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

BOLIVIA

PROJECT PAPER

COMMUNITY AND CHILD HEALTH
AMENDMENT NUMBER 2

AID/LAC/P-955
CR-440, 538

PROJECT NUMBER 511-0594

UNCLASSIFIED

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AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1 TRANSACTION CODE: C (A = Add, C = Change, D = Delete)

Amendment Number: PP Supplement

DOCUMENT CODE: 3

2 COUNTRY/ENTITY: BOLIVIA

3 PROJECT NUMBER: 511-0594

4 BUREAU/OFFICE: LAC 05

5 PROJECT TITLE (maximum 40 characters): COMMUNITY AND CHILD HEALTH

6 PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 07 DD 27 YY 98

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

A. Initial FY 88 B Quarter 4 C Final FY 97

8 COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B FX	C. L/C	D Total	E. FX	F L/C	G Total
AID Appropriated Total	2,000	700	2,700	9,500	16,500	26,000
(Grant)	(2,000)	(700)	(2,700)	(9,500)	(16,500)	(26,000)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1						
Other U.S. 2						
Host Country		1,100	1,100	--	11,200	11,200
Other Donor(s)						
TOTALS	2,000	1,800	3,800	9,500	27,700	27,700

9 SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1 Grant	C. PRIMARY TECH. CODE 2 Loan	D OBLIGATIONS TO DATE 1 Grant	D OBLIGATIONS TO DATE 2 Loan	E AMOUNT APPROVED THIS ACTION 1 Grant	E AMOUNT APPROVED THIS ACTION 2. Loan	F LIFE OF PROJECT 1 Grant	F LIFE OF PROJECT 2. Loan
(1) CS	510	510		9,369	-			13,000	
(2) HE	510	510		9,369	-			13,000	
(3)									
(4)									
TOTALS				18,738				26,000	

10 SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 550, 570

11 SECONDARY PURPOSE CODE: 580

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

A. Code

B Amount

13 PROJECT PURPOSE (maximum 480 characters)

To improve the access, coverage, quality and sustainability of an integrated package of essential community and child health interventions, and mobilize the demand for services in selected rural areas

14 SCHEDULED EVALUATIONS

Interim MM 11 YY 96 MM YY

Final MM 11 YY 97

15 SOURCE/ORIGIN OF GOODS AND SERVICES

☒ 000 ☐ 941 ☐ Local ☐ Other (Specify)

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

The USAID Controller has reviewed the financial procedures described herein and hereby indicates his concurrence

9/20/95

Richard J Goughnour
Controller

17 APPROVED BY

Signature

Title: Lewis W Lucke
Mission Director a i

Date Signed: MM 09 DD 28 YY 95

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

MM DD YY

AID 1330-4 (8-79)

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INSTRUCTIONS

The approved Project Data Sheet summarizes basic data on the project and must provide reliable data for entry into the Country Program Data Bank (CPDB) As a general rule blocks 1 thru 16 are to be completed by the originating office or bureau It is the responsibility of the reviewing bureau to assume that whenever the original Project Data Sheet is revised, the Project Data Sheet conforms to the revision

Block 1 -Enter the appropriate letter code in the box, if a change, indicate the Amendment Number

Block 2 - Enter the name of the Country, Regional or other Entity

Block 3-Enter the Project Number assigned by the field mission or an AID/W bureau.

Block 4 - Enter the sponsoring Bureau/Office Symbol and Code *(See Handbook 3 Appendix 5A, Table 1 Page 1 for guidance)*

Block 5 - Enter the Project Title *(stay within brackets limit to 40 characters)*

Block 6 - Enter the Estimated Project Assistance Completion Date *(See AIDTO Circular A-24 dated 1/26/78 paragraph C Page 2.)*

Block 7A - Enter the FY for the first obligation of AID funds for the project
Block 7B - Enter the quarter of FY for the first AID funds obligation
Block 7C - Enter the FY for the last AID funds obligations

Block 8 - Enter the amounts from the 'Summary Cost Estimates' and 'Financial Table' of the Project Data Sheet
NOTE The L/C column must show the estimated U S dollars to be used for the financing of local costs by AID on the lines corresponding to AID

Block 9 - Enter the amounts and details from the Project Data Sheet section reflecting the estimated rate of use of AID funds
Block 9A - Use the Alpha Code *(See Handbook 3 Appendix 5A Table 2, Page 2 for guidance)*

Blocks 9B , C1 & C2 - See Handbook 3, Appendix 5B for guidance The total of columns 1 and 2 of F must equal the AID appropriated funds total of 8G

Blocks 10 and 11 See Handbook 3, Appendix 5B for guidance

Block 12 Enter the codes and amounts attributable to each concern for Life of Project *(See Handbook 3 Appendix 5B Attachment C for coding)*

Block 13 Enter the Project Purpose as it appears in the approved PID Facesheet, or as modified during the project development and reflected in the Project Data Sheet

Block 14 Enter the evaluation(s) scheduled in this section

Block 15 - Enter the information related to the procurement taken from the appropriate section of the Project Data Sheet

Block 16 - This block is to be used with requests for the amendment of a project

Block 17 - This block is to be signed and dated by the Authorizing Official of the originating office The Project Data Sheet will not be reviewed if this Data Sheet is not signed and dated **Do not initial**

Block 18 - This date is to be provided by the office or bureau responsible for the processing of the document covered by this Data Sheet

PROJECT PAPER SUPPLEMENT
COMMUNITY AND CHILD HEALTH PROJECT, AID 511-0594

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C	Sanitary Model for Decentralized Health Care	(6 pages)
D	Plan Vida	(7 pages)
E	Host Country Contracting Certification and Procurement Plan	(14 pages)
F	Project's Mid-Term Evaluation Summaries	(11 pages)
G	Scopes of Work for International Technical Assistance	(15 pages)
H	Project's Statutory Check List	(26 pages)
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August 2, 1995

PROJECT PAPER SUPPLEMENT

COMMUNITY AND CHILD HEALTH PROJECT, AID 511-0594

1. RECOMMENDATION AND SUMMARY.

1.1 Recommendation

The amendment of the Community and Child Health Project responds to a series of changes in the national context and in the Project's environment, such as the Popular Participation Law and the official establishment of a New National Sanitary Model that promotes the decentralization of health services It is recommended that this amendment which returns to the Project's original objectives of supporting decentralized provision of health services at community levels be approved because the suggested strategies are more consonant with the current policy environment than the approach followed under previous amendments The current amendment will extend the life of the Project (LOP) to 10 years, with the Project completion date (PACD) on July 27, 1998, and with an increase in Project funding from $20 Million to $26 Million This amendment will correct the current fragmentation of the Community and Child Health Project into five components with five sub-purposes by re-introducing an integrated approach to health care The single purpose of the amended Project will be to improve access, coverage, quality and sustainability of an integrated package of essential community and child health interventions and mobilize the demand of these services in selected rural areas

The increases in life of project and funding, and the re visiting of an integrated approach to health care at district and community levels will contribute to current GOB efforts to improve and reform the national health care sector The project will seek three major outcomes 1 - increased utilization of existing health care facilities in selected rural districts through the development and delivery of an integrated package of health services, 2 - increased institutional capacity of the National Secretary of Health to guarantee quality health care services and mobilize community demand for health, and, 3 - changes in knowledge, attitudes and health care practices among local population groups through active participation of community organizations Whereas most of the activities to attain these outputs are a continuation of what was done in the past by the CCH Project, there are some new interventions that merit special mention These include the introduction of maternal

and reproductive health care, policy dialogue on decentralized health care systems, of counterpart financing from the newly created municipal governments, and project assistance to public, private and voluntary health care providers that work in the rural areas The new phase of the CCH Project will represent a 180° shift from previous operations from a central office and central government orientation to a community and client oriented project It also represents a change from a project designed around independent activities and inputs to a results oriented project that will assume responsibility for reaching rural beneficiaries and demonstrating an impact on their health

1.2 Summary

The original CCH Project objectives are even more relevant to the current policy environment than they were to the situation in 1988 This amendment to the Community and Child Health Project is designed to recover those original objectives and adapt them to new legislation, new institutional/organizational schemes for the National and Regional Secretaries of Health, and to be responsive to the new actors of the current health care sector Consequently the amended CCH Project abandons the earlier approach of funding virtually independent components (e g Chagas, Water & Sanitation, Immunizations, Diarrheal Diseases and District Development) in favor of a strategy that develops an integrated package of essential health services and strengthens decentralized health care systems at the district level National, regional, and municipal governments and community groups will work together to make local health care systems responsive to the needs of health service users The new CCH strategy is guided by the principles and statutes of the Popular Participation Law passed in 1994

The new amendment also addresses many of the lessons learned during the past six years of project implementation, particularly that centrally administered and implemented programs are not the most efficient way to deliver health care in rural areas Thus, the real challenge for the CCH will be to establish locally run health care systems, to train local personnel, to provide appropriate logistical support to those local health care systems, and to reach out to and involve poor and dispersed rural communities in their own health care Nevertheless, CCH Project will not provide health care services directly Rather, it will support different health care providers, public, private or voluntary, as long as they are located in the rural districts where the project operates CCH will act as a bridge between

the providers of health care services and the community groups that, through health education and social marketing, will raised their awareness, interest and demand for an essential package of health services the Government has denominated Plan Vida

In addition to continuing with the child survival activities, the Project will include maternal and community health interventions previously neglected This more holistic approach to health care is more consonant with community perceptions of health The Project will also return to the original target of providing services in 11 rural districts

Three recently established national policy guidelines will be the basis for the amended Project Popular Participation, the new National Sanitary Model and Plan Vida With Popular Participation the Project has to learn to be more responsive to popular demand and support community empowerment processes The new National Sanitary Model will be the basic framework for the institutional strengthening of the entire National Secretary of Health at the central, regional and local levels Plan Vida will define the parameters for an integrated package of essential community and child health services These policy guidelines are compatible with the Project's three strategic outcomes a) the development and implementation of an integrated package of health services, b) institutional development, and, c) community participation

The original USAID funding, in 1988, for the CCH Project was $16 5 Million Then, in 1992 the USAID funding was increased to $20 0 Million With the new amendment it will increase to $26 Million The Reproductive Health Services Project will provide an additional $2 5 million dollars to support reproductive health activities This increased level of funding is aimed at taking advantage of an unprecedented social and political climate in Bolivia that contributes to intense policy dialogue and the new health care options for the Bolivian public The CCH Project is the most appropriate vehicle for developing innovative ways to package essential health services and to mobilize informed community demand

A reduced and re-organized Central Management Unit will be responsible for managing the Project from La Paz and facilitating decentralization efforts that will be conducted and evaluated locally in three Departments and 11 health Districts

1.3 Reason for Modified Project

Although the objectives of the original CCH Project are compatible with the current health sector policy and environment, the Project was amended several times in ways that deviated Project implementation away from its original purpose and outcome Nevertheless, the Project achieved significant outputs and contributed to the improvement of the health status of the Bolivian population in selected rural districts By March 1995, each one of the Project components completed virtually all the outputs established for the Project as shown below

RESULTS OF THE SEMI ANNUAL REPORT (S A R) UP TO MARCH 31, 1995

	MAJOR OUTPUT INDICATORS	PLANNED	ACCOMPLISHED	% OF LOP
1	Diarrheal/Cholera Number of Community Based UROs	6,000	6,000	100%
2	Diarrheal/Cholera Number of Diarrheal Studies	5	7	140%
3	Immunizations One year olds fully immunized (%)	65/24	81	125%
4	District Development Auxiliaries Trained	Auxiliaries 250/0 Training Sessions N/A	135 573	54%
5	District Development Management systems installed	5	5	100%
6	Chagas' Disease Operations research conducted	10	10	100%
7	Chagas' Disease Houses improved	2,000	3,574	179%
8	Water and Sanitation Communities served No of water systems	120/0 120/0	122 97	102% 81%
9	Training - Long Term in Public Health M F	 1/0 1/0	 1 1	 100%
10	Training Short-term in Public Health M F	 3,000 3,000	 3,957 4,142	 132% 138%

The impact of the Project's achievements was tempered by the bureaucratic orientation and the fragmentation of the Project activities Consequently, the Project did not

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fulfill its purpose of reducing infant, child and maternal mortality through the use of an integrated package of community and child health services Furthermore, it provided minimal support for decentralization of health care services and the institutional development of selected rural health districts And, except for some health education and promotion activities, the Project did little to engage community participation

The Project, during this new and final phase, aims to return to the original Project's purpose and strategy Therefore, under the policy and normative guidance of the recently created Ministry of Human Development and the National Secretary of Health, the mission of the CCH Project in its final phase will be to improve the health status of rural and peri-urban communities It will develop and strengthen selected health care districts, mobilize community participation in the design and provision of health services and assist different types of local health care providers to provide an integrated package of health care interventions These efforts are aimed at increasing community demand for and use of quality rural health care services that are sustainable and replicable throughout the country

This orientation is even more appropriate now because of de facto health sector reform stimulated by new national popular participation and decentralization policies The NSH endorses the importance of the Project's original and newly amended objectives to provide an integrated health package, support decentralization and local institutional development, and to mobilize community participation at the rural district level[1] Therefore, the amended Project, during the final phase, will contribute to the decentralization process (Sanitary Model), concentrating most of its efforts and resources in selected rural Territorial Health Directorates (DITES) in La Paz, Cochabamba and Santa Cruz and facilitate coverage of the local population by an integrated package of health services (Plan Vida) through a variety of local health care providers At the same time, the Project will mobilize community demand for health care services through social marketing, health education and other community-based mechanisms that address cultural, geographical, and economic barriers to access to quality health care It will also contribute to strengthening the

[1] *Throughout this Project Paper Supplement the term district will be used indistinctly with the recently defined Territorial Health Directorate, or "DITES", which is a decentralized, multi-municipal network of health services, that aims at providing all primary & secondary health care to all the population of the municipalities involved A "DITES" or district unit is funded and supervised by the Regional or Departmental level*

institutional linkages between national, regional and local levels through information, supervision and other administrative support systems, making the decentralization and Popular Participation guidelines operational, transparent and accountable

2. AMENDED PROJECT BACKGROUND AND RATIONALE.

2.1 Changes in the National Context and in the Project's Environment.

The Community and Child Health (CCH) Project, AID 511-0594, started in July 1988 with a Grant Agreement signed by the then Minister of Planning and Coordination, Lic Gonzalo Sánchez de Lozada on behalf of the Bolivian Government and Reginald Van Raalte on behalf of USAID The Project's goal was to improve the health status of the rural population, and its purpose was to reduce infant and child mortality and morbidity The Project was an early effort to decentralize the provision of health services at the community level The Project assumed that the Ministry of Social Welfare and Public Health (MSWPH) would delegate responsibilities to its Departmental and District-level divisions and give them ample authority over planning and administration to insure timely and effective implementation of an integrated package of Project activities

The Project conducted two interim evaluations during the 1988-1994 period The findings of both of them emphasized the distortions that evolved from the apparent neglect of the original purpose to decentralize and integrate community and child health interventions Their findings highlighted a lack on emphasis in community health, a lack of an integrated approach, and a concentration on procurement of materials and equipment without much consideration of impact, sustainability or replicability (Becht, January 1992, Bartlett, October 1993) In addition to internal limitations of the earlier Project design, there are a series of external events that argue for amending the Project to respond better to both national and local needs for health care reform

Two recently passed laws, which reform and decentralize the health sector, provide a framework for a revised Community and Child Health Project First, Law that Reforms the Executive Branch of Government (passed September 1993) reduced the number of Ministries and created a new Ministry of Human Development under which a National Secretary of

Health (NSH) replaced the former Ministry of Social Welfare and Public Health The mandate for the newly created Secretary of Health is more regulatory and normative than direct service delivery Its current mandate is to develop local (decentralized) health care systems with community participation A second major change occurred in April 1994 with the signing of the Popular Participation Law that recognizes community groups as legal entities, establishes representative territorial organizations (OTBs) throughout the country, redistributes fiscal resources in favor of the newly created municipalities, and, redefines roles and responsibilities at the local level These new regulations affect the health sector directly by assigning resources to municipalities to provide health services, support health care infrastructure and to assume responsibilities for the health of their populations These new guidelines have created a national-local partnership (NSH/municipality/local community organizations OTBs)[2] for health, called the "joint management of health services with popular participation " Under joint management, municipal governments own the infrastructure and equipment and have responsibility over the recurrent costs, while the NSH maintains control over policy guidelines, norms and planning processes as well as over the human resources (nurses, physicians, etc) Community groups assume leadership for making the health care providers and financiers accountable to local citizens Finally, in 1994 the new National Secretary of Health developed and adopted a National Plan for accelerated reduction in maternal, Infant and child Mortality (Plan Vida), which aims to reduce national mortality rates by 50% in the next 4 years Plan Vida promotes an integrated package of health services and serves as the main guidelines for policy and action within the National Secretary of Health (See Annex D)

2.2 Changes in the Project Objectives.

The amendment revises the Project goal and purpose The original project purpose, to reduce infant and child mortality, is an objective that is beyond the capacity of the CCH Project to achieve on its own For instance, family income and education are just a few of factors that are essential to the reduction of premature mortality yet outside of the scope of the project Therefore, the amended Project design of CCH requires a purpose statement

[2] *A local Community Organization, according to the Popular Participation Law is an OTB (Territorially Based Community Organization) In a given District, between 30 to 100 OTBs exist, and participate in the constitution of a single Vigilance Committee of no more than 10-12 members*

that is clearly attributable to the Project and constitutes an attainable objective The amended Project purpose will be **to improve access, coverage quality and sustainability of an integrated package of essential community and child health interventions and to mobilize community demand for services in selected rural areas** The new goal of the Project is **to improve family health throughout Bolivia, focused on the reduction of infant, child and maternal mortality in rural areas.** Indicators at the Project's goal, purpose, output and input levels, have been adjusted accordingly At the goal level the revised Project indicators will measure the Project's impact on maternal, child and infant mortality and morbidity At the purpose level, the Project will measure impact in terms of the implementation of improved community and child health interventions, namely, utilization, access, coverage, quality and sustainability of health services At the output level, indicators measure progress toward development, operation, and management of 11 rural districts (DITES) and increased demand for services This new set of indicators provides a more systematic approach to Project monitoring than before, when impact, process and progress indicators were not appropriately linked with goal, purpose, and output objectives and, in some cases, were not attributable to Project efforts

The changes in the Project's objectives and indicators is supported by the recommendations of two CCH evaluations Additional changes in the Project's environment demonstrate the need for a new approach in the following terms

	OLD CCH		NEW CCH
*	Fragmented into 5 components with 5 sub-purposes	*	Integrated approach toward a single purpose
*	Oriented toward central government & providers	*	Community and client oriented on rural areas
*	Activity and input based	*	Results oriented
*	Left access barriers intact	*	Eliminates access barriers
*	Responded to MSWPH demand	*	Generates community demand for services
*	Established controls over the provision of inputs for bureaucratic levels	*	Experimental approaches for reaching beneficiaries
*	Followed bureaucratic norms and using nation-wide indicators	*	Assumes responsibility for outcomes, using attributable indicators
*	Accepted inadequate standards	*	Improves existing standards

The shift from central to decentralized activities, however, will not represent a total neglect of the central offices of the NSH The 1993-94 Child Survival Assessment for the Mission recommended that CCH should continue, although in an improved form, its support to central programs such as the Immunization Program and the National Control of Diarrheal Diseases Program Support to these key national child survival programs will continue in a revised form based on increasing GOB efforts and mobilizing government and private sector resources to support longer term sustainability Perhaps the most important area in support

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of NSH central office will be the development and establishment of coordination and information mechanisms that promote decentralized management and centralized policy implementation

2.3 Changes Based on New Demands for Project Services.

The CCH Project does not deliver health care services directly but rather depends on an existing network of health care providers Until 1993-1994, the main, and almost sole, health care providers in the rural areas were Ministry of Social Welfare and Public Health facilities Reform of the Executive Branch, the Popular Participation Law, and the new Sanitary Model allow for new sets of actors and institutional relations among health care providers in the Territorial Health Directorates (DITES) NSH personnel will remain in municipally-owned facilities at the DITES level and their salaries will continue to be paid by the National Secretary of Health However, the infrastructure owned by the municipal governments and manned by NSH personnel have limited capacity to cover all rural health needs Thus, NGOs and community groups are essential participants in a comprehensive Local Health System (SILOS) which guarantees access and coverage to local populations Such an arrangement calls for the joint management of health services The Project will, therefore, support joint management of health services by assisting multiple providers, public, private and voluntary Jointly, these potential multiple providers constitute a Local Health Care System (SILOS), and are one level of basic clients for revised CCH services The services the project will provide to health care providers include development of health intervention models, commodities and logistic systems, management, information and evaluation systems, and training In some areas where an existing network of health care facilities does not cover the entire population, especially in distant and dispersed populations, municipalities will have to construct new facilities The CCH Project will assist by providing technical guidance and equipment when needed, through the infrastructure units of the Regional Secretaries of Health

Furthermore, the population has lost confidence in the services the formal health care network provides, and has assumed a fatalistic attitude toward some easily preventable diseases and health problems Therefore, to concentrate project efforts <u>only</u> in the network of rural health care providers (in the supply side of health care) is a mistake An equally important focus of Project activities is the community as the critical point for identifying

survival risks and devising culturally viable solutions This requires education in health and health related practices, as well as support for active community participation in health care planning and implementation Thus, communities and their members constitute another important project clientele The Project will assume direct responsibility in mobilizing effective community demand for health care services and for addressing access barriers to quality care

CCH will become a bridge to assist health care providers (public, private or voluntary) in selected health care districts to provide quality health care services that respond to national norms, programs and standards It will also use the logistical support, supervision, training and information systems that CCH and the National Secretary of Health have developed in the past Improved services should provide a uniform package (Plan Vida) and respond to cultural and regional differences At the other end of the "bridge" is the community, which CCH will mobilize as a partner to decrease access barriers and to exercise an effective demand for the package of health services needed to support Plan Vida, through health education, community participation, social marketing, etc

CCH will also support central and regional offices of the National Secretary of Health The Project will provide assistance through the central programs (Immunizations and Diarrheal Diseases/Cholera), and through technical assistance for the institutional development required to coordinate, set norms, regulate, and support a decentralized health care system at district and municipal levels Therefore, in addition to the previous assistance in central programs, the CCH will assist the NSH to establish and operate management support systems, such as information, supervision The magnitude of those changes decreed in the executive branch and popular participation reforms will require a series of adjustments, discussions and revised operational procedures In this regard, the CCH Project will work through the DITES and the RSHs as a key instrument for policy dialogue

2.4 Changes in the Project's Supply of Services or Health Care Technology.

The changes that have taken place in the Project's immediate environment require a change in the Project's approach to providing services (logistics, management, etc) The Project will develop an integrated package of health care services that supports Plan Vida During the last phase of the project more than 50% of the remaining and new resources will

be devoted in rural districts (DITES) for the direct provision of services The Project will mobilize district or DITES-level teams to have a direct impact at the community level by organizing local providers and by assisting community groups to get involved in their own health care The Project will develop an approach that facilitates linkages between those that provide services and those that use them And finally, the Project will support different public, private and voluntary organizations that contribute to the implementation of national health care policies

2 4.1 Review of the Old Components.

