration Areas.</p> <p>b. Environmental Health Strategy Implemented</p> <p>c. MIS/Finance and Administration reforms developed and in use</p> <p>d. Supportive Supervision, Monitoring and Evaluation implemented in 15 demonstration areas.</p> <p>e. HIS implemented in 15 demonstration areas</p> <p>f. Improved MOH resource development capacity.</p> <p>g. Effective IEC policy approved</p>	<ul style="list-style-type: none"> • Community participation in health service delivery • SANAA regional offices established • Instrument for evaluating water systems approved. • Staff/equip an implementation unit in the MOH • Unit develops proposal for addressing management information needs. • Area budgets and workplans approved and rotating funds in place. • Initial health care financing TA plan developed and approved; analyses of recurrent costs initiated. • Protocols and instruments developed, approved and validated • Training initiated • Review and re-definition of information needs at each level, data collection and entry methods (including number and types of forms), and information flow charts. • Develop, test and validate operations manual • Assessment of possible interventions. • IEC workshop

ANNEX 4:

Customer Service Plan for Health Sector II

Definitions: USAID with our principal "partners" (most notably the Ministry of Health) will strive to meet the needs of "customers" through several "intermediate customers" as shown below.

Principal Partners:

Ministry of Health
CARE
SANAA
National Autonomous University of Honduras (UNAH)
La Liga de Lactancia Materna
Global Bureau, Population, Health and Nutrition Center (G/PHN), LAC/RSD, G-CAP, and Cooperating Agencies¹
Honduran PVOs in STD/AIDS Prevention²
Participating PVOs working in Water and Sanitation
Participating PVOs working in Family Planning/Reproductive Health under PSP III

Customers:

Women	15-49 years
Men	15-59 years
Adolescents	12-19 years
Children	0-5 years

AIDS/STD Target Groups: Commercial Sex Workers (CSW) and their Clients, Men who have sex with men (MWM), People in the Work Place (PWP), Garifunas

Intermediate Customers:

Community level institutions and personnel

- Health Volunteers
- Guardians and Health Promoters
- Peer Counsellors
- Promoters

¹ Including: The Partnership for Child Health --BASICS; Wellstart -- Expanded Promotion of Breastfeeding; John Snow, Inc -- OMNI, MotherCare, Family Planning Logistics Management (contraceptive logistics); Population Council -- INOPAL; Family Health International (FHI)-- AIDSCAP and Family Planning Research; Johns Hopkins University -- Population Communication Services; Central Contraceptive Procurement; Centers for Disease Control -- TAACS and Family Planning Logistics Management (Surveys); Association for Voluntary Surgical Contraception; University Research Corporation -- Quality Assurance Project; PAHO--Accelerated Immunization Project; Academy for Educational Development -- Regional (G-CAP) HIV/AIDS Prevention Project.

² Organizacion Fraternal Negra Hondureña (OFRANEH), Organizacion de Desarrollo Etnico Comunitario (ODECO), Fraternidad Sampedrana Lucha contra el SIDA (FSLCS), Centro de Orientacion y Capacitacion en SIDA (COCSIDA), Programas para el Desarrollo de la Infancia y la Mujer, (PRODIM), Centro de Estudios para el Desarrollo y la Participacion Social (CEDEPS)

- Traditional Birth Attendants
- Water Maintenance Technicians (TOM)
- Environmental Health Technicians (TSA)
- Rural Water Board Officials

MOH and personnel

- Staff of the Departments of Maternal and Child Health, Food and Nutrition, Environmental Health, HIV/AIDS, Cholera, and Health Education at Regional and Central level
- Staff of the nine health areas including all CESAMO and CESAR staff in these areas, and staff of three area hospitals, four MCH clinics, two regional urban hospitals and four community birthing centers.
- Staff of the six demonstration health areas in the remaining six health regions where USAID will assist strengthening of administrative support system (one health area per region)

NGOs/PVOs/Contractors and personnel

- NGOs working under AIDSCAP
- PVOs working in water and sanitation
- Other public and private sector providers
 - Physicians
 - Professional Nurses
 - Auxiliary Nurses
 - Pharmacists

Services Delivered:

USAID to Partners

- Technical Assistance
- Training and Professional Networking
- Procurement of Goods and Services
- Support for Operating Expenses
- Monitoring and Evaluation
- Audit and Financial Services Support