The integrated strategy proposed for the amended CCH Project is a fundamental change in the Project operations Thus, the amendment discontinues, reduces, and changes activities which were within the purview of independent components during earlier phases of the Project The status of Project components in light of the new strategy is reviewed below

a) **Water and Sanitation** - Except for the 3 or 4 new Water Systems to be done in conjunction with the Regional Corporations or FIS, construction of new water systems in the new districts and rural communities will not be part of the new Project CCH has reached preliminary agreements with the Regional Secretaries of Health in La Paz and Cochabamba and with CARE/Bolivia to coordinate activities in areas where CARE has completed the construction of 154 water systems in 5 rural districts of La Paz and Cochabamba If possible, CCH will incorporate these districts (with some of the CARE's field personnel, i e , nurses, physicians and health care promoters) in the new phase of the Community and Child Health Project

b) **Chagas Disease** - The Chagas Component was devised to establish a national program for control of Chagas disease The program was designed to work directly with the Ministry of Social Welfare and Public Health to build consensus and start programs in the following areas related to Chagas disease control 1 - Surveillance, 2 - Training in surveillance, laboratory procedures, and information systems, 3 - operations research 4 - training for community health educators, 5 - spraying programs 6- house-improvement program, 7 - program for local animal control, 8 - national education program in primary schools and, 9 - donor coordination As discrete outputs for the Project by September 1994, the research and training programs were completed, regional laboratories were established,

the spraying programs were regularly conducted and the Project improved 3,574 houses in Cochabamba, Tarija and Chuquisaca, (1,574 houses more than the original target) The Chagas Component has reached an end and will not continue in the final phase of the Project

c) **Diarrheal Diseases/Cholera** - The Project will continue this national program during the final phase of the Project It will provide approximately two million packets of Oral Rehydration Salts (ORS) per year to the NSH for use in the National Oral Rehydration Program In addition to that, the Project will contribute to beginning local production, commercialization, and social marketing of ORS CCH will be the major actor in a multi-donor effort to mobilize community demand for OR treatment in the rural areas of La Paz, Cochabamba and Santa Cruz The commercial and social marketing campaign will cover the entire country The Project will also monitor changes in behavior related to the use of ORS, changes in the attitudes of health care providers, as well as monitor actual use within the households in selected rural districts of the Project Research studies on diarrheal disease will continue

During the new phase, the Project will be part of a multidonor social marketing effort to increase sales of ORS packets through the private sector The campaign aims to generate demand for the ORS by creating a positive and useful image of the product This is an innovative new operations research effort under the amended Project

Although the Diarrheal Diseases/Cholera program is nation-wide, the Project will only take responsibility for the training, supervision and monitoring of service providers in the Project's eleven Districts Consequently the Project will not identify nor claim any intermediate service delivery or institution-building outputs associated with this program

d) **Immunizations** - Immunization activities and support will continue during the final phase of the Project The development of epidemiological and managerial information systems will be a major contribution of the Project to the regional and central levels of the NSH This component was designed to strengthen the national vaccination program The Project gave priority to children below the age of one year and distinguished itself by maintaining an 81% vaccination coverage rate of children in this age group in the Project's districts, thereby exceeding the original 65% target The Project during the past 6 years

contributed to around 15% of the total national budget for immunizations

This program responds quite successfully to the coordinated efforts of a variety of donors and cooperating agencies such as USAID, UNICEF, PAHO/WHO, PL-480, ROTARY Club, NSH The Project also trained 38 physicians from central, regional and district levels in Data for Decision Making which was a breakthrough in the use of epidemiological and managerial data for making public health decisions

e) **District Integrated Child Survival Program** - The greatest and most significant changes will occur in this program A majority of Project resources provided under the amended Project will go to 11 rural districts or Territorial Health Directorates (DITES) The Project will monitor impact in terms of access, coverage, utilization, quality and sustainability of health services at the district level The Project will also concentrate on changing knowledge, attitudes and health practices among community groups At the district level, the Project will assist, train, organize health care providers (public, private and voluntary) to form local health care systems (SILOS),

CCH will concentrate efforts both on the supply side and demand side of these services, i e , in social marketing, health education, community organization, planning, institution and coalition building, civic participation and public accountability The key link between supply and demand is open access Therefore the Project will direct its efforts toward increasing access by addressing geographical, social, economic and cultural barriers that impede use of services by rural populations

2 4.2 Areas that Require Renewed Emphasis.

Whereas CCH could achieve some of the changes by following previous approaches, it can not successfully achieve most of them without following a fundamentally different strategy and technical methodologies For instance, DDM support, under this new phase, must combine epidemiological, managerial and social marketing systems at the district or "DITES" level For that purpose the Project will assure that strong information systems are designed and operate in each one of the "DITES" where the Project is active They will be linked to the central levels/offices to improve the transparent flow of information between administrative levels Another major change will be an emphasis on non-medical issues,

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such as, community decision-making and stimulation of demand through health education, social marketing and popular participation mechanisms that were absent in earlier phases A third functional area that requires adjustments is financing of health care services at the district level The Popular Participation Law, provides municipalities with resources designated for health services on a per-capita basis Additional funds come from payments for services by the local population Fee for services payments were not systematically accounted for by the former MSWPH even though, according to UDAPSO/PAHO, they accounted for 20% to 30% of the total funding of health care services in Bolivia in 1993[3] Therefore, the Project, in its final phase, will place greater emphasis on cost recovery, while keeping in mind that current social and economic conditions, at the district-level, preclude total financial self-sufficiency The combined use of municipal, national, and user-generated funds require new and innovative financial mechanisms to make Local Health Care Systems operational CCH will help with the integration and coordination of these different funding sources at the municipal level

2.5 Potential Consequences and Limitations if Project is Not Amended.

The changes that are taking place in the health arena are equivalent to a de facto health care sector reform Many of the new processes and adjustments described affect the entire range of actors in health and not only the CCH Project Despite the preparation by the SNS and distribution the New Sanitary Model which CCH will follow, there is still the need for further definitive guidelines to orient this transformation (for instance, as of today, a proposed Decentralization Law is still in the making) Most adjustments will be experimental The new health care sector will have to adapt to a reform which is being established by factors outside the health sector Those institutions that have the greatest flexibility, the strongest experimental approach, and the ability to affect policy through demonstrated successful adjustment to new conditions are going to assume leadership roles In contrast, those that remain rigid in their approach and proceed within the old centralized model will lose their influence and efficacy As such, they may miss this historical opportunity and become marginal to course of future events

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[3] *Marina Cárdenas & Christina Darras; Unidad de Análisis de Políticas Sociales (UDAPSO), Gasto Nacional y Financiamiento del Sector Salud en Bolivia, December 1994*

All these changes argue for an amendment to the CCH Project The CCH Project has achieved sound administrative support systems, ample experience in the procurement and deployment of medicines, equipment and supplies, technical excellence in epidemiological based information systems, and a strong presence in the rural areas, all of which support a more dynamic and demonstrative role in reform processes

3 AMENDED PROJECT DESCRIPTION

3 1 Project Goal and Purpose

The Community and Child Health Project is a USAID-funded Project that supports the National Secretary of Health in the decentralization of health care services, through strengthening regional and district levels of the NSH

The amended Project goal is to improve family health throughout Bolivia, focused on the reduction of infant, child and maternal mortality in rural areas This goal corresponds to the Mission's Strategic Objective for Family Health The amended Project purpose is to improve the access, coverage, quality and sustainability of an integrated package of essential community and child health interventions, and mobilize the demand for these services in selected rural areas

End-of-Project status indicators of purpose achievement will measure improved institutional capacity at regional and district level in Project districts to deliver the integrated package of health interventions as defined by the National Plan for the Accelerated Reduction of Maternal, Infant and Child Mortality (Plan Vida) Indicators will measure 1) access to quality health services by the population of rural districts, 2) coverage of a package of selected health care interventions proposed by Plan Vida, 3) quality of health care services provided by public, private and voluntary health care providers in 11 districts, and 4) increased sustainability of the health care services provided through sound institutional, financial and administrative practices

Achievement of the purpose assumes that the NSH and the Project will delegate to its Departmental (Regional) and District-level organizations sufficient authority over the

planning and administration of Project activities to ensure timely and effective implementation It also assumes that the NSH, Departmental entities, USAID, PL-480 and the municipal governments will provide adequate financial, technical and material resources in a timely manner

3 2 Project Strategy

3.2.1 Differentiated Strategies.

The GOB and USAID will employ a multi-faceted strategy to achieve the Project purpose This will be achieved through activities that support 1 - appropriate community and child health interventions established by Plan Vida, 2 - implementation of these interventions according to the new Sanitary Model, and, 3 - community participation so as to mobilize demand for socially and culturally appropriate health care services

The Project's primary strategy consists of two key elements The first is to strengthen the operational capacity of 11 District Units or Territorial Health Directorates (DITES), according to the Sanitary Model, in three Departments Since the DITES receive technical, management and financial support from the Regional Secretaries of Health (RSHs), the Project -as part of this decentralization strategy- will also strengthen the RSHs' capacity to provide that support The second key element is to provide an integrated package of services (Plan Vida) by improving the technical capacity of local health care providers and by mobilizing rural communities to demand more effective and responsive health care services

The aim of this basic strategy is to improve and expand the coverage of rural populations with the integrated package of priority services described in Plan Vida through the decentralized National Sanitary Model The Project's strategy is compatible with new national guidelines for popular participation, decentralization, and an integrated approach to delivery of health care services By focusing Project support at the District and Departmental levels, the Project will reinforce current GOB initiatives to rapidly reduce maternal, child and infant mortality (Plan Vida), Popular Participation, and the New Sanitary Model that aims at decentralizing management of health services from the national Government to the Departments and to the joint (NSH/municipalities/local community

organizations, OTBs) management of Local Health Care Systems [4]

The strategy will be articulated in support of an integrated package of priority health services defined in Plan Vida and coordinated at the DITES level In addition to funding health interventions that reduce maternal, infant, and child mortality, the project will strengthen local networks of health care providers, support community health education programs, train local cadres of health and community workers, mobilize community groups through popular participation activities, strengthen health planning and financing capabilities of municipal governments, and advocate for overall improvement in rural living conditions A team of Project and NSH personnel will develop alternative forms of packaging to improve the supply, increase utilization of those services by mobilizing demand and will assist in sound and sustainable management and financing of those services

Innovative practices in popular participation and social mobilization link health care services with decision-making and demands from a more dynamic and participative population This will entail 1) responding to priorities identified and discussed with each Regional Secretary of Health, 2) monitoring the impact of specific activities on health care problems and on locally determined needs, and 3) assuming an aggressive stance in communicating, informing and educating community groups about health care needs and available health care services

The two element strategy will be reinforced by designing, operating,and training personnel in managerial and epidemiological surveillance systems (information and monitoring systems), at the district, regional and central levels, based on the positive results CCH obtained during the previous Project phases This will be the most technical part of the Project strategy and will cover local, regional and central levels, establishing in each one of these levels differentiated programs and procedures according to the different needs for

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[4] *Whereas in the New Sanitary Model the structuring concept is the existing network of health care services, in the Project areas one DITES represents the association of several municipalities In this sense one Rural DITES corresponds approximately 65,000 people in to 4 or 5 UBAGES (or municipalities) According to the Sanitary Model, each rural municipality (or segment of an urban or metropolitan municipality) is a Basic Health Programming Unit, UBAGES. In the case of the rural UBAGES where the project will be operative, the average total population will range from 5,000 to 15,000 people*

information and aggregate data The Data for Decision Making Project (with continuing TA support from CDC) will be the main source of assistance for this strategic component that ranges from the use of national health accounts at the central level, to the analysis of prevalent diseases at the regional level, to the analysis of service data at the local level

The Project will follow a secondary, but complementary, strategy with the remaining national-level programs such as Immunizations and Control of Diarrheal Diseases These programs, due to their "vertical" and national characteristics, will continue to be run by the Central Office of the NSH For these central programs the Project will assist the National Secretary of Health through technical assistance from BASICS, an organization which has been specifically designed to address issues related to the institutionalization of child survival programs at the national and regional levels BASICS will also provide technical assistance to various aspects of the Diarrheal Disease Control Program Finally, CCH will support ongoing efforts to promote local production and commercial distribution of Oral Rehydration Salts In addition to Diarrheal Disease and Immunizations, CCH-BASICS will provide technical support for nutrition interventions under Plan Vida that aim to rapidly reduce maternal and child mortality and underlying malnutrition Because of the inclusion of nutrition related activities, the CCH in coordination with the PL-480 Secretariat, will incorporate a small budget to be managed at the central level, for nutrition activities and education processes to be tested at the district levels where the Project is operative

3.2.2 Sustainability as a Project Objective and Strategy.

Sustainability of the Local Health Care Systems is an integral element of all Project objectives and a major component of the Project's strategy Sustainability of CCH actions is not only an outcome but also a process aimed at mobilizing and supporting conditions that guarantee long-term provision of health care services in the rural areas Sustainability in these terms is more than sound financial and administrative practices at local levels It also entails the development of institutional coalitions or networks among collaborating institutions with different functions, such as individual health care facilities, municipal governments, regional and district offices of the NSH, and the national logistical support systems developed by the Project By its completion date, the Project aims to prepare public, private and voluntary health care providers in each district to perform according to technical and managerial standards that guarantee their permanency in rural areas

The organization of local health care providers into local networks or coalitions will be one of the main Project outputs that will contribute to the sustainability of the services In each District or DITES there will be a Board of Directors made up of representatives of local community organizations (OTBs), the municipal governments, and the Regional Secretary of Health (CCH will participate as part of the Regional Secretary of Health) In addition, there will be a Territorial Health Council in each district designated to liaise with local private and/or voluntary health care providers The Territorial Health Council will seek the participation of NGOs, private practitioners, churches to cover areas not covered by public providers due to limitations in human and capital resources Once identified and approved by the RSH, the CCH Project will provide technical assistance and operational support (logistics, information systems, etc) to these non-governmental health care providers To receive such support, non-governmental providers will sign agreements with the Board of the DITES and with the CCH Project, stating their interest in participating in the Local Health Care System, their intent to respond to national health care policies and guidelines and to provide an integrated package of health services (Plan Vida), under specific quality control guidelines of the NSH and the Project CCH will agree to the level of support to providers in terms of logistics, information systems, administrative and financial support, training, social marketing, community mobilization, etc Non-governmental providers together with the public providers will prepare monthly service reports, and will discuss levels of performance and barriers to the attainment of the DITES' service targets on a quarterly basis

Another output in support of sustainable Local Health Care Systems will be municipal and regional governments capable of supporting locally sustainable health care programs Thus, sustainability of Project outcomes requires the establishment of sound financial and accounting practices in each District or rural DITES so that they are capable of capturing and tracking resources from a number of different sources By the end of the Project, per capita resources from a number of sources are expected to increase from the current NSH per capita contribution of $1 50 to combined NSH, municipal, and private contributions in the range of $6 00 per capita During the remaining life of the Project, CCH will contribute directly to the districts or "DITES" $3 5-$4 5 per person for the first year, $2 5-$3 5 in the second year, and $1 5-$2 5 the third and final year These funds will serve as leverage for national, regional and local contributions, and, based on the improved levels of health services, CCH anticipates an increase in the payments made by some community groups

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The Project will reduce progressively its contributions until the Project's end when the national, municipal and community contributions will suffice to maintain the Local Health Care System

During this period the Project will guarantee the operation of support systems such as accounting, procurement, logistical support, information, etc that, by the Project's end will be either incorporated into the central, regional and district levels of the NSH, or will be transferred to specialized health support units i e , locally developed health management systems that link the administrative and financing aspects of health with the provision of health services and the mobilization of the local demand for health

The project sustainability strategy is based on the efficient/effective development of institutional coalitions networks at the local level which will provide the continuation of project services CCH staff recurrent costs are in the process of being revised with the project personnel in order to reduce significantly the number of positions and salary levels This streamlining process is expected to result in substantial savings in staff costs during the remaining LOP Further, it is also expected that all CCH staff positions will be discontinued at the end of the project

3.3 Project Outputs.

The outputs and specific targets for the Project include

Output 1 - Increased utilization of existing health care facilities in selected rural Districts

Specific Targets

1 1 Local health care providers (public, private and voluntary) organized in 11 local partnerships or coalitions of health care providers for the provision of an integrated package of Community and Child Health care services by December 1996

1 2 A franchise support system established for the training, quality control and effective delivery of Community and Child Health services by December 1997

1 3 By December 1997, the number of visits per person per year to health services facilities increased 50% from current local baselines

Output 2 - Increased institutional capacity of the National Secretary of Health to guarantee quality health services and mobilize community demand for health

Specific Targets

2 1 One Sanitary Model with local and regional variations developed and operational in 11 rural Districts by December 1996

2 2 11 rural health care Districts in La Paz, Cochabamba and Santa Cruz developed experimentally for further replication under Popular Participation Laws by December 1996

2 3 A set of 7 management support systems developed, established and operational at the District level linked to regional and national levels by December 1997

Output 3 - Changes in knowledge attitudes and health care practices among local populations groups registered, documented and validated

Specific Targets

3 1 By July 1998, 33 selected organized community groups demonstrate increased demand for health services attributed to Project activities

3 2 An interactive system to increase the responsiveness of the local health care delivery system to the needs and health expectations of the local community groups established and operating by December 1996

3 3 Six regional assessments of how changes in behavior (increased demand for services) affect sustainable impact on health conducted and concluded by December 1997

3.4 Project Inputs and Activities.

The Project will be organized in District Teams in support of each one of 11 DITES

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A Central Support Unit and a Central Technical Assistance Group will be based in La Paz and will assist the central and regional offices of the NSH Approximately 50% of Project resources in the final phase will go to the Districts, 15% for the strengthening of the National Secretary of Health in its new role, 10% to the Regional Secretaries of Health of La Paz, Cochabamba and Santa Cruz , and no more than 25% of the Project's resources will be assigned to the Central Support Unit and the Technical Assistance Group These percentages include all the different inputs for the Project, such as technical assistance, commodities, etc which do not necessarily mean cash transfers to a district, a regional or a central office

The Project will facilitate the implementation of the National Plan for the Accelerated Reduction of Maternal, Infant and Child Mortality (Plan Vida) in 11 rural districts or "DITES", and will contribute to the achievement of its targets For that purpose the Project will develop coordination mechanisms with the National Directorate for Mother and Child Health which is responsible for the overall coordination of Plan Vida The Project will also facilitate testing and pilot implementation of the Sanitary Model in 11 rural "DITES" The Project will develop coordination mechanisms with the National Directorate for Medical Services (DOSS)

In coordination with these two National Directorates, the Project will conduct a series of workshops and strategic planning seminars, and will assist 11 rural districts in the local planning and programming of activities aimed at achieving the objectives of Plan Vida and the Sanitary Model Project assistance to Rural District Hospitals will improve performance, and develop support systems (communications and transportation systems, information, logistical support, etc) for networks of health care providers The Project will assist these rural hospitals by providing administrative support systems and by networking them with a variety of local health care providers

A two-pronged approach (improved supply and mobilized demand) is vital to implement Plan Vida and the Sanitary Model Health care providers in the rural areas suffer chronic shortages in equipment, materials, infrastructure and personnel, therefore the quality and continuity of the services is poor Consequently, the rural population has lost faith in the formal health sector This contributes to a vicious circle in which the rural poor are confronted with inadequate services and sub-standard health care facilities The challenge is to improve the quality and continuity of existing services, and at the same time, to mobilize

the community to be better and more informed consumers of priority health services Thus, another key area for the Plan Vida and the Sanitary Model will be training, health education, information and social marketing activities to mobilize community demand for health services The Project will thus play a double role on one hand it will increase the demand for services, and on the other it will promote an improvement in the quality of services offered by health care providers

The Project's integrated service packages (Plan Vida) includes

- **Maternal Health:** pre-natal control, birth and post-partum, breast feeding, information, communication, education and social marketing, family planning, treatment of sexually transmitted diseases, early detection of mamarian and cervical-uterine cancer, gynecological pathologies, tetanus toxoid

- **Child Health:** nutrition monitoring, immunizations, detection and treatment of prevalent diseases, pediatrics, growth monitoring, diarrheas, respiratory infections and TB Information, education, communication and social marketing

- **Community Health** general adult health care visits, infirmary, emergencies, references and counter-references, dentistry, laboratory, basic and essential medicines, vector control, tuberculosis, micronutrients, basic sanitation, health education, traditional medicine and family self care

These integrated packages of services will be complemented with popular participation and institutional development practices that include, but are not limited to development of human resources, establishment of information systems and improved administrative and financial practices

4 AMENDED PROJECT IMPLEMENTATION.

4.1 Start-up Workshops.

The Project will continue to use facilitated workshops involving key Project

participants (public, private and voluntary organizations) from the Central, Department and District levels The purpose of these start-up workshops will be to ensure common understanding by all parties of the Project objectives, clarify the participants' respective roles and responsibilities in it, define local priorities, plan future activities, and, define expected results During these workshops key issues to discuss will be the financial sustainability of services, the establishment of service networks, and, community contributions and participation

During the start-up workshops a series of other donors and institutions will be involved These events constitute an ideal setting for donor coordination and for the establishment of local institutional coalitions CCH will develop a Project strategic plan based on contributions of these coalitions that will facilitate the participation of a wide range of actors

4.2 Project Management Unit

The Project will be implemented through 11 District "DITES" Teams and one Central Management Unit which will provide 1 technical services, such as development of health care models, operations research, quality control, 2 technical support services, such as community health education, training, epidemiological surveillance and information systems, social marketing, 3 community or district services that will help District ("DITES") Teams to develop services, financial mechanisms, coordinate with other institutions, improve access, coverage, quality and sustainability, 4 administrative support services such as accounting, procurement, logistics, personnel, etc (See Diagram Page 27)

The Central Management Unit (CMU) requires re-invention The 1993-1994 evaluation recommended that the CMU should be maintained but at a reduced level (See section 5 3 Summary Budget, Central Office Support) The reduction/re-invention of the CMU will be an important preliminary action to support the decentralization efforts that the Project as a whole seeks and it will promote the transfer of authority and responsibility to the District Teams CCH will delegate Project implementation authority to the NSH District Teams, strengthen their operational capacity, and help establish publicly transparent accountability mechanisms

At the Central level, the Project will have an Executive Council made up of the

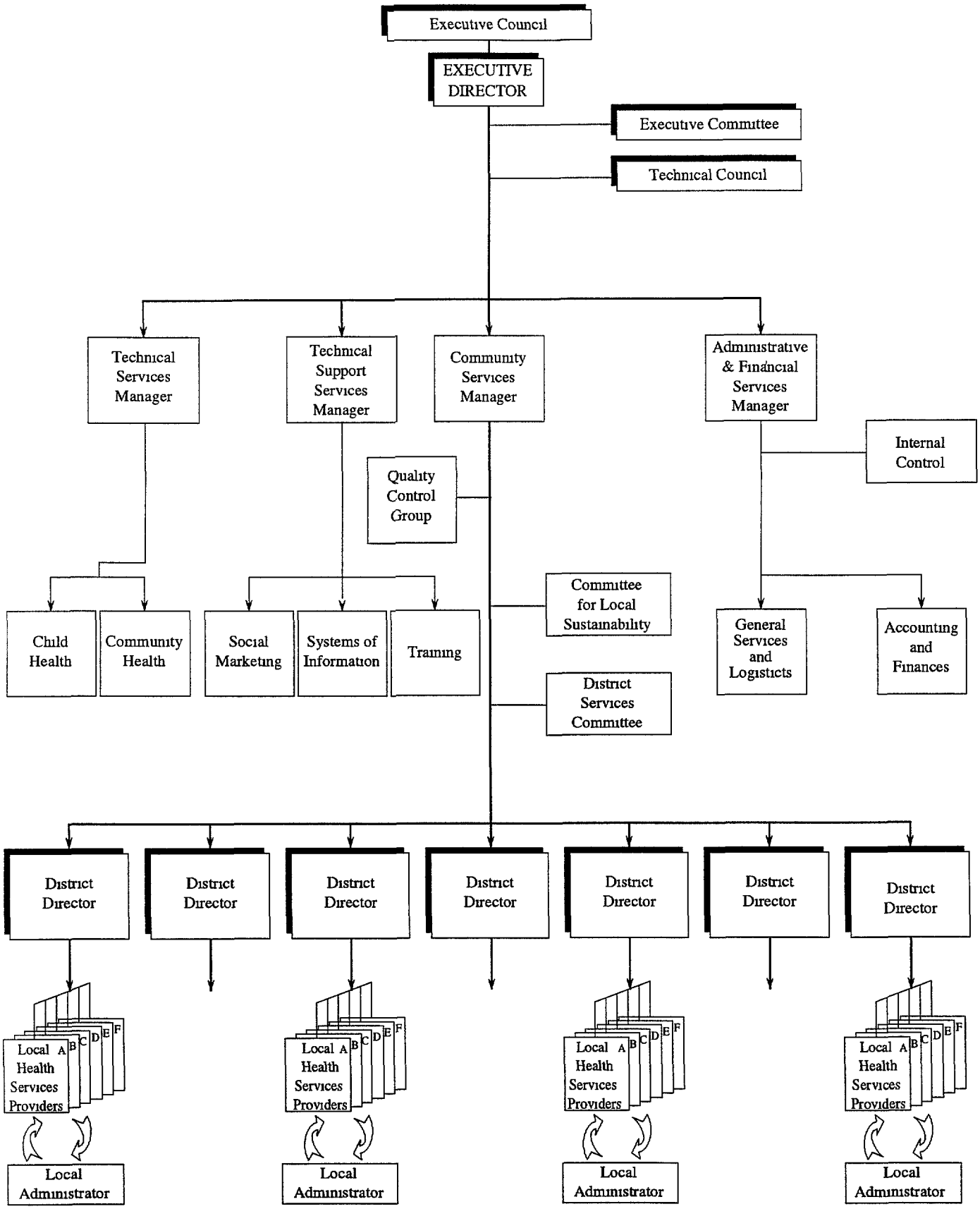
Under-Secretary of Health, the National Director of Mother and Child Health and the National Director of Planning and International Cooperation, a representative from the Ministry of Human Development, and a representative from the Executive Secretariat of PL-480 In addition, a representative from the USAID Health and Human Resources Office will participate as a full council member The Executive Council will provide policy guidelines to the Project It will oversee the competitive hiring and/or replacement of the top 5 senior-level positions in the Project The Council will discuss and decide on macro issues, and will provide policy orientation, leaving the responsibility of the actual Project implementation to the Project's Executive Director and team

The Project will be directed by an Executive Director in coordination with the National Director of Mother and Child Health and USAID's Project Manager The Executive Director is responsible to the NSH and to USAID for the management of the Project and for the submission of all financial and technical reports In addition to maintaining direct linkages with the NSH Director of Mother and Child Health, the Project Director will have strong operational linkages with the NSH Directorates of Medical Services, International Relations, Human Resources, and any others with jurisdictions related to Project activities

The Executive Director will have a Project financed staff which constitutes the Central Management Unit (see diagram above) The Project's Central Management Unit (CMU) will assume direct responsibility for Project outcomes and will support local implementation of Project activities through the DITES The Project's CMU, will also provide technical assistance to other USAID programs, such as the STD/AIDS Prevention and Control Project, in accordance with an agreed upon work plan

For the duration of the Project, the Project will fund a project coordinator and an administrative support person to assist in the preparation of Project related documents, studies and other activities within the Health and Human Resources Division of USAID Bolivia

CCH Project
ORGANIZATIONAL CHART 1995



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4.3 District or "DITES" Teams

As a result of decentralization, the District or "DITES" Teams will assume a number of responsibilities from the National Secretary of Health and the Project's Central Management Unit The "DITES" Teams will be composed of both NSH and Project personnel The teams will focus on an integrated package of services (Plan Vida), institutional development of the DITES, including of the network of health care providers, and, the mobilization of community demand for services The DITES-Teams, after start-up workshops, will prepare agreements with municipal governments to guarantee the provision of local resources for health, the most representative community groups to guarantee their participation in health care planning activities and different types of mobilization campaigns, and with a set of health care providers (at least 35% of all the local providers) to guarantee their association with the Project and their compliance with national norms and policies The Project will provide training and technical assistance to develop and strengthen technical, political, managerial and negotiating skills

Formal agreements between the DITES and different public, private and voluntary health care providers are the primary administrative mechanisms for achieving Project outcomes in the Districts They represent a partnership between the Project structure and individual or corporate professional groups of nurses and physicians, whereby physicians and nurses agree to provide health care under a uniform package of integrated services The services they provide will be subject to periodic assistance, control and supervision The Project, in turn will provide these groups with administrative, logistical, transportation, information, and financial systems, as well as with professional incentives, technical and managerial training, pharmaceuticals, and all the inputs necessary for the effective provision of health care services The Project will also assume two additional responsibilities 1) mobilization of community demand for health services, and 2) the deployment of a Project-funded administrator to each one of the municipal units or "UBAGES" (Basic Health Programming Unit) that are part of the partnership

The District Teams will have a dual role they will support the mobilization of community groups, health care education, social marketing, supervision, technical training, etc and they will promote partnerships with the public, private and voluntary health care providers (i e , the provision of supplies, protocols, supervision, information systems, etc)

The District Teams will assist, coordinate and monitor the performance of associated-providers, which will prepare uniform operational plans for each health care facility These teams will assist all health care providers to stimulate health care demand, and they will assume direct responsibility, along with selected associated health care providers, for assuring quality, access, sustainability and coverage

The basic DITES-Team will be constituted by

- One DITES Director, jointly selected by the NSH and CCH,
- One General Administrator, to be hired by CCH,
- One Educator or Communicator,
- One Secretary,
- One Coordinator of Health Services and Programs or Liaison Officer with the different health care providers, CCH funded,
- One Supervisory Nurse,
- One Statistician, responsible of the information system,
- One Driver, Messenger-Clerk

4.4 Decentralization and the Interaction between the Municipal Government and the NSH, a Road Map for Change.

In the case of the National Secretary of Health, there are two decentralized levels that require Project attention the Regional Secretaries and the "DITES" At the District level, the Project will have to address the interaction among central and regional levels of the NSH, and the emerging municipal health structures This is an area where further clarification of roles and responsibilities is needed because the roles of the NSH and the municipalities are still in flux at this point in the incipient decentralization process This will entail defining roles, responsibilities, legislation and regulations through case by case negotiation, mutual adjustment and conflict management

Therefore, the Project must develop the necessary skills to assist and/or mediate between both levels of government in the resolution of potential conflicts between local and regional structures Project activities, in each district, will be guided by the Sanitary Model for Decentralized Health care, developed by the National Directorate for Medical Services (DOSS) The model provides the required guidelines for implementing joint regional-local

activities (Annex C contains a detailed description of the Sanitary Model and supporting documentation)

The relationships between the national, regional and local levels will be clarified in the August 1995 Decentralization Law Once the Law is passed, the Project will conduct a series of workshops to develop the necessary institutional linkages that define the operational framework for the Project In the interim, the Project will develop a work plan and begin implementation through the CMU and DITES structures described above

4.5 Strategic and Implementation Plans.

The Project will initiate the planning process, in conjunction with national, regional and local authorities, through regional workshops Each DITES will develop a long-term or Project strategic plan and an Annual Operative Plan (AOP) mandated by the Popular Participation Law The operational planning cycle starts at the District level with the AOP which will be channelled through the Regional Secretary of Health for review and coordination Vigilance Committees have been established in each municipal government to oversee the compliance with priorities defined locally and expressed in each AOP

The Project's Central Office will prepare another annual Operative Plan (OP), which articulates the activities and expected outcomes during the year The Project's OP will include statistical annexes of services already provided and planned, as well as technical assistance and procurement plans, (see next Section), and detailed quarterly budgets for the planned activities

The Project's strategic plans at the DITES and at the CMU levels will follow a uniform format These strategic plans are Project specific documents that will be reviewed and up-dated annually to maintain focus on the long-term objectives of the Project and to respond to changes in the larger environment that encompasses the Community and Child Health Project

4.6 Institutional Assessment Capabilities for Host Country Procurement and Procurement Plan

The CCH Project underwent an institutional assessment and a procurement capacity certification between March and April 1995 Both assessments demonstrated that the Project is institutionally sound, and capable of conducting Host Country Procurement processes and channelling funds for the National Secretary of Health (See Annex E) However, the assessment team found out that CCH still has some weaknesses in its procurement system that should be strengthened and improved For that purpose the hiring of a logistics coordinator will be a major step as well as the training and certification of district administrators Despite these limitations the assessment team recommended the re-certification of the CCH Project as a Host Country Procurement Agent and as the direct implementator of its Procurement Plan (for a more detailed description of Project procurement actions, including estimated costs, procurement methods, proposed sources, and exceptions/waivers, see Annex E, Procurement Plan Table) Each year the CCH project should submit to USAID a report on the training and institutional development of procurement capacity at the district level

The CCH Procurement Plan is an extension of USAID procurement regulations It is the intent of this plan to insure the integrity of procurement and guarantee compatibility of CCH procedures with all current USAID procurement requirements While CCH will assume complete legal and fiscal responsibility for each procurement, it will seek the appropriate USAID Mission approvals when necessary Where no rule is directly specified, the Project will follow USAID procurement rules

During the course of the project, the CMU will delegate responsibility for small value procurement to the regional and district levels Petty cash purchases at the Central and "DITES" levels will be authorized up to a maximum of $150 All other purchases will require a fully documented process

The Project's procurement plan will be part of the overall Operational Plan, and it will include a training and institutional development component Future guidelines from the Decentralization Law, Popular Participation and other regulations that may affect country requirements for procurement will be included in the annual procurement plans

4 7 Technical Assistance.

* Data for Decision Making I (CDC) This is a Technical Assistance program, funded from 1992 to July 1998, which aims to improve data-informed public decision-making by health care policy-makers, the ability of program directors to use data effectively to influence higher-level policy decisions, and the epidemiologic, management and communications capabilities of key public health decision makers in Bolivia

* Data for Decision Making II (RTI/Harvard) This is a new phase of the DDM program which will improve the CCH Project's capacity to serve as a vehicle for policy dialogue with the National Secretary of Health Technical assistance provided under this contract will improve Go's and NGO's capacity to use data and data analysis to develop policies and to monitor policy impact

* BASICS The main objective of the BASICS Program is to support ongoing child survival interventions in areas that facilitate the re-organization and decentralization of health care services

* Reproductive Health Services Through a separate funding mechanism (AID 511-0568), the CCH Project will have access to more than 20 institutional contractors that provide technical assistance for reproductive health services

During the final phase of the Project (June 1995 - July 1998) CCH will contract the services of a National Long Term Advisor who will focus on policy planning and implementation, policy dialogue with the GOB, the coordination and streamlining of the technical assistance contractors, the development and implementation of institutional agreements and relationships, and advise on community mobilization strategies and activities Additional support to the National Secretary of Health, the Regional Secretaries of Health and Health Districts will be provided through several technical assistance contractors

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4.8. The Roles of USAID and PL-480

The PL-480 Executive Secretariat, in support of the Project, will periodically disburse counterpart funds, guarantee that counterpart funds are utilized properly, review Project books and accounting records, participate in meetings and discussions of the Project's Executive Council, participate in the periodic evaluations of the Project's activities

The USAID Project Officer and Project Committee will assume an active role both in planning and monitoring the implementation of the Project For example, direct participation in the prior review and approval of each annual work plan or one stage of work before work can begin on a subsequent stage, prior review and approval of substantive provisions of subordinate agreements or contracts, concurrence for staff appointments, monitoring to permit specified kinds of directions or re-directions of the work because of inter-relationships with other AID-financed Projects, and, joint participation in other aspects of implementation and evaluation activities

5 COST ESTIMATES AND FINANCIAL PLAN.

5 1 Methods of Implementation and Finance.

Funding for this Project will be obligated through a Bilateral Project Grant Agreement The main method of financing will be the periodic advance of funds (direct payment) In addition, technical assistance will be funded through buy-ins or OYB transfers to Global Bureau BASICS and Data for Decision Making Projects and with funds from the Mission's Reproductive Health Services Project to Global population projects

The following table shows cumulative and quarterly expenditures to date The graph below shows that the CCH Project expended around $1,000,000 per quarter to date That level of expenditure is expected to continue in order to attain the outcomes planned for the Project

5.2 Project Funding and Major Contributors

USAID/B and the PL-480 Executive Secretariat have been the major contributors for this Project They will continue to be the main sources of funding for the new phase of the Project New municipalities in the 11 DITES, however, will also contribute to financing activities under the Project

The Project has been implemented in four phases The objectives of the initial phase (from July 1988 to July 1990) were stated in the Project Paper and the funding was planned for $16 5 Millon (USAID), and $5 5 Million (PL-480) A second phase started in July 1990 with the addition of a Chagas Component and the increase in PL-480 funding to $8 0 Million In September 1992, Amendment No 9 defined a new phase that ended in April 1995 and entailed an increase in USAID Funding from $16 5 Million to $20 0 Million Through the current amendment, the fourth and final phase (1995-1998), re-establishes the decentralization objectives of the original Project Paper The budgets for each phase appear in the table below

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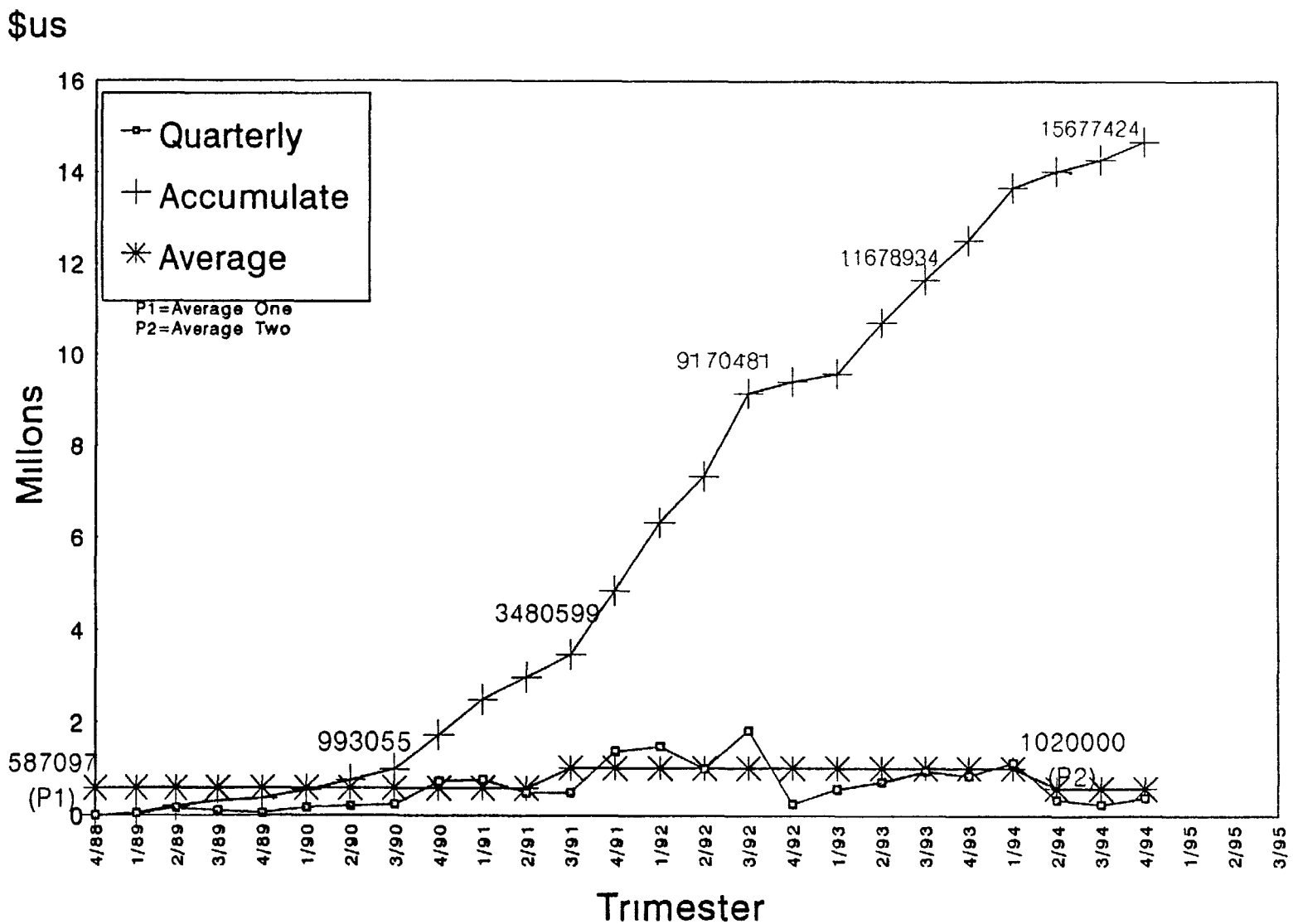
QUARTERLY EXPENDITURES
CCH Project
AID 07/88 -03/95



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TOTAL CUMULATIVE FUNDING 1988 - 1998
($000)

	1ST. PHASE 7/88-7/90	2ND. PHASE 7/90 - 9/92	3RD. PHASE 9/92 - 4/95	4TH. PHASE 5/95 - 7/98
USAID	16,500	16,500	20,000	26,000
PL-480	5,500	8,000	8,000	9,000
MUNICIPALITIES	0	0	0	2,200
TOTAL	**22,000**	**24,500**	**28,000**	**37,200**

ORIGINAL PROJECT BUDGET
(Project Paper July 1988)

	USAID	GOB	TOTAL
PERSONNEL	1,357	1,090	2,447
TECHNICAL MATERIALS AND SUPPLIES	2,816	778	3,594
MATERIALS AND SUPPLIES	4,954	712	5,666
OTHER COSTS	530	856	1,386
EQUIPMENT	3,490	0	3,490
BUILDINGS	0	88	88
TRAINING	327	1,146	1,473
HEALTH EDUCATION	1,160	0	1,160
RESEARCH & EVALUATION PRICE/QUANTITY	893	133	1,026
CONTINGENCIES	973	697	1,670
TOTAL	**16,500**	**5,500**	**22,000**