USAID & Partners to Intermediate Customers

- Skills Training
- Incentives/Salaries
- Materials and Supplies

Intermediate Customers to End Users

- Family Planning and Reproductive Health (FP/RH) Services
- Selected Child Survival Interventions
- Health, FP/RH and Nutrition Education
- Improved or New approaches and protocols for implementing proven Health Technologies
- Water and Sanitation Systems
- STD Treatment and STD/AIDS Prevention Services

Mechanisms to obtain customer feedback include:

- Effective supervision/training system in place at all MOH levels (UPS, Region, Center)
- Effective HIS in place which provides data for decision making
- Situational analyses/survey
- Quality Assurance Project technical assistance

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- Epidemiology and Family Health Survey (every two to four years)
- Interim survey research in nine target areas
- Health Area Planning Activities (ACCESO approach in nine focus Health Areas)
- Knowledge, Attitude, Behavior and Practice surveys of STD/AIDS awareness and prevention practices (AIDSCAP)
- Exit interviews in health and family planning facilities

Areas for Improvement in Service Delivery:

- Improve quality of services
- Increase access to services
- Increase self-financing of effective service delivery
- Increase active customer participation in the organization, design, implementation and management of HPN activities.

Customer Service Standards:

All customers have a right to:

- Information (contraindications, indications, and use of health and family planning technologies)
- Access (receive services regardless of gender, location, socio-economic status or relationship status)
- Choice (decide freely on services to use)
- Safety (that all services are safe and effective)
- Privacy (receive education, counselling and care in privacy)
- Confidentiality (certainty that all personal information is confidential)
- Dignity (to be treated with politeness, consideration and attentiveness)
- Comfort (to feel comfortable while receiving services)
- Continuity (receive services when needed and for the necessary period of time)
- Opinion (right to express opinion on services offered and the institution has the responsibility to respond)
- Availability (convenient hours/days of operation and availability of basic medicines, supplies, equipment and qualified personnel).

Customer Service Standards for SANAA:

All customers have a right to:

- Periodic monitoring visits from TOMs
- Access to SANAA regional offices for major problems
- Water quality monitoring by SANAA and MOH personnel

Communication Plan:

Survey results and standards will be communicated to customers through a variety of channels, including:

- Health education and IEC campaigns
- Product advertising (social marketing)
- Peer counselling and promotion (word of mouth)
- Publicity campaigns
- Recognition and awards - (e.g., recognizing "Baby Friendly Hospitals", "A" level UPSs, and "A" level water/sanitation system)

PLAN DE TRABAJO

OBJETIVOS	ACTIVIDADES
<p>1. Funcionar como equipo de trabajo, que en base al aprendizaje, las experiencias y la investigación de la realidad local, integren, generen y generalicen ideas de impacto, a través de la Sub-Secretaría de Redes de Servicio, en los diferentes niveles del Ministerio de Salud a fin de maximizar el acceso a servicios de salud con calidad.</p>	<p>1. <u>Generar y generalizar indicadores trazadores básicos para monitorizar la direccionalidad e impacto del Proceso.</u></p> <p>a) Elaboración de inventario de indicadores trazadores básicos, por grupo de trabajo.</p> <p>b) Jornada de profundización y análisis de los resultados del trabajo de grupo sobre indicadores.</p> <p>c) Sistematización de la información existente y publicación en documentos.</p> <p>d) Transferencia a los niveles intermedios en conjunto con las Unidades Técnico Normativas.</p> <p>2. <u>Generar y/o generalizar instrumentos¹ básicos para el desarrollo del proceso y los proyectos.</u></p> <p>a. Elaboración de inventario y selección de instrumentos básicos para el Proceso y Proyectos de Acceso por grupo de trabajo.</p> <p>b. Jornada de profundización y análisis de los resultados de trabajo de grupo sobre instrumentos básicos.</p>

^{1/} Se mencionan en calidad de ejemplos los siguientes instrumentos:

1. Seguimiento contable financiero.
2. Instrumentos de apoyo para la Gerencia en el Nivel Local: Actos, convocatorias, ayudas memorias, etc.
3. Planificación local.
4. Estrategias de ataque.
5. El desarrollo y la garantía de la calidad.
6. La contención del gasto.
7. El financiamiento y su análisis.
8. Como lograr, formular, concertar, poner en marcha y vigilar planes.
9. Análisis de condiciones de vida.
10. Análisis de situación de salud.
11. Análisis de la oferta de servicios de salud.
12. Análisis de la demanda de servicios de salud.