REVISED PROJECT BUDGET
CHANGING THE BUDGET ELEMENTS FROM 11 TO 3
(PROJECT IMPLEMENTATION LETTERS No 6 & 9, AUGUST 1989, APRIL 1990)

PROJECT ELEMENT	ORIGINAL PIL No. 6	A.I.D. REVISED PIL NO. 9	G.O.B.	TOTAL
I ORAL REHYDRATION				
A TECHNICAL ASSISTANCE	0	0	0	0
B TRAINING	0	0	0	0
C COMMODITIES	1,500,000	1,500,000	0	1,500,000
D OTHER COSTS	0	0	0	0
SUB TOTAL	1,500,000	1,500,000	0	1,500,000
II IMMUNIZATION				
A TECHNICAL ASSISTANCE	0	0	0	0
B TRAINING	500,000	400,000	300,000	700,000
C COMMODITIES	2,300,000	2,150,000	1,000,000	3,150,000
D OTHER COSTS	500,000	750,000	0	750,000
SUB TOTAL	3,300,000	3,300,000	1,300,000	4,600,000
III INTEGRATED CS				
A TECHNICAL ASSISTANCE	2,816,000	2,816,000	778,000	3,594
B TRAINING	327,000	327,000	1,146,000	1,473
C COMMODITIES	3,644,000	3,644,000	0	3,644
D OTHER COSTS	4,913,000	4,913,000	2,276,000	7,189
SUB TOTAL	11,700,000	11,700,000	4,200,000	15,900
TOTAL	**16,500,000**	**16,500,000**	**5,500,000**	**22,000,000**

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REVISED PROJECT BUDGET
CHANGING GOB CONTRIBUTION AND INTRODUCING CHAGAS AS FOURTH ELEMENT
(PROJECT AMENDMENT No. 5, JULY 1990)

PROJECT ELEMENT	CURRENT	A I D TRANSFER	REVISED	GOB	TOTAL
I ORAL REHYDRATION					
A TECHNICAL ASSISTANCE	0	0	0	0	0
B TRAINING	0	0	0	0	0
C COMMODITIES	1,500,000	-500,000	1,000,000	0	1,000,000
D OTHER COSTS	0	0	0	0	0
SUB TOTAL	1,500,000	-500,000	1,000,000	0	1,000,000
II IMMUNIZATION					
A TECHNICAL ASSISTANCE	0	0	0	0	0
B TRAINING	400,000	0	400,000	300,000	700,000
C COMMODITIES	2,150,000	0	2,150,000	1,000,000	3,150,000
D OTHER COSTS	750,000	0	750,000	0	750,000
SUB TOTAL	3,300,000	0	3,300,000	1,300,000	4,600,000
III INTEGRATED CS					
A TECHNICAL ASSISTANCE	2,816,000	0	2,816,000	778,000	3,594,000
B TRAINING	327,000	0	1,146,000	1,146,000	1,473,000
C COMMODITIES	3,644,000	0	[illegible]	0	3,644,000

PROJECT ELEMENT	CURRENT	A I D TRANSFER	REVISED	GOB	TOTAL
D OTHER COSTS	4,913,000	0	2,276,000	2,276,000	7,189,000
SUB TOTAL	11,700,000	11,700,000	4,200,000	4,200,000	15,900,000
IV CHAGAS' DISEASE					
A TECHNICAL ASSISTANCE	0	+400,000	400,000	340,000	740,000
A TRAINING	0	0	0	50,000	50,000
B COMMODITIES	0	+49,000	49,000	2,080,000	2,129,000
C OTHER COSTS	0	51,000	51,000	30,000	81,000
SUB TOTAL	0	+500,000	500,000	2,500,000	3,000,000
TOTAL	**16,500,000**	**0**	**16,500,000**	**8,000,000**	**24,500,000**

REVISED PROJECT BUDGET
INCREASING USAID AND CHANGING BUDGET ELEMENT FROM 4 TO 7
(PROJECT AMENDMENT No 9, SEPTEMBER 1992)

PROJECT ELEMENT	USAID LOP OBLIGATIONS	GOB LOP OBLIGATIONS	TOTAL LOP OBLIGATIONS
DIARRHEA AND CHOLERA CONTROL	1,000,000	0	1,000,000
IMMUNIZATIONS	5,800,000	1,300,000	7,100,000
DISTRICT DEVELOPMENT	8,300,000	4,200,000	12,500,000
CHAGAS	1,500,000	2,500,000	4,000,000
WATER & SANITATION	1,900,000	0	1,900,000
ADMINISTRATION	1,300,000	0	1,300,000
AUDITS AND EVALUATIONS	200,000	0	200,000
TOTAL	**20,000,000**	**8,000,000**	**28,000,000**

All the unexpended balances from USAID and PL-480 have been accounted for prior to beginning the fourth phase of the Project $4 39 Million of USAID funds and $1 95 from PL-480 are available for the fourth phase In addition, $6 0 million will be obligated from USAID's Child Survival Account $2 5 Million from the USAID's Reproductive Health Services Project will be available for technical assistance Another $1 0 Million will be available from PL-480 and municipalities included in the Project Districts or DITES will contribute $2 2 Million

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TOTAL USAID EXPENDITURES AS OF MARCH 31, 1995

PROJECT ELEMENT	1 AUTHORIZED TO DATE	2 OBLIGATED TO DATE	3 EXPENDED TO DATE	PIPELINE TO DATE (1-3)
ORAL REHYDRATION	1,450,000	1,450,000	707,486	742,514
IMMUNIZATIONS	5,000,000	4,538,000	3,812,490	1,187,510
INTEGRATED CS	8,300,000	8,099,700	7,397,927	902,073
CHAGAS	1,500,000	1,020,000	823,356	676,644
WATER & SANITATION	1,525,000	1,525,000	1,457,534	67,466
ADMINISTRATION	2,025,000	2,025,000	1,386,068	638,932
EVALUATIONS	100,000	40,000	0	100,000
AUDITS	100,000	39,000	28,000	72,000
TOTAL	**20,000,000**	**18,736,700**	**15,612,861**	**4,387,139**

TOTAL PL-480 EXPENDITURES AS OF MARCH 31, 1995

PROJECT ELEMENT	1 AUTHORIZED TO DATE	3 EXPENDED TO DATE	PIPELINE TO DATE (1-3)
ORAL REHYDRATION	0	0	0
IMMUNIZATIONS	1,300,000	797,276	502,724
INTEGRATED CS	4,200,000	3,240,274	959,726
CHAGAS	2,500,000	2,010,556	489,444
WATER & SANITATION	0	0	0
ADMINISTRATION	0	0	0
EVALUATIONS	0	0	0

PROJECT ELEMENT	1 AUTHORIZED TO DATE	3 EXPENDED TO DATE	PIPELINE TO DATE (1-3)
AUDITS	0	0	0
TOTAL	**8,000,000**	**6,048,106**	**1,951,894**

BALANCE OF FUNDS TO START THE NEW PROJECT PHASE (JUNE 1995 - JULY 1998)

PROJECT ELEMENT	USAID	PL-480	TOTAL
DIARRHEA AND CHOLERA CONTROL	742,514	0	742,514
IMMUNIZATIONS	1,187,510	502,724	1,690,234
DISTRICT DEVELOPMENT	902,073	959,726	1,861,799
CHAGAS	676,644	489,444	1,166 088
WATER & SANITATION	67,466	0	67,466
ADMINISTRATION	638,932	0	648,932
EVALUATIONS	100,000	0	100 000
AUDITS	72,000	0	72,000
TOTAL	**4,387,139**	**1,951,894**	**6,339,033**

FINANCIAL SUMMARY

- UNEXPENDED OBLIGATIONS PROJECT FUNDS			6,339,033	100%
- USAID	4,387,139	(69 2%)		
- PL-480	1,951,894	(30,8%)		
- NEW FUNDS TO OBLIGATE			8,500,000	72 7%
- USAID - CHILD SURVIVAL	6,000,000	(51,3%)		
- USAID - REP HEALTH	2,500,000	(21 4%)		
- NEW COUNTERPART FUNDS			3,200,000	27 3%
PL-480	1,000,000	(8,5%)		
MUNICIPALITIES	2,200,000	(18,8%)		
TOTAL FUNDS FOR NEW PHASE			**18,039,033**	

Old and new funds for the CCH Project amount to $26 Millon (plus an additional $2 5 available from Reproductive Health Services) in USAID funds, $9 0 Million from PL-480, and $2 2 Million from the municipal governments All these funds amount to a Grand Total of $39 7 Million over a period of ten years Most of the funds -during the previous phases- were used to strengthen the central programs such as Diarrheal Diseases/Cholera, and Immunizations, the construction of water systems and the pilot studies for Chagas Most of the remaining funds will support improvements in the quality of health for 650,000 people in rural districts

The following table shows the use of Project funds by participating institutions Project monitoring will include careful follow-up of the different functions to guarantee institutional development at all levels

FINANCIAL SUMMARY
(OLD PLUS NEW FUNDS)
6/1/95-7/30/98

ELEMENT	USAID (PLUS RHS)	PL-480	MUNICI-PALITIES	TOTAL	%
NATIONAL SECRETARY OF HEALTH				2,470	13 7%
- Strengthening of Central Programs	1,270	1,150	0	2,420	
- Decentralized Health Services	0	0	0	0	
- Central Office Support	0	0	0	0	
- Evaluations	50	0	0	50	
- Audits	0	0	0	0	
REGIONAL SECRETARIES OF HEALTH				1,700	9 4%
- Strengthening of Central Programs	0	0	0	0	
- Decentralized Health Services	1,342	308	0	1,650	
- Central Office Support	0	0	0	0	
- Evaluations	50	0	0	50	
- Audits					
DISTRICTS (DITES)				9,429	52 3%
- Strengthening of Central Programs	130	100	0	230	
- Decentralized Health Services	6,345	469	2,200	9,014	
- Central Office Support	0	0	0	0	
- Evaluations	50	0	0	50	
- Audits	135	0	0	135	
PROJECTS CENTRAL OFFICE				4,440	24,6%
- Strengthening of Central Programs	250	0	0	250	
- Decentralized Health Services	0	300	0	300	

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ELEMENT	USAID (PLUS RHS)	PL-480	MUNICI-PALITIES	TOTAL	%
- Central Office Support	3,100	625	0	3,725	
- Evaluations	50	0	0	50	
- Audits	115	0	0	115	
TOTAL	**12,887**	**2,952**	**2,200**	**18,039**	**100%**

PROJECT BUDGET BY ACCOUNTS
USAID FUNDS

PROJECT ELEMENT	DIRECT ACCOUNT FX	SPECIAL ACCOUNT (CC)	TOTAL FUNDS
- Strengthening of Central Programs	1,400	250	1,650
- Decentralized Health Services	0	*7,687	7,687
- Central Office Support	**450	2,650	3,100
- Evaluations	90	110	200
- Audits	0	250	250
TOTAL	**1,940**	**10,947**	**12,887**

* At the present time the Project anticipates that all the support to Central Programs (Immunizations, Diarrheal Diseases, Respiratory Infections, etc) will be funded through the special account If in the future there are activities, that demand of US Dollar payments, those funds will be transferred from the special account to the Direct Account through a Project Implementation Letter (PIL)

** A Project Manager and an Administrative Assistant to work in USAID in support of Project activities, and miscellaneous costs that are Project related will be funded through the Direct Account

A fourth contributor to the Project is the National Secretary of Health which will pay

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for the salaries of a portion of the existing health personnel in Project districts The budget does not include a formal accounting of NSH contributions Similarly, user fees for health services are not included in the Project budget but will be accounted for by the District teams and by Project administrators deployed in individual health care facilities within the Project area These funds will be budgeted in each Annual Operative Plan (AOPs)

5.3 Summary Budget and Disbursement Schedule.

As mentioned previously (section 3 3), approximately 50% of the combined USAID and PL-480 new and remaining resources, including the municipal contributions, will go to the 11 Territorial Units (DITES), 15% will go to the strengthening of the National Secretary of Health in its new role, 10% to the Regional Secretaries of La Paz, Cochabamba and Santa Cruz and no more than the 25% of the Project's resources will be assigned to the Central Support Unit This distribution ensures that, through Technical Assistance, Training, Social Marketing, Audits, Evaluations, etc , each level of the NSH will receive proportional benefits from the Project's resources and activities

A 25% cap on expenditures for the Central Management Unit has been imposed to prevent a centralized concentration of Project resources as had occurred during earlier phases of the Project The Project has devised a strategy to bring salaries in line with other USAID Child Survival Projects so as to limit costs in the Central Management Unit

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FINAL PHASE
COMMUNITY AND CHILD HEALTH Project, AID 511-0594
JUNE 1995
(IN THOUSANDS $)

	EXISTING FUNDS (As of 03/31/95)		NEW FUNDS (As of 4/1/95 - 7/30/98)				
	USAID	PL-480	USAID CHILD SURVIVAL FUNDS	USAID REPRODUCTIVE HEALTH FUNDS	PL-480	LOCAL GOVERNMENT	TOTAL
1 Strengthening Central Programs	500	600	900	250	650	0	2,900
2 Decentralized Health Services	2,987	727	3,250	1,450	350	2,200	10,964
3 Central Office Support	750	625	1,600	750	0	0	3,725
4 Evaluations	150	0	0	50	0	0	200
5 Audits	0	0	250	0	0	0	250
TOTAL	**4,387**	**1,952**	**6,000**	**2,500**	**1,000**	**2,200**	**18,039**

Municipal governments will assign resources to the Project on a yearly basis, responding to Annual Operative Plans (AOPs) The PL-480 funds will be disbursed on a quarterly basis, responding to a Three-Year Implementation Plan Disbursement of USAID funds will be monthly, based on quarterly requirements and supported by approved Annual Operational Plans (OPs)

The disbursement schedule for the Project is the following

DISBURSEMENT SCHEDULE
OF USAID FUNDS
(JUNE 1995- JULY 1998)

QUARTER FY	ANTICIPATED QUARTERLY ADVANCES	CUMULATIVE DISBURSEMENTS	ANTICIPATED CUMULATIVE EXPENDITURES	OBLIGATION SCHEDULE	CUMULATIVE OBLIGATIONS	(PIPELINE)
3QTR 1995	1,000	1,000	-	3,124 (Current Pipeline)	3,124	2,124
4QTR 1995	1,250	2,250	-	-	-	874
1QTR 1996	1,250	3,500	3,124	2,000	5,124	1,624
2QTR 1996	1,250	4,750	4,020	-	-	374
3QTR 1996	1,250	6,000	-	2,500(*)	7,629	1,624
4QTR 1996	1,100	7,100	-	-	-	524
1QTR 1997	1,100	8,200	7,740	2,000	9,624	1,424
2QTR 1997	1,100	9,300	-	-	-	324
3QTR 1997	977	10,277	-	2,000	11,624	1,347
4QTR 1997	900	11,177	-	-	-	447
1QTR 1998	700	11,877	11,350	1,253	12,877	1,000
2QTR 1998	500	12,377	-	-	-	500
3QTR 1998	500	12,877	12,877	-	-	0

(*) Transfer from Reproductive Health Care funds

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6. MONITORING, AUDITS AND EVALUATION.

6 1 Monitoring

The monitoring of the Project activities at the DITES and CMU level will be carried out by the NSH In addition, USAID/B will conduct independent Project monitoring activities Internal Project monitoring will be conducted by the Project's Central Management Unit and by a Quality Control Group (see organigram) responsible for maintaining partnerships with different health care providers Due to the difficulty of monitoring 11 rural Districts in three different Departments, the Quality Control Group will have two senior physicians per region to coordinate monitoring activities at the district level They will provide assistance within the Regional Secretaries of Health In addition, an Administrator and a Statistician or Information Specialist will work with the Regional Secretaries of Health to operate information systems

The Project's Unit for Technical Support Services (See diagram in page 27a) and the USAID Project Manager will ensure that the necessary monitoring systems are operative at the Central, Regional and Local levels They will also be responsible for establishing baseline values and setting targets Technical assistance from the Data For Decision Making Project will help to the design, operate and link different levels and components of the monitoring system The monitoring system, will provide monthly national, regional and DITES reports

Although USAID/B will have open access to monitoring data, the Project Director will report quarterly to USAID/B on the status of Project indicators (See Logical framework) in the standard format of Semi-Annual Reports (SARs) or any new report that replaces SARs

6.2 Assessments and Evaluations.

The Project will conduct annual internal performance assessments and external evaluations to review and address management and process issues The annual assessments will be conducted in coordination with the NSH and will be part of the annual planning process The number and timing of external evaluations will be determined by the USAID

project manager Evaluations will assess progress made on increasing access, coverage, quality and sustainability of services

The managed care perspective of the CCH (packaging of the supply and mobilization of the demand) is an innovative approach for providing health services in rural areas If successful, it could become a model for future Andean rural health care Projects Consequently external evaluations will examine costs and benefits relative to other models of rural health care service delivery In addition, with the shift to a client-oriented Project, the final evaluation of the Community and Child Project should assess changes in health status and behavior of community members

6.3 Audits.

The CCH Project and contractors, components, and Districts receiving more than $100,000 per year will be subject to annual audits Audits will be contracted by the CCH in strict adherence to the USAID guidelines for financial audits and in compliance with applicable policies and regulations as issued by the Inspector General's Office for Latin America (RIG/SJ)

To cover the costs involved in conducting these external audits, the Project budget has a separate line item solely for audit purposes which will be administered by the CCH Project Management Unit with oversight by USAID/Bolivia Comptroller's Office

7. REPORTS.

Each one of the DITES will prepare a concise monthly services report to be reviewed by the CMU The Project Executive Director will be responsible for providing quarterly reports to USAID and PL-480 on Project indicators, advances, problems encountered and future activities, in the format of USAID's Semi Annual Reports (SARs) The Project Director will also provide monthly financial reports in accordance with new disbursement procedures Institutional contractors will submit reports through the CCH Project Executive Director as stipulated in their contracts

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ATTACHMENTS

A DETAILED BUDGET CALCULATIONS

(20 pages)

PROYECTO SALUD INFANTIL Y COMUNITARIA
AID 511-0594

CONSOLIDADO
FONDOS AID
CUENTA ESPECIAL
PRESUPUESTO 1995-1998
(EN MILES $US)

DETALLE	GESTIONES 1995 ENE-DIC	1996 ENE-DIC	1997 ENE-DIC	1998 ENE-DIC	TOTAL
2 - FORTALECIMENTO PROGS CENTRALES	1 176	820	590	314	2,900
3 - SIST DE SERVICIOS DE SALUD	3 556	3 375	3 119	914	10 964
6 - OFICINA CENTRAL	1 010	992	1 094	629	3 725
8 - EVALUACION		100	60	40	200
9 - AUDITORIAS	45	75	75	55	250
TOTAL	5 787	5 362	4 938	1 952	18 039

ESTRUCTURA PRESUPUESTO

1 - FONDOS USAID	$US 12.887
2.- SECRETARIA EJECUTIVA PL-480	$US. 2.952
3 - MUNICIPIOS DITES C C H	$US 2 200
TOTAL	$US 18 039

PROYECTO DE SALUD INFANTIL Y COMUNITARIA
DISTRIBUCION DE RECURSOS
POR AREA OPERACIONAL
(EN MILES $US)

2.- FORTALECIMIENTO PROGRAMAS CENTRALES S.N.S. S.R.S $US 2.900

ASISTENCIA TECNICA $US 790

A) INTERNACIONAL $US 790 CUENTA DIRECTA
B) NACIONAL $US 0 CUENTA ESPECIAL

BIENES $US 1.450

$US 1.450 CUENTA ESPECIAL

OTROS COSTOS $US. 1.060

$US 1.060 CUENTA ESPECIAL

3 - SISTEMAS DE SERVICIOS DE SALUD $US. 10.964

DESARROLLO 11 DIRECCIONES TERRITORIALES DE SALUD

ASISTENCIA TECNICA $US 1.000

A) INTERNACIONAL $US 890 CUENTA DIRECTA
B) NACIONAL $US 110 CUENTA ESPECIAL

CAPACITACION Y FORTALECIMIENTO GERENCIAL $US 1.375

$US 280 CUENTA DIRECTA
$US 1.180 CUENTA ESPECIAL

BIENES $US 1.250

$US 1.250 CUENTA ESPECIAL

OTROS COSTOS $US. 7.389

$US 7.389 CUENTA ESPECIAL

6.- ADMINISTRACION $US. 3.725

$US 165 CUENTA DIRECTA
$US 3.560 CUENTA ESPECIAL

PROYECTO DE SALUD INFANTIL Y COMUNITARIA
DISTRIBUCION DE FONDOS
POR AREA GEOGRAFICA
(EN MILES $US.)

8.- EVALUACION			$US.	200
	$US	200	CUENTA DIRECTA	
	$US	100	CUENTA ESPECIAL	
9 - AUDITORIA			$US.	250
	$US	250	CUENTA ESPECIAL	
			TOTAL $US.	18.039

PROYECTO DE SALUD INFANTIL Y COMUNITARIA
DISTRIBUCION DE RECURSOS
(EN MILES US $)

2 - FORTALECIMIENTO PROGRAMAS CENTRALES				$US. 2 900
A - ASISTENCIA TECNICA			$US 250	
A 1) INTERNACIONAL		$US 100		
D.O.M. HALVARD	$US	100		
BASICS	$US	140		
A 2) NACIONAL		$US 150		
NIVEL NACIONAL	$US	150		
C - BIENES			$US 1 450	
APOYO AL P.A.I		$US. 700		
EDA/COLERA		$US 150		
MONIT & CONTROL 5 AÑOS		$US 200		
I.P.A		$US 100		
NUTRICION		$US. 250		
SIST. INFORM. & COMUN		$US 50		
D.- OTROS COSTOS			$US. 1 060	
APOYO AL P.A.I		$US 390		
EDA/COLERA		$US 210		
MONIT & CONTROL 5 AÑOS		$US. 50		
I.P.A		$US. 50		
NUTRICION		$US 100		
SIST. INFORM & COMUN.		$US. 50		
APOYO S.N.S. S.P.S		$US 210		

PROYECTO DE SALUD INFANTIL Y COMUNITARIA
DISTRIBUCION DE RECURSOS
(EN MILES $US)

3 - SISTEMAS DE SERVICIOS DE SALUD			$US 10.964
A - ASISTENCIA TECNICA			$US 1.000
A 1) INTERNACIONAL		$US 890	
D.D.M. HARVARD	$US	200	
BASILS	$US.	260	
SALUD REPRODUCTIVA	$US	180	
OPS/ SALUD	$US	250	
A 2) NACIONAL		$US 110	
NIVEL REGIONAL	$US	110	
B CAPACITACION-FORTALECIMIENTO GERENCIAL			$US 1.375
B 1) CAPACITACION SERVICIOS		$US. 120	
CAPACITACION SERVICIOS	$US.	70	
BECAS MEDICOS F.E.U.U.	$US	30	
OTRAS ACTIVIDADES EDUC.	$US	10	
BECAS TEP S.N.S. S.F.S.	$US	10	
B 2) CURSO D.D.M./C.D.C.		$US 250	
ALTA GERENCIA	$US	100	
EQUIPO DE CONDUCCION	$US	100	
CAPACIT. GERENCIA SOCIAL	$US	50	
B 3) CAPACITACION DISTRITOS		$US. 725	
CAPACITACION SERVICIOS	$US	100	
CAPACITACION DISTRITOS	$US.	320	
BECAS MEDICOS E.E.U.U.	$US	115	
OTRAS ACTIVIDADES EDUC.	$US	30	
MOVILIZACION COMUNIDAD	$US	100	
BECAS EN ESCUELAS DE S.F.	$US	60	
B 4) EDUCACION EN SALUD		$US 230	
EDUCACION EN SALUD + ORGANIZACION COMUNITARIA	$US	180	
MATERIAL EDUCATIVO	$US.	50	

PROYECTO DE SALUD INFANTIL Y COMUNITARIA
DISTRIBUCION DE RECURSOS
(EN MILES $US)

C BIENES			$US. 1 250
EQUIPAMIENTO		$US 1 150	
EQUIPO Y INFRAESTR	$US	1 100	
SIST AFONIA	$US	100	
SISTEMAS DE COMPUTACION	$US	50	
D - OTROS COSTOS			$US 7 [illegible]
D 1) DESARROLLO DE SERV		$US 6 277	
SALUD MATERNA	$US	960	
SALUD INFANTIL	$US	960	
SALUD COMUNITARIA	$US	960	
SISTEMAS DE APOYO	$US	2 197	
GRUPO DE TRANSICION	$US	800	
CONTRATOS ONG S	$US	450	
D 2) MERCADEO SOCIAL		$US 762	
PRODUCTOS Y SISTLOGISTICOS	$US	500	
MERCADEO SOCIAL	$US	262	
D 3) SISTEMAS DE INFORMACION Y MONITOREO		$US 400	
SISTEMAS DE INFORMACION	$US	160	
MONITOREO	$US	240	

PROYECTO DE SALUD INFANTIL Y COMUNITARIA
DISTRIBUCION DE RECURSOS
(EN MILES $US)

6 - OFICINA CENTRAL				**$US. 3 725**
A - ASISTENCIA TECNICA			$US 60	
A.1) NACIONAL		$US 60		
OFIC. CENTRAL	$US 60			
D - OTROS COSTOS			$US 3 665	
D 1) COSTOS ADMINIST. (CUENTA DIRECTA)		$US 165		
D 1.1) PERSONAL		$US 1 751		
SUELDOS PERS. O.C.	$US 1 439			
APORTES S.S.	$US 312			
D 1.2) OPERACIONES		$US 748		
ALQUILERES LPZ	$US. 236			
MANTENIMIENTO OFICINAS	$US 42			
MANTENIMIENTO VEHICULOS	$US 42			
SEGUROS	$US 50			
COMUNICACIONES	$US 44			
PASAJES	$US. 123			
VIATICOS	$US. 186			
SERV. AGUA LUZ TELF.	$US. 25			

PROYECTO DE SALUD INFANTIL Y COMUNITARIA
DISTRIBUCION DE RECURSOS
(EN MILES $US.)

8.- EVALUACIONES			**$US. 200**
A - ASISTENCIA TECNICA		$US 200	
EVAL. EXTERNA INTERNAC	$US	70	
EVAL. INTERNA NACIONAL	$US	60	
ESTUDIOS DE IMPACTO	$US	50	
9.- AUDITORIAS			**$US. 250**
D - OTROS COSTOS		$US 250	
EVAL. FINAN OFICINA CENTRAL	$US.	45	
EVAL. FINAN. 11 DISTS	$US.	155	

PROYECTO SALUD INFANTIL / COMUNITARIA
AID 511-0594

FONDOS AID
CUENTA DIRECTA
PRESUPUESTO 1995-1998
(EN MILES $US)

DETALLE	GESTIONES 1995 ENE-DIC	1996 ENE-DIC	1997 ENE-DIC	1998 ENE-JUL	TOTAL
I - FORTALECIMIENTO PROGRAMAS CENTRALES DE SALUD					
A - ASISTENCIA TECNICA					
A 1) INTERNACIONAL					
A 1 1) D D M HARVARD	100				100
A 1 2) BASICS	140				140
SUB TOTAL	240				240

FONDOS AID
CUENTA ESPECIAL

A 2) NACIONAL					
A 2 1) NIVEL NACIONAL					
ASESOR D E L P	36	50	50	14	150
SUB TOTAL	36	50	50	14	150

PROYECTO SALUD INFANTIL Y COMUNITARIA
AID 511-0594

FONDOS AID
CUENTA ESPECIAL
PRESUPUESTO 1995-1998
(EN MILES $US)

DETALLE	GESTIONES 1995 ENE-DIC	1996 ENE-DIC	1997 ENE-DIC	1998 ENE-JUL	TOTAL
A - FORTALECIMIENTO PROGRAMAS CENTRALES DE SALUD					
C - BIENES					
C 1) APOYO AL P A I	250	250	100	100	700
C 2) EDA/COLERA	30	70	50		150
C 3) MONIT & CONTROL < 5 AÑOS	50	50	50	50	200
C 4) I R A	30	30	20	20	100
C 5) NUTRICION	100	50	50	50	250
C 6) SIST INFORM & COMUN	50				50
SUB TOTAL	510	450	270	220	1 450
D - OTROS COSTOS					
D 1) APOYO AL P A I	130	130	90	40	390
D 2) PROM SOBRE DE LA VIDA	50				50
D 3) EDA/COLERA	20	70	70		160
D 4) MONIT & CONTROL < 5 AÑOS	20	10	10	10	50
D 5) I R A	20	10	10	10	50
D 6) NUTRICION	30	30	20	20	100
D 7) SIST INFORM & COMUN	50				50
D 8) APOYO S N S S P S	70	70	70		210
SUB TOTAL	390	320	270	80	1 060
TOTAL	1 176	820	590	314	2 900

PROYECTO SALUD INFANTIL Y COMUNITARIA
AID 511-0594

FONDOS AID
CUENTA DIRECTA
PRESUPUESTO 1995-1998
(EN MILES $US)

DETALLE	GESTIONES 1995 ENE-DIC	1996 ENE-DIC	1997 ENE-DIC	1998 ENE-JUL	TOTAL
C - SISTEMAS DE SERVICIOS DE SALUD					
A - ASISTENCIA TECNICA					
A 1) INTERNACIONAL					
A 1 1) E D M HARVARD	200				200
A 1 2) BASICS	260				260
A 1 3) SALUD REPRODUCTIVA	50	70	60		180
A 1 4) SERV DE SALUD	50	100	100		250
SUB TOTAL	560	170	160		890

FONDOS AID
CUENTA ESPECIAL

A - ASISTENCIA TECNICA					
A 2) NACIONAL					
A 2 1) NIVEL REGIONAL	40	40	30		110
SUB TOTAL	40	40	30		110

PROYECTO SALUD INFANTIL Y COMUNITARIA
AID 511-0594

FONDOS AID
CUENTA DIRECTA
PRESUPUESTO 1995-1998
(EN MILES $US)

DETALLE	GESTIONES 1995 ENE-DIC	1996 ENE-DIC	1997 ENE-DIC	1998 ENE-JUL	TOTAL
B - CAPACITACION Y FORT GERENCIAL					
B 1) INTERNACIONAL					
B 1 1) CAPACITACION SERVICIOS					
BECAS MEDICOS EN E E U U	15	15			30
B 1 2) CAPACITACION DISTRITOS					
BECAS PER DITES EN E E U U	25	40	50		115
SUB TOTAL	40	55	50		145
FONDOS AID CUENTA ESPECIAL					
B 2) CAPACITACION SERVICIOS					
B 2 1) CAPACITACION SERVICIOS	25	25	20		70
B 2 2) OTROS ACTV EDUCATIVAS	5	5			10
B 2 3) BECAS PER S N S S P S	5	5			10
SUB TOTAL	35	35	20		90
B 3) CURSO D D M/C D C					
B 3 1) ALTA GERENCIA DDM/CDC	58	42			100
B 3 2) EQUIPO CONDUCCION	55	45			100
B 3 3) CAP GEREN SOCIAL	37	13			50
SUB TOTAL	150	100			250

PROYECTO SALUD INFANTIL Y COMUNITARIA
AID 511-0594

FONDOS BID
CUENTA ESPECIAL
PRESUPUESTO 1995-1998
(EN MILES $US)

DETALLE	GESTIONES 1995 ENE-DIC	1996 ENE-DIC	1997 ENE-DIC	1998 ENE-JUL	TOTAL
B - CAPACITACION Y FORT GERENCIAL					
B 4) CAPACITACION DISTRITOS					
B 4 1) CAPACITACION SERVICIOS	40	30	30		100
B 4 2) CAPACITACION DISTRITOS	120	100	100		320
B 4 3) OTROS ACTV EDUC ADM	20	10			30
B 4 4) MOVILIZACION COMUNIDAD	40	30	30		100
B 4 5) BECAS EN ESCUELAS DE S P	20	20	20		60
SUB TOTAL	240	190	180		610
B 5) EDUCACION EN SALUD + B 5 1) ORGANIZ COMUNITARIA	90	50	40		180
B 5 2) MATERIAL EDUCATIVO	10	25	15		50
SUB TOTAL	100	75	55		230

PROYECTO SALUD INFANTIL Y COMUNITARIA
AID 511-0594

FONDOS AID
CUENTA ESPECIAL
PRESUPUESTO 1995-1998
(EN MILES $US)

DETALLE	GESTIONES 1995 ENE-DIC	1996 ENE-DIC	1997 ENE-DIC	1998 ENE-JUL	TOTAL
B - SISTEMAS DE SERVICIOS DE SALUD					
C - BIENES					
C 1) EQUIPO & INFRAESTR	550	250	250		1 050
C 2) 2 SISTEMAS A&S CAPINOTA	50	30	20		100
C 3) SISTEMAS DE COMPUTACION	50				50
C 4) MAT SISTEMA AGUA SEGURA	50				50
SUB TOTAL	700	280	270		1 250
D - OTROS COSTOS					
DESARROLLO DE SERVICIOS					
D 1) SALUD MATERNA	180	300	300	180	960
D 2) SALUD INFANTIL	180	300	300	180	960
D 3) SALUD COMUNITARIA	180	300	300	180	960
D 6) SISTEMAS DE APOYO(*)	578	650	650	319	2 197
D 7) GRUPO DE FRANQUICIA	250	250	300		800
D 8) CONTRATOS ONG S	96	150	104		350
SUB TOTAL	1 464	1 950	1 954	859	6 227

PROYECTO SALUD INFANTIL Y COMUNITARIA
AID 511-0594

FONDOS AID
CUENTA ESPECIAL
PRESUPUESTO 1995-1998
(EN MILES $US)

DETALLE	GESTIONES 1995 ENE-DIC	1996 ENE-DIC	1997 ENE-DIC	1998 ENE-JUL	TOTAL
SISTEMAS DE APOYO(1)					
D 6 1) DITES A " S 152 000 HAB	100	70	70	60	300
D 6 2) DITES CAPINOTA 42 673 HAB	60	35	35	22	152
D 6 3) DITES VALLE PUNA 64 505 HAB	60	50	50	20	180
D 6 4) DITES CHAPARECO VALLE 62 375 HAB	50	45	45	38	178
D 6 5) DITES VALLES CRUCEÑOS 68 269 HAB	60	50	50	30	190
D 6 6) DITES CHIQUITANIA SUD 67 945 HAB	80	70	70	24	244
D 6 7) DITES CHIQUITANIA CENTRO 42 929 HAB	40	30	30	22	122
D 6 8) DITES LOS ANDES-M YAPAC 82 759 HAB	26	90	90	30	236
D 6 9) DITES NOR Y SUD YUNGAS 59 720 HAB	30	60	60	20	170
D 6 10) DITES CHAPARE TROPICAL 90 000 HAB	42	90	90	28	250
D 6 11) DITES CHIQUITANIA NORTE 61 008 HAB	30	60	60	25	175
SUB TOTAL	578	650	650	334	2 197

TOTAL 794 183 HAB

PROYECTO SALUD INFANTIL Y COMUNITARIA
AID 511-0594

FONDOS AID
CUENTA ESPECIAL
PRESUPUESTO 1995-1998
(EN MILES $US)

DETALLE	GESTIONES 1995 ENE-DIC	1996 ENE-DIC	1997 ENE-DIC	1998 ENE-JUL	TOTAL
7 - SISTEMAS DE SERVICIOS DE SALUD					
D 4) MERCADEO SOCIAL-PROD Y SIST LOGISTICOS					
D 4 1) PRODUCTOS Y SIST LOG		300	200		500
D 4 2) MERCADEO SOCIAL	142	50	70		262
SUB TOTAL	142	350	270		762
D 5) SISTEMAS DE INFORMACION Y MONITOREO					
D 5 1) SISTEMAS DE INFORMACION	80	40	40		160
D 5 2) MONITOREO	5	90	90	55	240
SUB TOTAL	85	130	130	55	400
TOTAL	3 556	3 375	3 119	914	10 964

PROYECTO SALUD INFANTIL Y COMUNITARIA
AID 511-0594

FONDOS PTI
CUENTA ESPECIAL
PRESUPUESTO 1995-1998
(EN MILES $US)

DETALLE	GESTIONES 1995 ENE-DIC	1996 ENE-DIC	1997 ENE-DIC	1998 ENE-JUL	TOTAL
B - SOPORTE OFICINA CENTRAL					
A - ASISTENCIA TECNICA					
A 1) NACIONAL					
A 1 1) OFIC CENTRAL	20	20	20		60
SUB TOTAL	20	20	20		60
C - BIENES					
C 1) BIENES & MAT OFICINA	30	15	15		60
SUB TOTAL	30	15	15		60

CUENTA DIRECTA
PRESUPUESTO 1995-1998
(EN MILES $US)

D - OTROS COSTOS					
D 1) GASTOS ADM USAID	95	30	20	20	165
SUB TOTAL	95	30	20	20	165

FONDOS AID
CUENTA ESPECIAL

D 2) PERSONAL & OPERACIONES	865	927	1 039	609	3 440
SUB TOTAL	865	927	1 039	609	3 440
TOTAL	1 010	992	1 094	629	3 725

PROYECTO SALUD INFANTIL Y COMUNITARIA
AID 511-0594

FONDOS AID
PRESUPUESTO 1995-1998
DETALLE
(EN MILES $US)

DETALLE	GESTIONES 1995 ENE-DIC	1996 ENE-DIC	1997 ENE-DIC	1998 ENE-JUL	TOTAL
D 2) PERSONAL & OPERACIONES					
D 2 1) Sueldos Pers O C	575	644	764	456	2 439
D 2 2) Aportes S S	80	88	95	50	313
D 2 3) Alquileres LPZ CBA SCZ	67	67	67	35	236
D 2 4) Mantenimiento Oficinas	12	12	12	6	42
D 2 5) Mantenimiento Vehiculos	12	12	12	6	42
D 2 6) Seguros	15	15	15	5	50
D 2 7) Comunicaciones	12	12	12	8	44
D 2 8) Pasajes	35	30	20	13	98
D 2 9) Viaticos	50	40	35	26	151
D 2 10 Serv agua luz telf	7	7	7	4	25
SUB TOTAL	865	927	1 039	609	3 440

PROYECTO SALUD INFANTIL Y COMUNITARIA
AID 511-0594

FONDOS AID
CUENTA DIRECTA
PRESUPUESTO 1995-1998
(EN MILES $US

DETALLE	GESTIONES 1995 ENE-DIC	1996 ENE-DIC	1997 ENE-DIC	1998 ENE-JUL	TOTAL
B - EVALUACIONES					
A - ASISTENCIA TECNICA					
A 1) INTERNACIONAL		30	30	30	90
SUB TOTAL		30	30	30	90
		FONDOS AID CUENTA ESPECIAL			
NACIONAL					
A 2) NACIONAL		15	15	30	60
A 3) IMPACTO REGIONAL		20	20	10	50
SUB TOTAL		35	35	40	110
TOTAL		65	65	70	200

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PROYECTO SALUD INFANTIL Y COMUNITARIA
AID 511-0594

FONDOS AID
CUENTA ESPECIAL
PRESUPUESTO 1995-1998
(EN MILES $US)

DETALLE	GESTIONES 1995 ENE-DIC	1996 ENE-DIC	1997 ENE-DIC	1998 ENE-JUL	TOTAL
9 - AUDITORIAS					
D - OTROS COSTOS					
D 1) OFICINA CENTRAL	45	20	20	10	95
D 2) 11 DITES		55	55	45	155
TOTAL	45	75	75	55	250

ATTACHMENTS

B. LOGICAL FRAMEWORK FOR THE PROJECT'S NEW PHASE

(5 pages)

LOGICAL FRAMEWORK
REVISED COMMUNITY AND CHILD PROJECT, AID 511-0594
AS AMENDED IN 1995

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
GOAL			
To improve family health throughout Bolivia	Reduce infant, child and maternal mortality by 50% in the next 4 years (Plan Vida, National Secretary of Health)	Demographic Health Survey National accounts and statistics	Political stability will continue The National Plan for the Accelerated Reduction of Maternal, Infant and Child Mortality will have continuity and resources as planned
PURPOSE			
To improve the access, coverage, quality and sustainability of an integrated package of essential Community and Child Health interventions and mobilize the demand for these services in selected rural area	1 Increased Geographic, economic, and cultural access of men, women, and children to health services of the population of 11 rural districts, by July 1997[1] 2 85% of the total catchment population (desegregated by gender/age) using health care services based on plan vida in 11 rural districts	-Records of 3 Regional Secretaries of Health -Project quarterly reports -Project evaluations -Records of 3 Regional Secretaries of Health	The guidelines for Popular Participation and the contributions of the municipal governments will improve the funding and management of health care services The National Secretary of Health and the municipal governments will devise schemes for the joint funding and provision of health services

[1] *Purpose indicators of access will be determined during the development of the health office s results package during September 1995*

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
	3 Increase the quality of health care services provided by public, private and voluntary health care providers in selected rural districts, by Dec 1997 [2]	-Project quarterly reports -Project evaluations -Records of 3 Regional Secretaries of Health	The National Secretary of Health needs to reinvent & further develop its regional and district structures to implement new national policies and sanitary models
	4 Increase the sustainability of health services through sound financial and administrative practices, by PACD [3]	-Project quarterly reports -Project evaluations -Records of 3 Regional Secretaries of Health	The Secretary of Health will delegate authority to the Regional Secretaries and to the Project personnel to implement Project activities
OUTPUTS			
1 Increased utilization of existing health care facilities in selected rural Districts by pregnant women and children 5 and under	1 1 Number of users of prenatal services/number of expected child births 1 2 Number of visits by children 5 and under/number of children requiring medical attention 1 3 By Dec 1997, the number of visits per person per year to health services facilities increased 50% from current local baselines	-National Health Services Information System (SNIS) -Project monitoring plan, and franchise controls -Project information system -Project quarterly reports	-Sufficient human resources from the Secretary of Health are deployed in project Districts to implement the project and to strengthen the Secretary's presence in rural areas -Sufficient health care providers exist in rural areas to constitute local networks

[2] *Quality will be measured by the % of health care providers in selected health districts that follow NSH norms and standards and by the number of patients that return to a health centre for a check up within a single illness episode*

[3] *The following criteria will be used as measures of sustainability a) % of health facilities in the 11 selected districts with sound financial and administrative systems and practices b) % of health care facilities in 11 selected districts receiving at least 50% of their operating resources from local government s popular participation funds c) % of health care facilities in 11 selected districts with locally-generated funds equal to funds provided by local governments*

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
2 Increased institutional capacity of the National Secretary of Health to guarantee quality health services and mobilize community demand for health	2 1 One Sanitary Model with local and regional variations developed and operational in 11 rural Districts by Dec 1996 2 2 11 rural health care Districts in La Paz, Cochabamba and Santa Cruz developed experimentally for further replication under Popular Participation Laws by Dec 1996 2 3 A set of 7 management support systems developed, established and operational at the District level linked to regional and national levels by Dec 1997 2 4 Local health care providers (public, private and voluntary) organized in 11 local partnerships or coalitions of health care providers for the provision of an integrated package of Community and Child Health care services by Dec 1996 2 5 A franchise support system established for the training, quality control and effective delivery of Community and Child Health services by Dec 1997	-Project evaluations -Records of health care District units -Records of health care providers -Records of community groups that participate in project activities	-There are culturally acceptable means of improving health care behavior -Political climate allows existing health care providers, & community organizations can be mobilized in support of the project -Municipalities are willing to participate with project in the constitution of local networks and contribute counterpart funding There is adequate political support for restructuring the Secretary of Health and its dependent agencies Private, public and voluntary health care providers accept and respond to uniform support systems, provided by the project