OBJETIVOS	ACTIVIDADES
	<ul style="list-style-type: none"> c. Sistematización de la información obtenida y publicación de documentos. d. Transferencia a los niveles intermedios en conjunto con las Unidades Técnico Normativas. <p>3. Facilitar la sostenibilidad del Proceso en el quehacer nacional.</p> <ul style="list-style-type: none"> a. Fortalecer la institución. <ul style="list-style-type: none"> a.a. Desarrollar en el Nivel Regional Equipos de Apoyo Técnico al Proceso con los responsables del mismo. a.b. Planificación de trabajo conjunto del GAT con Regiones/Áreas para el apoyo político-técnico y logístico en el desarrollo del nivel local. a.c. Planificar con las U.T.N. el apoyo técnico necesario para el desarrollo del nivel local. b. Fortalecer la articulación interinstitucional. <ul style="list-style-type: none"> b.a. Facilitar la elaboración de Planes de Trabajo locales (municipales) que involucren las instituciones oficiales, ONGs y comunitarias. <p>4. Desarrollo y recuperación de los equipos humanos.</p> <ul style="list-style-type: none"> a. Participación en jornadas y talleres con las instituciones formadoras y gremiales para informar sobre los hallazgos del proceso, que pueda servir en la elaboración de planes de enseñanza y/o sus ajustes. b. Talleres para socializar e inducir y el Proceso Nacional y los Proyectos. <p>5. Fortalecer al GAT a lo interno, hasta lograr su cohesión como equipo.</p> <ul style="list-style-type: none"> a. Desarrollar una comunicación permanente entre los miembros del GAT.

OBJETIVOS	ACTIVIDADES
	<ul style="list-style-type: none"> a.a Intercambio de información acerca de las visitas a Regiones, Areas y Nivel Local. a.b Círculos de Estudio sobre temas o metodologías identificadas como una necesidad de aprendizaje. b. Organizar y sistematizar las Reuniones del GAT. <ul style="list-style-type: none"> b.a Adecuar calendario (frecuencia y horario) b.b Elaborar agendas. b.c Presentar relatorías finales en la siguiente reunión. b.d Actualizar los roles del grupo orientador, grupo técnico administrativo, grupo de trabajo. Coordinador, Facilitador y Relator. 6. Organizar y sistematizar las giras del GAT. <ul style="list-style-type: none"> a) Preparar agendas de trabajo previo a la gira destacando los objetivos de la misma. b) Análisis de informes anteriores. c) Nombrar coordinadores de giras. d) Evaluar diariamente la gira, durante su desarrollo. e) Presentar ayuda memoria y/o informe de las giras. f) dar seguimiento a las recomendaciones de la gira.

OBJETIVOS	ACTIVIDADES
<p>2. Conformar un equipo con capacidad de monitorear las acciones que le son atinentes y que a través de la supervisión capacitante en los diferentes niveles de la institución, puedan vigilar el avance y la direccionalidad del Proceso Nacional de Acceso y los proyectos que lo dinamizan.</p>	<p>1. Supervisión (Capacitante, de análisis, de confrontación-concertación y de ajuste):</p> <p>a) En conjunto con el nivel intermedio (regional y/o de área), del corto plazo (mensual) local mediante el control de las rutinas (trabajo con equipos locales, de sector, "comités", en sus reuniones mensuales de acuerdo a programación de las instancias y cronograma atinente.</p> <p>b) En conjunto con el nivel intermedio (regional y de área) del mediano plazo (trimestral) de las redes locales (área) mediante la evaluación ex-post y ex-ante del plan cuatrimestral. Se incluye la Eval. Administrativa (financiera).</p> <p>c) Apoyando a la Sub-Secretaría de Redes de Servicio del largo plazo (anual) en evaluación ex-post y ex-ante nacional, de las áreas en el proceso y los proyectos.</p> <p>d) De la intersectorialidad (Planes Municipales), apoyando a la Sub-Secretaría de la Red de Servicios y/o CONSUMI en evaluación ex-post y ex-ante.</p>
<p>3. Participar en el aprender-haciendo, en la construcción de la viabilidad de las proposiciones de cambio (innovación) surgidas en la práctica y la coyuntura en el nivel local y medir el impacto .</p>	<p>1. Para las áreas apoyadas por proyectos:</p> <p>a) Talleres de entendimientos, instrumentos y bases conceptuales del Proceso de Acceso con participación del GAT, Unidades Técnico Normativas, niveles intermedios y locales.</p> <p>b) Socialización de la información existente, relativa a el proceso de acceso:</p>

OBJETIVOS	ACTIVIDADES
	<p>c) Seminarios trimestrales (1. al interior del GAT; 2. A las Unidades Técnico -Normativas; 3. A los niveles intermedios.</p> <p>d) Difusión de material para enseñanza y aprendizaje.</p> <p>d1) Hoja informativa d2) Boletín informativo d3) Información de supervisiones d4) Bibliografía actualizada. d5) Videos</p> <p>3. Facilitar en el nivel intermedio <u>las investigaciones</u> centradas en tópicos sustantivos y operacionales que surgieran de las evaluaciones y la monitoría estratégica, el control de las rutinas y las supervisiones.</p> <p>4. Facilitar la toma de decisiones en el nivel local e intermedia en base a la <u>información</u> existente.</p> <p>a) Facilitar el desarrollo de una cultura de análisis de la situación actual y las tendencias, derivada de la información, obtenida a través de los sistemas existentes.</p> <p>b) Desarrollar nuevos tipos de información, en base a los hallazgos de la monitoría estratégica, la supervisión, el control de las rutinas y las evaluaciones.</p>

INITIAL ENVIRONMENTAL EXAMINATION

Project Location : Honduras
Project Title : Health Sector II, Amendment 23
Project Number : 522-0216
Funding : Total \$ 67,490,000
This Amendment \$ 10,190,000
Life of Project : FY 99
IEE Prepared by : Albert L. Merkel, USAID/Honduras
Mission Environmental Officer
Recommended Threshold Decision : Negative Determination

MISSION DIRECTOR'S DECISION

Approved: *Eric Burman*
Date: 6/22/96

LAC CHIEF ENVIRONMENTAL OFFICER'S REVIEW

Concurred: _____
Date: _____

Clearance:	HPN	<u><i>DL for</i></u>
	SO 3	<u><i>DL for</i></u>
	DF	<u> </u>
	DMD	<u><i>WKh</i></u>
	ODP	<u><i>R. Rhoda</i></u>

INITIAL ENVIRONMENTAL EXAMINATION Health Sector II Project

Project Description

The HS II Project has been instrumental in enabling Honduras to adopt effective child survival technologies and in providing important administrative, management and logistics support. Among the many notable achievements have been advances made in cholera and diarrheal disease control, the nationwide expansion and maintenance of near universal vaccination coverage for immuno-preventable childhood diseases, and the construction and maintenance of community-managed water and sanitation systems in rural areas. In addition, the HS II project has been instrumental in strengthening national and regional-level public health management systems and in implementing a number of significant policy reforms. Notwithstanding these achievements, several of the specific project objectives and benchmarks are still to be fully achieved. The focus of this three-year project extension will be to complete the work which USAID, the Honduran Ministry of Health (MOH), and our U.S. PVO partners have begun -- namely, to insure a sustainable and effective public primary health care system in Honduras by providing technical assistance, training, equipment and supplies, and other inputs -- both administrative and technical -- to improve the quality, accessibility and sustainability of effective child survival, family planning and reproductive health, and STD/AIDS prevention services.

This three year project extension will focus on four components: (1) introducing new or improved child survival technologies in nine health demonstration areas (which have 226 clinics and hospitals and serve about 25% of the nation's population); (2) improving the quality, access and availability of MOH family planning and reproductive health services especially in rural areas; (3) improving the delivery of STD/AIDS prevention and STD treatment programs among high-risk target groups, and (4) introducing and implementing administrative reforms to improve decentralized financial management and local cost recovery, and to improve supervision, management and health information systems, human resource development, and health education.