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
3 Changes in knowledge attitudes and health care practices among local populations groups registered, documented and validated	3 1 By July 1998, 33 selected organized community groups with knowledge of preventative and curative services available 3 2 Number of revisits by new users 3 3 Percentage of people demonstrating changes in health-related behavior	Surveys/focus gps/participant observation Six regional assessments of how changes in behavior (increased demand for services) affect sustainable impact on health conducted and concluded by Dec 1997	

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS				MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
INPUTS LOG FRAME PROJECT BUDGET ($ 000)	US DOLLARS ($000)				Project information system -Project financial records -National Regional & District records	- There are funds availab'e from all contributing sources as scheduled
	USAID	PL 480	OTHER	TOTAL		
TOTAL AUTHORIZED FUNDS AS 03/31/95	20 000	8 000	0 00	28 000		The Government of Bolivia has formally requested a change in Project orientation to respond more effectively to new decentralization processes and to the new roles in health of municipal governments - Municipal governments are willing to counter fund Project's health care activities
TOTAL EXPENDITURES TO DATE AS 03/31/95	15 613	6 048	0 00	21 661		
BALANCE OF FUNDS FOR 04/01/95-07/31/98	4 387	1 952	0 00	6,339		
ADDITIONAL FUNDING 04/01/95 07/31/98	8 500	1,000	2 200	11 700		
TOTAL FUNDING NEW PHASE	12 887	2 952	2,200	18,039		

USAID FUNDS FOR NEW PHASE
(Balance of Funds Plus Additional Funds)

PROJECT BUDGET (6-95/7-98)	1995	1996	1997	1998	TOTAL
1 Strengthening of Central Programs	1 176	820	590	314	2 900
2 Decentralized Health Services	3 556	3,375	3 119	914	10 964
3 Central Office Support	1,010	992	1 094	629	3 725
4 Evaluations		100	60	40	200
5 Audits	45	75	75	55	250
TOTAL	5 787	5 362	4 938	1 952	18 039

Notes

(*) Purpose indicators of access, coverage, quality and sustainability are composed indicators such as physical, cultural and economic access that have to be combined into one common index The same for overall coverage (% of mothers, % of two year-olds, etc), overall quality of services and the financial and institutional sustainability of the local health care networks

(**) These outputs -to be attained from now to the PACD- are listed in addition to those outputs initially stated, which have been completed (more than 100% completion) as of September 1994

ATTACHMENTS

C SANITARY MODEL FOR DECENTRALIZED HEALTH CARE

(6 pages)

HACIA UN SISTEMA NACIONAL DESCENTRALIZADO Y PARTICIPATIVO DE SALUD (Fundamentos y Criterios Orientadores)

MINISTERIO DE DESARROLLO HUMANO

Secretaria Nacional de Salud
Secretaria Nacional de Politica
e InversionSocial

La Paz, abril de 1994

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PRESENTACION

El proceso sanitario se viene desarrollando, en la situacion actual, en el contexto de una profunda Reforma Social en curso, que tiene como su pilar fundamental la aplicación de la Ley de Participación Popular unida a otras trascendentes medidas de cambio Entre éstas se encuentran las implicancias de la nueva concepción del desarrollo y la redefinición de la Política Social contenidos en el PLAN DE TODOS y EL CAMBIO PARA TODOS, la transformación institucional que significa la creación del Ministerio de Desarrollo Humano como consecuencia de la Ley de Ministerios del Poder Ejecutivo, así como el inicio de la Reforma Educativa

Por la magnitud y trascendencia de las reformas, la Secretaría Nacional de Salud no puede ni debe estar al margen, máxime si es el ente rector y regulador del sector de la salud en su conjunto Por ello, la promulgacion y aplicacion de la Ley de Participación Popular significa un reto muy grande y una oportunidad sin precedentes para la construcción y el desarrollo de un Sistema Nacional Descentralizado y Participativo de Salud, orientado por los principios básicos de universalidad, solidaridad, equidad, eficacia y eficiencia y mas acorde con las necesidades reales de desarrollo humano y de las condiciones de salud del pueblo boliviano

La Ley de Participacion Popular redefine radicalmente las relaciones que se establecen entre las instancias ejecutivas nacionales del Estado y la sociedad a través del fortalecimiento del rol de los Gobiernos Locales, generando un proceso de descentralizacion con participación de la ciudadanía a partir de sus organizaciones sociales de base territorial Por su naturaleza y alcance, la Ley de Participación Popular es el instrumento estrategico mas importante del proceso de Reforma Social que se ha puesto en marcha Su sola aplicacion en el sector de la salud da lugar a un proceso de adecuación que implica llevar a cabo transformaciones profundas en los aspectos medulares del Sistema Nacional de Salud que configuran, de hecho, el inicio de una Reforma de la Salud

El sector de la Salud ha sido por mucho tiempo el más avanzado conceptual y metodológicamente en la formulacion y desarrollo de las políticas publicas en el ámbito de lo social Con los procesos en curso de Reforma del Estado y Reforma Social, por primera vez el impulso y el sentido de las transformaciones en el modelo sanitario y sus estilos de gestión vienen determinados por factores exógenos y extrasectoriales En este sentido, la Reforma de la Salud es un proceso inducido que ya se ha iniciado, que tiene en la Ley de Participación Popular el factor catalizador más importante y, en su proceso de adecuación, los primeros pasos de avance hacia la transformación

Una de las consecuencias más importantes que conlleva la aplicación de la Ley de Participación Popular es la creacion de nuevos actores del proceso sanitario, lo que se acompaña de una nueva delimitacion de atribuciones y competencias en el campo de la salud a nivel municipal, que modifica sustancialmente los roles de los actores tradicionales Se produce una descentralizacion efectiva hacia el espacio local, donde el Municipio asume un rol determinante buscando incorporar las demandas y necesidades

locales sin que por ello se pierda la unidad técnico-politica ni la visión estratégica y de conjunto que debe caracterizar a un Sistema Nacional de Salud

Al mismo tiempo, se le da fundamento jurídico a la participación social popular y se le otorga poder real de influenciar las decisiones sobre la asignación de recursos y la capacidad de control social a las organizaciones sociales agrupadas en las Organizaciones Territoriales de Base (OTBs) De esta manera, se busca institucionalizar la participacion popular en el Gobierno Local y en la gestión y control de la prestaciión de los servicios sociales de carácter público Se ayuda a generar las condicones favorables para desatar un genuino proceso de democratizacion de la salud y de las políticas sociales

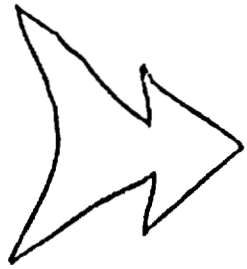
En términos de la gestión de los servicios de salud, la Ley de Participación crea una situación inédita, sin precedentes en América Latina Por un lado, le transfiere al Gobierno Municipal la propiedad de los bienes muebles e inmuebles afectados a la infraestructura física de los servicios públicos de salud y la responsabilidad de administrarlos, mantenerlos y renovarlos De otro lado, retiene en la Secretaría Nacional de Salud la obligacion de regir los servicios médico-profesionales adscritos a los servicios públicos transferidos así como la responsabilidad de su administración y remuneración Es decir, se distribuyen los factores productivos —y los atributos de propiedad que conllevan— entre un nivel politico y administrativo local y una instancia tecnica administrativa nacional, ambos bajo la presencia tutelar y el control de las organizaciones sociales de base

Se crea, en términos sociales, una situación de "poder compartido" entre el Gobierno Municipal y la Secretaria Nacional de Salud, con la obligación de ambas partes de concertar con las Organizaciones Territoriales de Base, ya que nadie puede disponer de los recursos unilateral o discrecionalmente sin el consentimiento previo del otro Traducido esto al proceso de toma de decisiones que afectan la asignación y uso de los recursos, se tiene una situación inedita de "Gestion Compartida con Participación Popular" compartida entre el Gobierno Municipal y la Secretaría Nacional de Salud y concertada entre ambos y las OTB Esto significa una situación radicalmente distinta a las antípodas entre "municipalización de la salud" y la simple desconcentración administrativa (o "descentralización selectiva") de los servicios de salud a nivel municipal

La nueva situacion creada, al replantear radicalmente las reglas de juego del proceso sanitario, obliga a la Secretaría Nacional de Salud, en su condicion de órgano rector sectorial, a formular una nueva normatividad lo suficientemente clara y precisa como para poder cumplir simultáneamente un doble propósito Por un lado, asumir el reto de una rápida y eficaz adecuación a las demandas de la Ley de Participacion Popular, mejorando en el proceso la capacidad de gobernalidad de la Secretaría Nacional de Salud Y, de otro lado y al mismo tiempo, hacerlo con la creatividad y la orientación suficientes para que el proceso de adecuacion se convierta en una extraordinaria oportunidad para iniciar la transformación efectiva del sector y la construccion de un Sistema Nacional Descentralizado y Participativo de Salud

UPROS

UNIDAD DE PROGRAMACION DE SALUD



- AYLLU
- CANTON
- TENTA
- CAPITANIA
- BARRIO
- COMUNIDAD

UBAGES

UNIDAD BASICA DE GESTION DE SALUD

- MUNICIPIO
- MANCOMUNIDAD DE MUNICIPIOS
- DISTRITO MUNICIPAL

DITES

DIRECCION TERRITORIAL DE SALUD

- ASOCIACION DE MUNICIPIOS
- ASOCIACION DE DISTRITOS MUNICIPALES

UPEGS

- √ Area de influencia y de responsabilidad programática
- √ Establecimiento
- √ Capacidad instalada
- √ Programa y produce servicios con la participación activa de la población

COMITE POPULAR DE SALUD
"Acta de Compromiso"

UBAGES

- √ Programa y produce servicios
- √ Definida por la la Ley de Participación Popular
- √ Gestión compartida con el Municipio y participación de OTBs

DIRECTORIO LOCAL DE SALUD
"Convenio Local de Salud"

DITES

- √ Garantiza una Red de Servicios
  - accesibilidad
  - capacidad instalada
  - potencial de desarrollo
  - aspectos epidemiologicos
- √ Dinámico
- √ Flexible
- √ Territorialidad
- √ Financiamiento
- √ Planifica y conduce el conjunto de establecimientos y de prestación de servicios
- √ Articula Municipios de acuerdo a desarrollo de Red de Servicios

DIRECTORIO TERRITORIAL DE SALUD
"Convenio Territorial de Salud"

ELEMENTOS BASICOS DEL NUEVO MODELO SANITARIO ADECUADO A LA LEY DE PARTICIPACION POPULAR

NIVELES DE ATENCION	NIVELES DE COMPLEJIDAD			NIVELES DE GESTION			INSTANCIAS DE GESTION COMPARTIDA CON PARTICIPACION POPULAR	INSTRUMENTOS DE GESTION COMPARTIDA CON PARTICIPACION POPULAR
	Prototipo	Tipos Existentes	Recurso Nuclear	Local	Regional	Nacional (SNS)		
Nivel Primario (I)	Centro de Salud (C.S)	Casa Pop Salud UROCs, Boquines RPS, Parteras Medicina Tradicional	Individuo Familia Comunidad	Unidad de Programación en Salud (UPROS)			Comité Popular de Salud (en todos los establecimientos sanitarios de acuerdo a delegados designados po las OTBs)	Acta de Compromiso de Planific. Participativa (a nivel de todas las UPS para recoger las demandas y necesidades sentidas de la población)
		Puesto Sanitario	Auxiliar de Enfermería				Directorio Local de Salud	
		Equipo Móvil	Médico/Enfermera Odontólogo y Auxiliar Transporte					
		Consultorio Sanitario	Médico/Enfermera o Auxiliar	Unidad Basica de Gestión (UBAGES)				
		Centro de Salud	Equipo de Salud Laboratorio Básico					
		Ctro de Salud con Camas	Equipo de Salud con resolución Parto Normal e Internación Temporal					Convenio de Salud
		Centro de Referencia Ambulatoria	Ambulatorio con Especialistas Lab Mediana Complejidad					Plan Territorial de Salud
Nivel Secundario (II)	Hospital Básico de Apoyo	Hospital Basico de Apoyo	Cuatro Especialidades Básicas. Anestesiología. Resolución Quirurgica de la Emergencia Obstétrica Emergencia 24 Hras Lab de mediana complejidad Banco de Sangre Odontología	Dirección Territorial de Salud (DITES)			Directorio Territorial de Salud	Presupuesto Anual Operativo Municipal de Salud (PAO - SALUD)
Nivel Terciario (III)	Hospital General de Apoyo	Hospital General ~~Regional~~	Especialidades Básicas, Otras Especialidades Emergencia 24 Hras Lab y Métodos Complementarios de Diagnóstico de alta complejidad	Secretaría Regional de Salud				Programa de Mantenimiento y Recuperación de Infraestructura Programa Estratégico de Inversiones en Salud
		Hospital Especializado	Idem Hosp Regional de Apoyo Equipos especializados					Plan Regional de Salud

INSTITUTOS NACIONALES DE INVESTIGACION Y NORMALIZACION

POLITICAS Y ESTRATEGIAS NACIONALES DE SALUD

A Servicio Nivel Popular

ATTACHMENTS

D PLAN VIDA

(7 pages)

MINISTERIO DE DESARROLLO HUMANO
Secretaría Nacional de Salud

Plan Vida

Plan Nacional para la Reducción Acelerada de la Mortalidad Materna, Perinatal y del Niño

Bolivia
1994 - 1997

UNFPA
Fondo de Población de las Naciones Unidas

Agencia de los Estados Unidos para el Desarrollo Internacional

Fondo de las Naciones Unidas para la Infancia

Organización Panamericana de la Salud

El Plan Vida ¿Qué es?

De todas las tragedias de la vida, la muerte de una madre y de un niño probablemente son las más tremendas y dramáticas, porque quitan la presencia de un ser sobre el que gira la estabilidad familiar y corta la esperanza que todo niño trae

La mortalidad materna e infantil debe ser vista, pues, en el contexto de su dramática realidad, dolorosa, profundamente humana y no sólo en términos de cifras frías e insensibles Cuando así lo hacemos existe una urgencia de resolverla, de combatirla, de minimizarla, de luchar por la vida.

El Plan Vida precisamente apunta a esto y todos los que trabajaron y trabajarán en él, desde su planificación hasta su ejecución, son heraldos de la salud, del bienestar familiar, de la VIDA con mayúsculas, cuyos resultados no sólo se miden en cifras, sino en rostros de niños y madres sonrientes que podremos arrebatar a la enfermedad y la muerte

Nuestro trabajo por la salud, visto así, es como un hada madrina que quiere cuidar a los suyos, especialmente a los más "pequeños"

Mucha gente participa en la elaboración de un Plan y no es posible dar nombres, ni viene al caso, pero es necesario resaltar el trabajo abnegado, comprometido y esforzado del equipo técnico de la Dirección de Salud y Nutrición de la Mujer y el Niño de la Secretaría Nacional de Salud Ellos saben que lo que se sembró con esfuerzo, se cosechará con alegría.

Para reducir la mortalidad del niño menor de 5 años y la muerte materna, sabemos qué es lo que hay que hacer Sabemos que las intervenciones de control del crecimiento y desarrollo, de las inmunizaciones, del manejo oportuno de las diarreas e infecciones respiratorias, del control pre-

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natal con enfoque de riesgo, del parto hospitalario (particularmente en la complicación obstétrica y embarazo de riesgo), del espaciamiento gestacional, del uso de la planificación familiar y de la promoción de la lactancia materna son las actividades médicas básicas y necesarias para iniciar el proceso de su reducción

Pero sabemos también que acciones médicas aisladas, desarticuladas y muchas veces no aceptadas por la comunidad, son totalmente insuficientes si no van acompañadas de educación popular en salud, de trato cortés, delicado, cálido y de capacitación de Responsables Populares de Salud de las comunidades

Y también sabemos que aún esto es insuficiente si no tenemos redes de comunicación, transportes y de solidaridad funcionando con hospitales distritales con capacidad resolutiva y que es necesario mejorar el saneamiento básico, la nutrición y la educación formal enfocada a la salud

Sabemos todo esto y sabemos cómo hacerlo y precisamente esto es el Plan de Vida, que es la respuesta en salud que nuestro pueblo necesita y que va más allá de la pura imagen sanitaria. El Plan Vida se incorpora en el campo social para trabajar con la comunidad, sufriente y enferma que es con la única que podemos resolver nuestros problemas de salud, con ella y no al márgen de ella

El Plan Vida proyectado hasta 1 997 para alcanzar las metas propuestas, seguirá funcionando más allá del tiempo y en todos los sitios de Bolivia, con el nombre que sea, porque es lo que Bolivia necesita. El Plan Vida le pertenece al pueblo

César Peredo Alaiza
DIRECTOR DE SALUD Y NUTRICION
DE LA MUJER Y EL NIÑO

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3. SERVICIOS, INTERVENCIONES BASICAS Y ACTIVIDADES

a Principales intervenciones de los servicios

La disminución de la morbimortalidad materna y del niño no puede ser resultado de acciones aisladas Se la debe encarar con proyectos sociales integrales que trasciendan la supervivencia y que garanticen el ejercicio pleno de los derechos de la mujer y del niño Desde el campo de la salud se debe contribuir al conjunto de las intervenciones consolidando la atención integral a la mujer, la consulta pediátrica integral y la universalización de procedimientos estandarizados para el manejo de las complicaciones del embarazo y del parto, del niño desnutrido, con diarrea y neumonía Se necesita implementar una amplia gama de acciones destinadas no sólo a la atención de mujeres y niños con complicaciones, sino tambien a las mujeres con embarazos y partos normales así como al crecimiento de los niños

Las actividades propuestas en relación a la mortalidad materna están basadas en el hecho de que la disminución de esta mortalidad ocurre como resultado del tratamiento de las complicaciones del embarazo El momento y la gravedad de estas complicaciones no puede ser predecido o prevenido, por lo que el tratamiento rápido y oportuno es la única manera efectiva de disminuir las muertes maternas Por tanto, el Plan se asienta en un modelo estadístico hipotético que prevé la reducción de la mortalidad materna y perinatal a través de dos mecanismos (a) incremento de la cobertura de atención perinatal, con énfasis en el parto hospitalario (en especial de los embarazos de alto riesgo y complicados), (b) mejoramiento de la calidad de atención obstétrica (para reducir la mortalidad materna y perinatal en hospitales distritales y maternidades)

Sin embargo, el lograr un control adecuado del embarazo y un tratamiento oportuno y efectivo de sus complicaciones es una tarea que debe ser liderada por el sector salud, pero en la que debe colaborar toda la sociedad La disminución de la mortalidad materna necesita del compromiso, la movilización social y la participación popular en todos los niveles de la sociedad

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Las actividades que se proponen para disminuir la mortalidad infantil y del niño menor de 5 años, se basan en que los daños que concentran la mayor magnitud de la mortalidad son también pocos (diarreas y neumonía en asociación con la desnutrición) y que pueden ser prevenidos o recibir tratamiento adecuado y oportuno a nivel de la familia, comunidad o el primer nivel de atención

La reducción acelerada de la mortalidad del niño menor de 5 años se pretende lograr a través de 3 mecanismos incremento de la cobertura de atención de casos de neumonía, diarrea y desnutrición por los servicios de salud y agentes comunitarios, mejoramiento en la calidad de atención a través del desarrollo de la consulta pediátrica integral, la aplicación correcta de la TRO y del tratamiento estandarizado de las infecciones respiratorias agudas

El Plan propone desarrollar acciones destinadas al fortalecimiento y desarrollo de los sistemas locales de salud, al desarrollo de los recursos humanos, a la educación popular para la salud, a la alimentación complementaria durante el embarazo y fomento a la lactancia materna, apoyo a procesos orientados a lograr la seguridad alimentaria en el hogar, al desarrollo y fortalecimiento de los sistemas de registro, procesamiento y análisis de información, a la movilización de recursos locales, a generar y efectivizar la participación popular en las diferentes etapas de implementación, priorizando el proceso de la evaluación participativa y la promoción de la investigación operativa.

El Plan desarrollará una serie de intervenciones globales en tres de los niveles del sistema local de salud comunidad – primer nivel de atención – Hospital de referencia.

i **A nivel de la comunidad**

En el caso de la mujer el Plan se propone (a) conocer las percepciones, ideas y prácticas relacionadas al embarazo, el parto y a los cuidados del recién nacido, usándolas para formular mensajes para la educación acerca de los signos de alarma y señales de riesgo relacionados al embarazo y el cuidado de los niños, (b) conocer las facilidades en transporte y comunicación de la comunidad que permitan una oportuna atención de las complicaciones, (c) identificar y cambiar las prácticas inapropiadas en el control del embarazo, de la atención del parto y del recién nacido, así como la importancia de las prácticas higiénicas durante el parto; (d) Establecer una adecuada relación y promover la coordinación entre los recursos comunitarios (parteras, médicos, enfermeras, auxiliares de enfermería, estudiantes de ciencias de la salud, maestros, militares, policías, responsables populares de salud, etc) y los servicios de salud del nivel local, (e) identificación y referencia de las gestantes y mujeres en riesgo obstétrico y reproductivo a los servicios de salud, (f) proveer asistencia alimentaria a embarazadas y nodrizas que se encuentren desnutridas o anémicas, (g) identificar rápidamente las complicaciones de la labor de parto y el puerperio y asegurar su referencia oportuna a los servicios de salud, (h) Contar con parteras empíricas y comunidad adiestrada con conocimientos sobre las oportunidades en la prevención de la mortalidad materna relacionada

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con causas como anemia, infección, trastornos hipertensivos del embarazo y el aborto y (l) Articular funcionalmente los diferentes servicios comunitarios, privados y de seguridad social, de manera que funcionen coordinadamente con los servicios públicos dentro de los principios de la ley de participación popular

En cuanto al niño, se propone (a) Dar pautas para el monitoreo comunitario del crecimiento, manejo correcto de la diarrea en el hogar, reconocimiento de signos de peligro de neumonía y alimentación del menor de 5 años, (b) Identificar y capacitar agentes comunitarios para la promoción de la salud, vigilancia de la mortalidad del menor de cinco años, el monitoreo del crecimiento y la aplicación de la TRO, (c) Identificar prácticas inapropiadas en la alimentación y atención del niño sano y del enfermo, (d) Articular funcionalmente a los diferentes subsectores del sistema nacional de salud de manera que trabajen coordinadamente con los servicios públicos dentro de los principios de la ley de participación popular, (d) Identificación y referencia de niños con signos de neumonía grave y diarrea con algún grado de deshidratación a los servicios de salud, (e) Proveer a los niños menores de cinco años elementos nutritivos que complementen su alimentación, (f) Identificar en forma oportuna y precisa los signos de peligro de casos de neumonía y de deshidratación, (g) Identificar redes alternativas de distribución de SRO, (h) Captación de niños sin esquema completo de vacunación

ii En el primer nivel de atención

Para la atención de la mujer se propone (a) Articular una red de establecimientos de salud, capaces de controlar y conducir un adecuado control prenatal y una labor de parto normal, así como la detección y referencia de las gestantes en riesgo, (b) Mantener una adecuada y oportuna provisión de insumos, equipos, materiales, medicamentos y anticonceptivos, (c) Asegurar transporte y comunicación oportuna con apoyo de la comunidad, (d) Asegurar la presencia de personal capacitado para el control del embarazo, la atención del parto normal y la detección de complicaciones, así como para ofertar métodos anticonceptivos seguros y efectivos, incluyendo los tradicionales o naturales

En el primer nivel de atención de salud al niño se propone (a) Articular una red de servicios de salud de manera que puedan aplicar en forma correcta los pasos de la Consulta Pediátrica Integral y los tratamientos estándard de diarrea y neumonía, para lo cual se garantizará la capacitación en procedimientos clínicos del personal y la provisión regular oportuna y gratuita de sobres de rehidratación oral, paracetamol pediátrico y cotrimoxazol pediátrico, (b) En este nivel se prevé el manejo ambulatorio de la neumonía, la administración de rehidratación oral (SRO) en salas de administración transitoria (plan B), (c) Fomentar grupos de apoyo a la lactancia materna para trabajo de consejería con las madres, (d) Promoción del consumo de aceite en niños que tienen retardo en su crecimiento, en relacion a su indicador peso/edad, (e) la vigilancia de la seguridad alimentaria en hogares con incompatibilidad familiar

iii **A nivel del Hospital de Referencia (hospital de distrito, maternidad u hospital pediátrico)**

Para la atención y el cuidado de la mujer (a) Se fortalecerá la capacidad de respuesta de estas instituciones para que puedan ofrecer todas las funciones obstétricas esenciales, incluyendo cirugía, anestesia, transfusión de sangre y la oferta de anticoncepción con métodos seguros, (b) Se apoyará una adecuada y oportuna provisión de insumos, equipos, materiales, medicamentos y anticonceptivos, (c) Se asegurará que el costo de la atención o los medicamentos no constituyan un limitante para el acceso a los servicios, (d) Se apoyará el proceso de articulación docente asistencial así como el desarrollo de las instancias de capacitación y formación de recursos humanos, basados en los principios de responsabilidad social, calidad en el desempeño y respeto al usuario, (e) Se apoyará el desarrollo de investigaciones operativas destinadas a mejorar la oferta de una atención de calidad y la disminución de las barreras que limitan el acceso a los servicios de atención materna y de planificación familiar

En el caso de la atención al niño es deseable distinguir un segundo y un tercer nivel de atención En el segundo nivel se busca (a) Disminuir las tasas de letalidad en los hospitales distritales aumentando la capacidad resolutiva, (b) Elaborar y aplicar un protocolo de funciones que permita disponer de unidades de atención pediátrica, (c) Dotar a los servicios de medicamentos de primera línea, oxígeno–terapia, personal capacitado en procedimientos clínicos, recuperación de desnutridos, administración de soluciones parenterales, laboratorio con exámenes básicos y eventualmente transfusiones Para el tercer nivel de atención se propone (a) Articular el proceso docente asistencial desarrollando centros de capacitación clínica que permitirán la formación de recursos humanos altamente calificados en procedimientos estandarizados para el diagnóstico precoz de la patología pediátrica, (b) Mejorar la calidad en la prestación de servicios con la promoción de la eficiencia y del trato humanizado al usuario, (c) Promover las prácticas adecuadas de lactancia materna, alimentación complementaria, apego precoz, madre canguro y madre acompañante, (d) Promover la iniciativa de Hospitales Amigos de la Madre y el Niño

De esta manera, el Plan se propone situar el problema de la atención materna, perinatal y del niño a nivel del sistema local de salud, creando un modelo provincial/distrital/municipal de atención integral a la mujer y al niño, que permita la detección temprana, la referencia rápida y el tratamiento oportuno de las complicaciones obstétricas y pediátricas, así como la prevención oportuna del riesgo reproductivo y de las enfermedades comunes mediante una oferta adecuada de métodos de planificación familiar y el desarrollo de la consulta pediátrica integral En la implementación de estas acciones previstas, se aplicará el principio básico del costo–beneficio, destinado a proveer el mejor cuidado con los recursos disponibles

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ATTACHMENTS

E. HOST COUNTRY CONTRACTING CERTIFICATION AND PROCUREMENT PLAN

(14 pages)

UNITED STATES GOVERNMENT

Action Memorandum to the Director

DATE May 19, 1995

REPLY TO ATTN OF Paul G Bonner, Director HHR Office

SUBJECT Assessment and Certification of Host Country Contracting Capacity for the CCH Project (511-0594) Office under the Ministry of Health,

TO Lewis W Lucke, Director

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90 STATE 399975 established the requirement that USAID Mission Directors certify the capacity of host government entities to undertake USAID-financed host country contracting before authorizing procurement in excess of $250,000 Certifications are to be based on a relatively formal assessment of the contracting agency's organizational structure, contracting authorities and procedures, the qualifications of its personnel and experience

A USAID/Bolivia team composed of Fernando García, RCO, Deborah James, RLA, José Diaz, CONT and Rafael Indaburu, HHR, recently conducted the required formal assessment of Community and Child Health Project Office's contracting capacity, as a prerequisite to authorizing USAID-funding for a large value procurement of health materials, equipments and medications for the Community and Child health The results of this assessment are contained in the attached report by the team, which concludes with the recommendation that you certify Community and Child Health Project's capacity to conduct USAID-funded host country procurement The present report updates a certification prepared for the CCH Project Office in 1991 Although it is not

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anticipated, at this time, that the CCH Office will conduct individual procurements over $250,000 in value, the cumulative value of smaller procurements conducted by CCH has prompted us to prepare this update

Based on the attached report and its conclusions, HHR and the clearing officers recommend that you certify Community and Child Health Project's contracting capacity by signing below the following statement required by 90 STATE 399975

Based upon an assessment, carried out by the above named USAID/Bolivia assessment team and summarized in the attached report dated May 3, 1995, of the capability and integrity the CCH Office to carry out the procurement process from solicitation to audit and closeout, in accordance with applicable procedures (set forth in USAID Handbook 11), and based upon the recommendations of the project officer, contracting officer, legal advisor, and controller (initials shown above and below), I have determined that Community and Child Health Project is capable of undertaking procurement actions financed by USAID/Bolivia This determination should be reviewed at any appropriate time that staff, organization, legal, or other changes suggest that a current assessment would be appropriate and will in any event be repeated, or updated by limited reviews, within three years from the date indicated below

Lewis W Lucke
Acting Mission Director
USAID/Bolivia

5/25/95
Date

ANEXO

PROYECTO DE SALUD INFANTIL Y COMUNITARIA

EXTIMACION DE COSTOS -

Este anexo muestra el detalle de la estimacion de costos estructurado por los nueve elementos de acuerdo al presupuesto del Plan Financiero, exponiendo las principales actividades de cada uno

Asimismo para aclaracion indicamos que ano 7 es igual a 1995, año 8 igual a 1996, ano 9 igual a 1997 y ano 10 igual a 1998

ELEMENTO 1 - ASISTENCIA TECNICA $US 1,450

A) INTERNACIONAL $US 1,130 CUENTA DIRECTA

D D M HARVARD (FX) $US 300 AÑO 7

Contrato con la Universidad de Harvard y Research Triangle Institute para asistir con capacitacion Gerencial a la N S

BASICS (FX) $U 400 AÑO 7

Contrato con BASICS para la realizacion de investigaciones para el manejo y capacitacion de Diarreas/Colera en coordinacion con la S N S y S R S

SALUD REPRODUCTIVA (FX) $US 100 AÑO 7, 8, 9

Asistencia Tecnica para la confeccion de Planes de implementacion de SR en las Direcciones Territoriales de Salud asignadas al Proyecto

SERVICIOS DE SALUD (FX) $US 130 AÑO 7 Y 8

Contratacion Asistencia Tecnica para estudios especializados de apoyo a Oficina Central y Direcciones Territoriales de Salud dependientes del Proyecto

B) NACIONAL (LC) $US 320 CUENTA ESPECIAL AÑO 7, 8, 9

Contratacion Asistencia Tecnica para estudios especializados de apoyo a Oficina Central y Direcciones Territoriales de Salud dependientes del Proyecto

SALUD COMUNITARIA SUC 1,200

- Consulta General Adultos - Atencion de enfermeria - Emergencias y referencias	Su	120
- Atencion Dental (Fluorinizacion)	Suc	120
- Laboratorio Basico	Suc	120
- Medicamentos Esenciales	Suc	120
- Control de vectores	Sus	240
- Tuberculosis	Suc	100
- Nutricion micronutrientes	Su	120
- Saneamiento Basico	Suc	100
- Educacion en salud	Su	80
- Medicina Tradicional	Su	20
- Autocuidado de la familia Mat IFC	Su	50

BEST AVAILABLE COPY

ELEMENTO 9 - AUDITORIA $US 250

$US 250 CUENTA ESPECIAL AÑO 7, 8, 9, 10

- Contratacion de servicios de Impresas de Auditoria Externa, requisito necesario y obligatorio para dar cumplimiento de Convenios de Donacion por el uso de fondos entregados al proyecto por USAID/B tanto a nivel de Oficina Central como asi tambien a las 11 DITES bajo responsabilidad del Proyecto CCH y a Organizaciones no Gubernamentales beneficiadas con Contratos

A) EVAL FINANCIERA OFICINA CENTRAL	$US	85
B) EVAL FINANCIERA 11 DITES	$U	165
	$US	250

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ELEMENTO 1 - CAPACITACION Y FORTALECIMIENTO GERENCIAL $US 1,437

BECAS MEDICOS F F U U (EX) $US 10 AÑO 7, 8, 9

Otorgacion Becas a especialistas de los DILES del CCH en Hospitales de U S A para su posterior apoyo a las regiones y Direcciones Territoriales de Salud dependientes del Proyecto

A - CAPACITACION $US 1 272 CUENTA ESPECIAL AÑO 7 8 9

1) NACIONAL $U 190

NIVEL NACIONAL	$US	60		=	60
NIVEL REGIONAL	$U	80	50		130
		TOTAL			190

2) CAPACITACION DISTRITOS $US 480

OTRAS ACTIVIDADES	$US	10	10	10	=	30
MOVILIZACION COMUNIDAD	$US	50	50	50	=	150
BECAS EN ESCUELAS DE S P	$US	50	50	50	=	150
OFIC CENTRAL	$U	50	50	50	=	150
			TOTAL			480

B) FORTALECIMIENTO GERENCIAL DIM/CIC $US 450 AÑO 7, 8

ALTA GERENCIA	$US	90
SECRETARIAS REGIONALES	$US	150
EQUIPO DE CONDUCCION	$US	120
CAPACIT GERENCIA SOCIAL	$U	90
TOTAL		450

C) CAPACITACION ADMINISTRACION BASES DE DATO SALUD $US 152 AÑO 7, 8, 9

SECRETARIAS REGIONALES	$US	50	50	52

ELEMENTO 3 - FORTALECIMIENTO PROGRAMAS CENTRALES $US 2,300

$US 2,300 CUENTA ESPECIAL AÑO 7, 8, 9, 10

APOYO AL P A I 1,090

Presupuesto de apoyo al Programa Ampliado de Inmunizaciones para la adquisicion de Insumos como vacunas jeringas y acciones operativas y evaluaciones tanto de nivel central como regional

EDA/COLERA 410

Presupuesto de apoyo al Programa EDA COLERA para realizacion de investigaciones manejo de casos en servicios de salud, promocion de uso de SRO, etc

MONIT & CONTROL < 5 AÑOS 250

Presupuesto de apoyo al Monitoreo y Control del menor de 5 años con adquisicion de balanzas Salter tallimetros e impresion del carnet de salud para su aplicacion y uso a nivel nacional

I R A 150

Realizacion de Investigaciones de Infecciones Respiratorias Agudas e impresion de material educativo y de difusion a nivel nacional

NUTRICION 450

Apoyo para la adquisicion de Insumos como Sulfato Ferroso, Vitamina A como colaboracion al Programa Nacional de Micronutrientes de la S N S

SIGI INFORM & COMUN 50

Equipamiento de apoyo a la S N S y R S con equipos de computacion, Impresoras Modem's de comunicaciones y software aplicado original

ELEMENTO 4 - SISTEMAS DE SERVICIOS DE SALUD $US 7,002

$US. 7,002 CUENTA ESPECIAL AÑO 7, 8, 9 10

A) EQUIPAMIENTO $US 1,300

Presupuesto de apoyo a las 11 Direcciones Territoriales de Salud asignadas al Proyecto CCH, con equipos de transporte y comunicaciones, mejoramiento de la infraestructura para la atencion a las comunidades considerando dentro del mismo los Convenios con los Municipios como fondos de contraparte

EQUIPO & INFRAESTR	$US	1,000
- Materiales medicos	Uns	120
- Suministros medicos	Uns	120
- Equipos medicos	Uns	120
- Equipos de parto	Uns	150
Equipos de Comunic&transp	Uns	200
- Equipos Audiovisuales	Uns	50
- Medicamentos esenciales	Uns	200
- Adecuacion ambientes PM	Un	240
SISTEMAS DE A & A	$US	100
- Materiales construccion Sistemas de agua Caranota	Uns	40
- Mantenimiento sistemas A&A	Un	30
- Mat cursos de operacion	Uns	30

ELEMENTO 5 - MERCADEO SOCIAL-EDUCACION EN SALUD $US 1,350

$US 1,350 CUENTA ESPECIAL AÑO 7, 8, 9

A) PRODUCTOS Y SIST. LOGISTICOS $US 650

Provision oportuna de medicamentos esenciales y material de atencion de salud tanto a nivel de DIFES, UPAGES y UPROS con el fin de que puedan contar con provisiones oportunas y suficientes de los mismos, como asi tambien apoyo para el establecimiento de la Red de Servicio en cada DIFES de acuerdo al Model Sanitario de la S.N.S.

B) MERCADEO SOCIAL $US 350

Fondos asignados para la realizacion de estudios e investigaciones destinados a estimular a la poblacion de las comunidades comprendidas dentro de los DIFES para el incremento de la demanda de servicios de salud, incluyendo la utilizacion de medios de comunicacion (promocion) mediante radio, Television local, etc.

C) EDUCACION EN SALUD Y
ORGANIZACION COMUNITARIA $US 200

Apoyo a la realizacion de eventos destinados a mejorar las coberturas de incremento de la demanda de servicios de salud mediante la realizacion de talleres de informacion, educacion y comunicacion a las comunidades.

Complementando a la organizacion Comunitaria se colaborara a los municipios y mancomunidades a la preparacion Organizacion para la definicion del compromiso de definir su participacion en el proceso de planificacion de la Salud dentro de los lineamientos de apoyo a la Participacion Popular, diagnostico de situacion, control, evaluacion y ajuste de los PAO'S relacionados a la Salud.

D) MATERIAL EDUCATIVO $US 50

Costos de distribucion de material educativo relacionado a temas de la Salud Infantil, materna y Comunitaria a las comunidades, a traves de reuniones programadas por los educadores de cada DIFES
de los educadores asignados a cada DIFES.

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ELEMENTO 6 - ADMINISTRACION $US 3,600

(FX) $US 100 CUENTA DIRECTA AÑO 7, 8, 9, 10

Fondos asignados para el apoyo de un Asistente Administrativo a la Gerencia del Proyecto en USAID como así también para gastos de comunicaciones y otros relacionados con el apoyo que se brinda al Proyecto

$US 3,500 CUENTA ESPECIAL AÑO 7, 8 9 10

Recursos destinados para la cancelacion de los sueldos de los funcionarios del Proyecto asignados en la oficina central aportes a la Seguridad Social, comunicaciones equipamiento alquileres viaticos, pasajes, gastos de mantenimiento, gastos bancarios etc

ELEMENTO 7 - SISTEMAS DE INFORMACION Y MONITOREO $US 450

$US 450 CUENTA ESPECIAL AÑO 7, 8, 9 10

A) SISTEMAS DE INFORMACION [illegible]

Provisión de una Red de Comunicacion (LAN) para el manejo de los procesos de administracion de los datos de caracter tecnico administrativos financieros y de impacto mediante procesos de Teleproceso con las 11 DITES

Adquisicion de Software Original para las diferentes aplicaciones por parte del Proyecto

Adquisicion de Hardware de equipos de computacion impresoras, etc para los nuevos DITES

Diseño desarrollo e implementacion de sistemas de Informacion para su aplicacion en Oficina Central 11 DITES [illegible]

B) MONITOREO [illegible] 200

Establecimiento de metodos de control estandar para la evaluación en forma cuantitativa y cualitativa de procesos de salud en determinados lapsos de tiempo a ser aplicados en 11 DITES

BEST AVAILABLE COPY

ELEMENTO 8 - EVALUACION $US 200

$US	90	CUENTA DIFERIDA	AÑO 8, 9, 10
$US	110	CUENTA ESPECIAL	AÑO 8 9, 10

- Contratacion de servicios de Evaluacion tecnica externa y nacional sobre ejecucion de acciones de salud y de impacto realizadas por el Proyecto C C H

A) EVALUACIONES EXTERNAS INTERNAC (EX)	$US	90
B) EVALUACIONES EXTERNAS NACIONAL	$US	60
C) ESTUDIOS DE IMPACTO	$US	50
	TOTAL	200

B) DESARROLLO DE SERVICIOS $US 3 600

SALUD MATERNA	$US	1 200
SALUD INFANTIL	$US	1 200
SALUD COMUNITARIA	$US	1 200

SALUD MATERNA $U 1 200

- Atencion prenatal	$US	120
- Atencion del parto	$US	120
- Control del puerperio	$US	60
- Planificacion Familiar y Consejeria	$U	160
- Toxide tetanico	$U	60
- Cancer Cervo Uterino	$US	70
- ETS/SIDA	$US	100
- Consulta General de la mujer		
Capacitacion	$US	100
Supervision	$US	90
Mat de IEC	$US	100

SALUD INFANTIL $U 1 200

- Control del crecimiento y desarrollo Menores de 1 ano 1 a 5 años	$US	100
- P A I Vacuna antipolio DPT Antisarampionosa BCG	$US	500
- EDA/Cólera	$US	100
- I R A	$US	120
- Consulta general Ninos	$US	130
- Atencion del recien nacido	$US	130
- Mat IEC	$US	120

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C) SISTEMAS DE APOYO 110, 2 093

- Talleres de Planificacion y Evaluacion estrategica de planes locales de Salud y preparacion de PAO [de salud anuales lus 240

- Contratacion de Organizaciones sin fines de lucro para apoyo tecnico incremento de cobertura y servicios en 2 DITES lus 700

- desarrollo del manejo administrativo y logistico para fortalecimiento servicios en 11 DITES lus 1 553

ATTACHMENTS

F. PROJECT'S MID-TERM EVALUATION SUMMARIES

(11 pages)

8A 1

AID EVALUATION SUMMARY - PART I

1. BEFORE FILLING OUT THIS FORM, READ THE ATTACHED INSTRUCTIONS
2. USE LETTER QUALITY TYPE, NOT DOT MATRIX TYPE

IDENTIFICATION DATA

A. Reporting AID Unit

Mission or AID/W Office BOLIVIA

(ERR# ____ ____ ____)

B. Was Evaluation Scheduled In Current FY Annual Evaluation Plan?

Yes [X] Slipped [ ] Added [ ]

Evaluation Plan Submission Date: FY ____ Q ____

C. Evaluation Timing

Interim [X] Final [ ]

Ex Post [ ] Other [ ]

D. Activity or Activities Evaluated (List the following for the project or program identified in the activity title and number)

Project No	Project /Program Title	First PIOAG or Equivalent (FY)	Most Recent PACD (Mo/Yr)	Planned LOP Cost (000)	Amount Obligated to Date (000)
511-0594	Community and Child Health	88	7/94	16,500	11,291

ACTIONS

E. Action Decisions Approved By Mission or AID/W Office Director

Action(s) Required	Name of Office/Unit Responsible for Action	Date Action to be Completed
1. Amend the project to add $3 5 million to the Diarrheal Disease/Cholera, Immunization and Chagas' Components and to revise the PP and PROAG descriptions of the Integrated Child Survival Component as recommended.	Mahlon Barash	8/92
2 Develop strategies to focus the implementation of the integrated child survival component on water and sanitation, training and institutional development	Charles Llewellyn	4/92
3 Redefine organizational structure and supporting technical assistance for CCH Project	Charles Llewellyn	6/92
4. The GOB will be required to fill vacant items in the Project Health Districts and requested to create new items to absorb Project personnel	Charles Llewellyn	6/92

(Attach extra sheet if necessary)