Potential for Environmental Impacts

The original project required an environmental assessment (EA) because of a significant component related to vector control for malaria and construction of water and sanitary treatment facilities. The malaria control component has been completed and no longer is part of the project or the proposed amendment. There were procedures approved in the original EA relating to these project components. These procedures were included in the EA recommendations approved by LAC/EA in the cable numbered 88State 279117 authorized by Jim Hester. The requirements for water and sanitation activities will be followed in the new amendment and are considered to be adequate as written. The water and sanitation environmental review procedures are comprehensive and will identify any environmental hazard that might be the result of the action. It should be noted that there are no new water or sanitation systems planned to be funded under this amendment.

The amendment to the Health Sector II Project does not have any potentially significant negative environmental impact. The emphasis in this Amendment has moved from constructing new water systems to maintaining those 700-plus systems which have already been constructed.

Medical Waste Medical waste disposal requires specific discussion. Some activities will produce medical waste. The waste will be produced from various medical procedures such as sterilization, births, treatment of diseases, and other such activities. After surveying the potential quantities and types of waste produced, it appears that there is no one place where large quantities of waste accumulate or are produced. There are several hospitals of various sizes in the program. In these hospitals, waste produced by project activities will be disposed of with the other waste produced by hospital operations. Waste from project activities is only a small percentage (less than 5%) of the total waste produced from hospital operations. In clinics, the estimate is 25% of much smaller quantities of waste than produced in hospitals. The project will contribute a very small amount of extra waste to the medical waste problem in Honduras.

Some estimates of medical waste produced:

	Average/Day	Project Related
1. National Hospitals	2,200 kg/day	110 kg/day
2. Regional Hospitals	162 kg/day	8 kg/day
3. Area Hospitals	25 kg/day	1.5 kg/day
4. Maternal-Infant Clinic	25 kg/day	2.5 kg/day
5. Second. Clinic (CESAMO)	5 kg/day	> 1.5kg/day
6. Primary Clinic (CESAR)	1 kg/day	> 0.25 kg/day

These wastes are produced in diverse locations throughout the country. The national hospitals produce the most waste in any single point. The other production points are distributed in both urban and rural clinics throughout the country. As such they do not produce large quantities of waste in any particular area.

Nonetheless, USAID/Honduras wishes to assure the proper handling and disposal of the wastes generated by the activities of this project. In our survey, we found that the Ministry of Health does not have published rules and instructions on the proper handling and disposal of medical waste at any level in the country. Furthermore in the principal hospital in San Pedro Sula, the medical waste incinerator, with capability to handle all medical waste in the San Pedro Sula area, is not functioning. There has been no training on proper medical waste management provided to health workers in the treatment facilities, except where voluntarily done by a particular administrator with concern for such issues.

The GOH is also concerned about the issue of medical waste. The GOH has entered into a project with the European Economic Union to develop waste management procedures for hospitals and clinics in Tegucigalpa. USAID/Honduras has reviewed the European Economic Union's project to assist the GOH with development of norms for medical waste management medical wastes from health care facilities. This program should produce the required rules and procedures for disposal of medical wastes.

USAID/H will ensure that adequate procedures are in place prior to funding project activities that produce medical waste. USAID/H will further insure that people involved in the project are trained and follow the procedures. Where necessary, the project will assure that containers, disposal units, and other required equipment. are provided. USAID will assist the GOH to get the incinerator at the San Pedro Sula hospital in operational condition and with the training on its operation as required. These actions are further discussed in the "Mitigation Actions" section below.

Please note that the quantities of medical waste produced at any one place are a small part of the total waste produced at these locations. As such USAID funded activities do not materially increase the amount of medical waste produced. For this reason and the fact that we will be able to leverage the GOH into putting better medical waste disposal procedures into place nationally, we feel that the project will produce overwhelmingly positive environmental impact, while the mitigation actions required under the project will prevent negative environmental impact resulting from USAID funded activities.

It should also be noted that this project supports activities that improve health in Honduras and combat the spread of AIDS. As such the project is attacking a very serious environmental problem that will have increasing impact on the environmental conditions in Honduras. The balance between fighting a serious health epidemic (AIDS) and resolving a rather minor problem of disposal of medical waste must be considered in this project. USAID/H mitigation actions are designed to minimize the disposal problem while reducing the time required to meet the environmental concerns of the US public and USAID.

Attached are the Project Results Indicators from Annex 2 of the Project Amendment for your information. All planned activities are represented in these results.

Mitigation Measures

Mitigation measures will be included in the final version of the Amendment. Measures required are:

1. A covenant will be included in the project document that will not allow funding of waste-producing activities at individual sites until that site has in place procedures that govern handling and disposal of medical waste and confirms that employees have had training in these procedures. After the project amendment is authorized, a PIL itemizing these procedures and training and committing the project implementors to follow the rules will be issued and countersigned by the implementing agency of the GOH. The wording of the covenant is:

"The Ministry of Health shall institute a medical waste management system that insures proper disposal in all project medical facilities where amounts of waste accumulate (i.e., CESAR, CESAMO, Maternal-Infant Clinic, and Hospitals).

Project activities in the nine focus Areas will result in the production of certain amounts of medical waste (syringes, bandages, etc.) which, if not properly disposed, could constitute a public health risk. In order to reduce to the maximum extent possible such risk, the Ministry of Health agrees to institute and

implement a medical waste management system mutually agreeable to USAID and the Ministry of Health (MOH) (as set forth in a PIL). This system shall include procedures appropriate at each medical facility level for medical waste management (including training of personnel) and shall specify monitoring and enforcement of these procedures. Additionally, the MOH shall insure that disposal containers, incinerators and/or other appropriate means of handling wastes are available and in use. The MOH further agrees not to use USAID or project counterpart funds for procuring medical supplies and equipment that lead to the production of medical wastes for use in any medical facility project funded activity until such a system is implemented."

2. Periodic measures of the quantity of medical waste generated in the clinics which receive funding from the project. These quantities will be reported in the periodic reports submitted to USAID by the MOH. The project officer (PO) will evaluate the quantities and if significant changes are seen, will report this to the Mission Environmental Office for action. The PO will periodically review the adherence to the procedures and verify the quantities of waste produced during required PO site visits. Observations on the compliance of disposal of medical waste will be included in the PO's site visit reports.

3. Provision of written instructions to the clinics about how to handle medical wastes
4. Training of all personnel in the clinics on proper handling and disposal of medical wastes.

5. Provision of appropriate waste containers and needle disposal systems to the clinics.

6. The project will assist the GOH in repairing the medical waste incinerator at the Mario Caterina Rivas Hospital in San Pedro Sula. The operators will be trained in the proper disposal of medical wastes using this facility.

7. Each planned Project Evaluation shall have instructions included to analyze the quantity of medical waste produced and the disposal procedures at each clinic. The evaluations will also review compliance with the mitigation actions in this IEE. The results will be clearly presented in the evaluation findings. The findings shall be reviewed by the Mission Environmental Officer, who may propose additional mitigation measures if needed.

8. Any new water or sanitation systems funded by USAID must have the Environmental Review Surveys completed as required in the Health Sector II Project EA approved in (88) State 279117 from LAC/EA. These will be presented to the SO Team for their review and approval.

9. Project annual reports will attach all Environmental Review Surveys completed during the reporting year. These must be reviewed by the SO 3 Team.

All mitigation procedures in this IEE will be incorporated into the Project design with support from the budget. The project amendment budget has set aside \$ 50,000 to support the environmental mitigation actions required in this IEE. The mitigation measures shall be included in appropriate project documents, including budgets, PILs, and agreements.

When the final U.S. Environmental Protection Agency rules on medical waste disposal are published, the project shall comply with those regulations. If unable to comply, Mission Environmental Officer shall submit justification to LAC/RSD/E Chief Environmental Officer for approval.

Recommended Environmental Threshold Decision

The activities of this project will lead to improved environmental conditions in Honduras. The mitigation actions are designed to both meet the requirement of US law as well as to encourage the GOH to resolve a problem with medical waste disposal that does not originate from the activities of this project. Because the activities of the project contribute a very small amount to the total medical waste problem in Honduras, it is not feasible or desirable for the project to resolve the existing problem. The actions undertaken in this project insure that USAID will not contribute to the problem. These actions further provide USAID with some leverage in assisting the GOH in recognizing their problem and discussing applied solutions.

Negative Determination in accordance with ADS 204 and 22 CFR 216, Paragraph 216.1(c) (3) and (11) is requested for all project activities. This determination indicates that no significant environmental effects can be identified resulting from the activities planned in Amendment 23 to the Health Sector II Project . The original EA approved in (88) State 279117 by LAC/EA remains in effect and those mitigation procedures recommended in the EA apply to Health Sector II, Amendment 23.