APPROVALS

F. Date Of Mission Or AID/W Office Review Of Evaluation (Month) 2 (Day) 28 (Year) 92

G. Approvals of Evaluation Summary And Action Decisions

	Project/Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or AID/W Office Director
Name (Typed)	Charles E Llewellyn	Alvaro Muñoz-Reyes	Elizabeth Visnic	Carl H Leonard
Signature	[signature]	[signature]	[signature]	[signature] for
Date	3/4/92	3/4/92	3/4/92	

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ABSTRACT

H Evaluation Abstract (Do not exceed the space provided)

The project proposes to assist the government of Bolivia's (GOB) Ministry of Health (MOH) to reduce infant, child and maternal mortality through assistance to national immunization and diarrheal disease programs, an integrated child survival component in selected health districts, and a pilot Chagas' disease component The project is being implemented by the MOH through a project management unit (PMU) assisted by two institutional contractors This mid-term evaluation (11 - 12/91) was conducted by a TvT Associates team on the basis of review of project documentation, field visits and interviews with project, GOB and USAID officials The purpose was to measure progress towards achieving project implementation targets and to provide analysis and recommendations for future improvement The major findings and conclusions are

* The immunization, diarrheal disease and Chagas' components are functioning well and should be continued with additional funding

* The complex integrated child survival component lacks definition and focus Although considerable progress has been made, administrative and managerial problems have reduced its impact The project should focus the component on three areas- integration of water and sanitation with education, training of MOH personnel, and institutional development Specific strategies should be developed for institutional development, community participation, health promotion and education, data collection, monitoring and evaluation, and training

* Technical assistance for the integrated child survival component should focus on developing strategies and plans, instead of implementation

* Operations research should be conducted on alternative financing options

The evaluators noted the following "lessons

* Water and sanitation and child survival must be interdependent for long-range health impact

* The most important resource in delivering PHC services is the front line health worker

* Projects which have different objectives, strategies and resource needs often function more efficiently under separate management and financing structures

COSTS

I Evaluation Costs

I Evaluation Team

Name	Affiliation	Contract Number OR IDIV Person Days	Contract Cost OR IDIV Cost (U.S. $)	Source of Fun
James N Becht	TvT	Delivery Order 7		Project
Geri Marr Burdman	TvT	IQC PDC-0085-I-	96,000	
Bernard J Fisken	TvT	00-9087-00		
		72 person days		

2 Mission/Office Professional Staff Person Days (Estimate) 15

3 Borrower/Grantee Professional Staff Person Days (Estimate) 30

AID EVALUATION SUMMARY - PART II

SUMMARY

J Summary of Evaluation Findings Conclusions and Recommendations (Try not to exceed the three (3) pages provided)
Address the following items

- Purpose of evaluation and methodology used
- Purpose of activity(ies) evaluated
- Findings and conclusions (relate to question)
- Principal recommendations
- Lessons learned

Mission or Office	Date This Summary Prepared	Title And Date Of Full Evaluation Report
USAID/Bolivia	January 31, 1992	Midterm Evaluation of the Community and Child Health Project (511-0594) 1/31/92

The purpose of this scheduled mid-term evaluation was to measure progress towards achieving project implementation targets and to provide analysis and recommendations aimed at improving performance during the remaining life of the project The evaluation was conducted in November-December 1991, during the 14th quarter of this six-year project, by an external three-person team A participatory approach was used, beginning with a Team Planning Meeting and involving project, technical assistance contractor and Mission personnel Data collection methods included a review of documents, key informant interviews, field site observations and community focus groups Debriefings were held with the project management unit, institutional contractor, USAID project committee and HHR, and senior Ministry of Health officials

The goal of the CCH project is to improve the health status of the urban and rural population The project purpose is the improve community health by reducing infant, child and maternal mortality through child survival interventions, institutional development and community participation The initial project design called for concentrated effort in 11 health districts, in three departments, and increasing the capability of the MOH department -and district- level institutions and community organizations to plan, implement and sustain child survival interventions

The Project Agreement was signed on July 28, 1988, initially committing $16 5 million in A I D funds and $5 5 million in Government of Bolivia (GOB) funds over a five year period to support (1) the National Diarrheal Disease Control Program, (2) the National Immunization Program, and (3) an Integrated Child Survival effort to strengthen the operational capacity of the MOH health districts Later, a Chagas' Disease Control component and $2 5 million in GOB counterpart funds were added to the project and the project assistance completion date was extended to July 1994. As of November 1991, a total of $9 4 million (57%) of A I D funds had been expended or committed for project activities

The project is managed by a specifically created project management unit (PMU), whose executive director is contracted by the GOB and is directly responsible to the MOH Director General of Health John Short & Associates (JSA Healthcare) was contracted by USAID in November 1989 to provide long -and short- term technical assistance, assistance in local procurement including the management of field operational expenses and local contract personnel (with PL-480 funds), and support for participant training activities

The CCH project seeks to combine three distinct strategies of assistance under one management structure The DDC/ORT control and immunization components primarily provide commodity support to existing national-level programs and require frequent coordination with other donor agencies as well as MOH national normative divisions The integrated child survival component provides technical assistance, training, commodity, and operational support to strengthen child survival and water and sanitation interventions and support systems in selected health districts. This component supports the current MOH strategy to decentralize and management and sustainability of primary health care services in rural areas The Chagas' disease control component is a pilot, experimental effort which seeks to identify appropriate models to break the transmission of this endemic disease and eventually contribute to the formation of a national Chagas' Disease Control Program These efforts are being

carried out in health districts other than those selected for the integrated child survival activities

This consolidation of distinct strategies, primarily for A I D. focused programming and budgeting convenience, is one of several factors which has complicated project management and has caused confusion in implementation priorities, organizational structure and functions, and the roles of the various implementing agencies The project design also underestimated the type and number of staff needed for financial management and procurement, as well as the capabilities of the MOH Department of Environmental Sanitation (since disbanded by the MOH) to implement the water and sanitation activities The institutional contractor (JSA) was given both administrative (line) and technical advisory (staff) responsibilities Also, the JSA team was not in place until early 1990 (the seventh project quarter) due to delays in contracting and, unfortunately, the Chief of Party subsequently resigned prematurely Overall leadership and management advisory capabilities were allegedly very deficient The position remains vacant

The process of implementation and the availability of financial and material resources were significantly delayed, in part due to inexperience with PL-480 accounting requirements, which has caused frustration and a loss of project credibility within the MOH and health districts JSA has been absorbed under the management structure of the PMU and overly burdened with administrative tasks at the expense of providing needed technical assistance, particularly at the department and district levels No advisors have been placed at the regional sanitary units as was originally proposed in the project agreement

The integrated child survival component is currently assisting four Health Districts, with a fifth District to be included in early 1992 through a sub-contract with Project Concern International Resources have been concentrated at the District level with very little support provided to the regional sanitary units A very positive and encouraging development has been the (albeit delayed) introduction of water and sanitation model which utilizes appropriate technologies, facilitates community participation in decision making and management, and appears to be potentially sustainable To date, three systems have been completed and sixteen are in construction, almost all by contracts with non-governmental organizations (NGOs) The current methodology, however, does not yet integrate the child survival interventions in community organization or health promotion and education, as a unified, coherent effort at the community level

Baseline surveys and health education needs assessments have been carried out in each of the districts These studies were done only in the communities in which water and sanitation projects would be implemented and where the greatest impact was felt to be forthcoming An ambitious and comprehensive health education plan has been developed, based on district-specific needs, but has not yet been implemented Some district-level and off shore participant training has been undertaken but not within the framework of a global training strategy and plan which includes the strengthening of management functions as well as child survival technologies.

Institutional development and community participation, two of the three thrusts of this project, have not received the attention and focus needed to assure the sustainability of project benefits To be sure, a number of activities and resources have been applied which can and may contribute to these objectives, but in the absence of focused, coherent and comprehensive strategies and plans these efforts may be diffused and, perhaps, even ill conceived Project energies to date have focused on the delivery of resources and services, which in some cases, particularly in terms of the regional support structures, may be counterproductive to the development of sustainable systems and models The degree to which institutionalization should take place within the MOH is an issue on which the MOH Director General of Health and the CCH Executive Director have different opinions All parties agree, however, that local self-financing mechanisms must be developed to enhance and sustain community and District operations These are two critical areas for which technical assistance has not been anticipated or forthcoming

SUMMARY (Continued)

The following recommendations are generic to achieving an overall impact through more effective and efficient implementation and provide a basis for actions in individual areas

1. The institutional contractor (JSA) should continue to provide technical assistance through the end of its current contract (July 1973) and then be evaluated to determine whether an extension is in order A capable and functional Chief of Party should be hired without delay
2 The principal agency participants --PMU, MOH, JSA and USAID-- should initiate a concerted process of organizational development and strategic planning as soon as possible The process should be on-going and directed by a seasoned outside facilitator
3. The project management structure should reflect and support the operational differences between administrative and technical functions, the managerial independence between the integrated child survival and Chagas' components, and the institutional autonomy of the CCH/PMU, the MOH Health Districts, and JSA
4 The project needs to develop coherent and unified strategies and feasible but focused implementation plans for institutional development, community participation, health promotion and education, data collection, monitoring and evaluation, and training
5. The Government of Bolivia must fill currently vacant positions and create new positions for critical staff in all project Districts as stipulated in the Project Agreement
6 The integrated child survival component should focus its efforts on a strategy of integrating water & sanitation, health promotion & education, and improved management support systems A full service" strategy should be developed for those select communities with water and sanitation systems, and a second broader strategy would improve health promotion/education and management support systems for the remaining communities in the Health district
7 JSA should provide technical assistance to design and conduct operations research to identify and test alternative local financing mechanisms, appropriate staffing patterns, and cost analysis
8 The project should strengthen its financial liquidation system with the PL-480 Secretariat by: accepting the Secretariat's offer to provide training; engaging the USAID/ARD office as an honest broker; adding key PL-480 issues to the District field manual; and developing PILs to resolve impediments

Lessons learned or confirmed in this evaluation include:

* Water and sanitation and child survival must be seen as completely interdependent if any long-range impact on health at the community level is to be sustained.
* The most important and indispensable resource in delivering PHC services is the front-line health worker, sufficient in numbers and appropriately trained.
* Resources and technical assistance requirements for health promotion and education often underestimated and inadequate to ensure sustainable benefits.
* A data collection, monitoring and evaluation plan should be developed very early in project life so as to guide priority interventions and assure regular analysis and use.
* Technical assistance needs at the district and area levels are very basic. Advances take place one step at a time, requiring continuous and flexible technical assistance.
* Projects which have different objectives, strategies and resource needs often function more efficiently under separate management and financing structures.
* Projects which involve several autonomous implementing agencies require high levels of communication, coordination and negotiation.
* Organizational development and team building are essential at the inception as well as at all critical phases of a project in order to clearly define roles, expectations and operational plans of action.

ATTACHMENTS

K. Attachments (List attachments submitted with this Evaluation Summary; always attach copy of full evaluation report even if one was submitted earlier; attach logframe, surveys, etc. from ongoing evaluation if relevant to the evaluation report.)

Midterm Evaluation of the Community and Child Health Project (511-0594)
January 31, 1992

COMMENTS

L. Comments By Mission, AID/W Office and Borrower/Grantee On Full Report

The Mission compliments the team on a thorough, concise evaluation of a very complex project The recommendations are practical and insightful

The Mission is in general agreement with the findings of the Evaluation The project is operating well, especially the Diarrhea, Immunization and Chagas' Disease Components The more complicated Integrated Child Survival Component has been successful for the most part, but could be improved with stronger attention to the management issues described in the Evaluation, and has suffered from a lack of focus and overall vision

The JSA Healthcare contract may be continued, provided that JSA Healthcare can provide a strong Chief of Party as Management Advisor Should they be unable to fill this position, HHR, in consultation with the RCO, will review possible alternative contracting options including revision and/or termination of the JSA institutional contract

The project will be amended in August 1992, based on the results of this Evaluation, providing $3 5 million additional resources for the Immunization, Diarrheal Disease and Chagas' Disease components Internal Strategy planning sessions will be held to recommend modifications to the Integrated Child Survival Component of the Project Paper and Agreement Recommended changes may include reducing the number of districts from 11 to 6, and concentrating on the three synergistic areas of water and sanitation, training, and institutional development The PACD will be extended until July 28, 1995

A I D EVALUATION SUMMARY - PART I

1 BEFORE FILLING OUT THIS FORM READ THE ATTACHED INSTRUCTIONS
2 USE LETTER QUALITY TYPE NOT DOT MATRIX TYPE

IDENTIFICATION DATA

A Reporting A I D Unit

Mission or AID/W Office USAID/BOLIVIA
(ES# _____)

B Was Evaluation Scheduled In Current FY Annual Evaluation Plan?

Yes ☐ Slipped ☐ Ad Hoc ☒
Evaluation Plan Submission Date FY 94 Q 1

C Evaluation Timing

Interim ☒ Final ☐
ExPost ☐ Other ☐

D Activity or Activities Evaluated (List the following information for project(s) or program(s) evaluated If not applicable list title and date of the evaluation report)

Project – No	Project/Program Title	First PROAG or Equivalent (FY)	Most Recent PACD (Mo / Yr)	Planned LOP Cost (000)	Amount Obligated To Date (000)
511 0594	COMMUNITY AND CHILD HEALTH PROJECT	1988	9/95	20 000	15 494

ACTIONS

E Action Decisions Approved By Mission or AID/W Office Director

Action(s) Required	Name of Officer Responsible for Action	Date Action to be Completed
Curtail activities in water and sanitation Integrate CCH personnel into Ministry of Health Develop activities for child survival interventions at the district level	Paul Ehmer	4/94

APPROVALS

F Date Of Mission Or AID/W Office review Of Evaluation (Month) (Day) (Year)
10 14 93

G Approvals of Evaluation Summary And Action Decisions

	Project Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or AID/W Office Director
Name (Typed)	Sigrid Anderson	Alvaro Muñoz Reyes	Anne Beasley	Carl Leonard
Signature	Sigrid Anderson	[illegible]	Anne Beasley	[illegible]
Date	02/18/94	02/18/94	2/18/94	2/18/94

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ABSTRACT

II Evaluation Abstract (Do not exceed the space provided)

This is a midterm assessment of the Community and Child Health Project in Bolivia The assessment has five objectives 1) to evaluate the overall child survival situation in Bolivia 2) to identify specific interventions or management improvements that could be implemented by the National Secretariat of Health which would have the greatest impact on saving lives and improving health over the next five years 3) to determine in which programs interventions USAID has a comparative advantage 4) to analyze how USAID can make a significant contribution to institutionalizing Secretariat of Health implementation of these interventions and 5) to develop recommendations for the redesign of the CCH project to strengthen its assistance to the Secretariat of Health in identified areas The assessment was carried out by a four person team from the Office of Health AID/W and HHR/USAID/Bolivia It was conducted from October 4 14 1993 The team reviewed documents and conducted interviews with members of the Bolivian Government staffs of NGOs and other donr agencies and USAID The team visited two rural health districts supported by the project and one member attended the final day of a Secretariat of Health planning meeting Findings of the assessment identify four principal causes of infant and child morbidity and mortality outside the neonatal period They are diarrheal diseases respiratory infections birth problems and prematurity and vaccine preventable diseases

USAID should focus its efforts on improving health systems in areas where it has a comparative advantage Eight areas are indicated

1) Communication and social marketing for behavior change in support of child survival interventions
2) Policy
3) Health care financing and sustainability
4) Commodities and logistics systems
5) Training
6) Program development management information and evaluation systems
7) Service utilization and quality of care
8) Research

Many of the findings and conclusions of this study indicate that the real challenge for the remaining life of project will be in the rural areas Emphasis should now be placed on preparing district level personnel to reach out to rural populations Better delivery and distribution systems are needed so that rural facilities are adequately stocked with supplies and pharmaceuticals This will improve the quality of care and should result in greater utilization of the facilities Innovative health care interventions which are culturally sensitive should be developed by health workers who interact directly with targeted communities Pilot activities which upgrade the quality of child survival interventions should also be designed for districts

COSTS

I Evaluation Costs

1 Evaluation Team Name	Affiliation	Contract Number OR TDY Person Days	Contract Cost OR TDY Cost (U S $)	Source of Funds
Dr Al Bartlett	Office of Health AID/W	10	14 658	Office of Health AID/W
Dr Mary Ann Anderson	Office of Health AID/W	10		
Mr Paul Ehmer	USAID/Bolivia/HHR	10		USAID/Bolivia
Ms Jennifer Macias	USAID/Bolivia/HHR	10		

2 Mission/Office Professional Staff Person Days (Estimate) 12 (to review and revise report)

3 Borrower / Grantee Professional Staff Person Days (Estimate) 10

A I D EVALUATION SUMMARY - PART II

SUMMARY

J Summary of Evaluation Findings Conclusions and Recomendations (Try not to exceed the three (3) pages provided)
Address the following items
Purpose of evaluation and methodology used
Purpose of activity(ies) evaluated
Findings and conclusions (relate to questions)
Principal recomendations
Lessons learned

Mission or Office	Date This Summary Prepared	Title and Date Of Full Evaluation Report
USAID/BOLIVIA	1/24/94	Midterm Assessment of the Community and Child Health Project 511 0594

The purpose of the Community and Child Health (CCH) Project is to contribute to the reduction of infant child and maternal mortality in Bolivia through an integrated package of child survival interventions institutional development and community participation This assessment has five objectives 1) to evaluate the overall child survival situation in Bolivia 2) to identify specific interventions or management improvements that could be implemented by the National Secretariat of Health (SNS) which would have the greatest impact on saving lives and improving health over the next five years 3) to determine in which program interventions USAID has a comparative advantage 4) to analyze how USAID can make a significant contribution to institutionalizing SNS implementation of those interventions and 5) to develop recommendations for redesign of the CCH Project to strengthen its assistance to the SNS in identified areas

This assessment was conducted from October 4 14 1993 It included a review of documents and interviews with members of the Bolivian Government staff of NGOs other donor agencies and USAID It also included visits to two rural health districts supported by the project and attending a planning meeting of the National Secretariat

Findings identify four principal causes of infant and child morbidity and mortality outside the neonatal period They are diarrheal diseases respiratory infections birth problems and prematurity and vaccine preventable diseases Over 60% of the rural population lacks access to basic health care In rural areas it is estimated that only 31% of the women receive prenatal care and only 18% have institutional births Malnutrition is an underlying cause in 57% of all deaths of children under six Most children especially in rural areas do not attend clinics where their growth could be monitored

USAID should focus its efforts on improving health systems in areas where it has a comparative advantage These include the following

1) **Communication and Social Marketing for Behavior Change in Support of Child Survival Interventions** Many Bolivians especially in rural areas do not use health services Marketing efforts to increase use of services should be culturally appropriate Some USAID projects which have successfully developed culturally sensitive programs include Interactive Radio Learning MotherCare and Prosalud

2) **Policy** USAID should carry out policy dialogue for health care reform at the national level The timing is right because Bolivia s new government is contemplating a series of structural changes to improve services in all social sectors The A I D Data for Decision Making (DDM) could contribute to this process

3) **Health Care Financing and Sustainability** USAID has positive experience in this area, especially with Prosalud which it can share with the Bolivian Government

4) **Commodities and Logistics Systems** In Bolivia USAID has had a major role in supplying and efficiently distributing vaccines and ORS for the national health program through the CCH Project It has distributed contraceptives to the private sector through the Reproductive Health Project The CCH Project has a smoothly functioning procurement system which should be retained

5) **Training** USAID should development a system of in service training for district area and sector level health workers This system should be based on a training needs assessment and would include training for nurses and mid wives

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A I D EVALUATION SUMMARY - PART II

SUMMARY

J Summary of Evaluation Findings Conclusions and Recomendations (Try not to exceed the three (3) pages provided)
Address the following items

Purpose of evaluation and methodology used
Purpose of activity(ies) evaluated
Findings and conclusions (relate to questions)
Principal recomendations
Lessons learned

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6 When a project is directed towards strengthening administrative and management capacities at different levels i e central regional, district and outlying activities should be tailored towards each level If most of the project resources are channelled to the higher levels impact at lower level facilities which purport to serve the targeted population will be less That is why pilot activities should be designed at the district levels to provide model responses to upgrade the quality of child survival interventions for the targeted population

ATTACHMENTS

G. SCOPES OF WORK FOR INTERNATIONAL TECHNICAL ASSISTANCE

(15 pages)

PROGRAM DESCRIPTION
INCREMENTAL FUNDING FOR PROPOSED ACTIVITIES IN BOLIVIA
DATA FOR DECISION-MAKING/HARVARD
COOPERATIVE AGREEMENT

I. Background

The recently elected government of Bolivia has shown receptivity to technical assistance in the policy area. Accordingly, USAID/Bolivia is planning an expansion of USAID support to policy initiatives under the Community and Child Health (CCH) project (FY 94) and the Reproductive Health Services (RHS) project (FY 95/96) to create an environment supportive of the articulated and legislated desire of the Government of Bolivia (GOB), Ministry of Human Development (MHD), Ministry of Sustainable Development and Environment (MSDE), and National Secretariat of Health (NSH) to decentralize the provision of health services, and to reform the financing system in the sector to improve maternal and child health The implementing agencies of DDM/Policytech Project, Harvard University and the Research Triangle Institute, with the financial support of USAID/Washington, already have made technical assistance site visits to Bolivia and have explored options with several public and private sector Bolivian institutions for assistance in policy reform.

In developing new policies and plans to deal with these health sector reform issues, Bolivia lacks critical institutional capability at all levels of the health system Specifically:

1 Essential basic data and analytic capacity are lacking for developing reform strategies and for monitoring and evaluating progress in the health sector reforms.

2. The GOB currently does not have a unit or division with sufficient technical capacity to organize, utilize, and disseminate the appropriate data and analysis for health planning and policy reform.

3. Several national level groups make significant contributions to decision making. Sub-national governmental and nongovernmental organizations (NGOs) and institutions are also important decision makers in planning and policy reform. There is as yet no orderly process for focussing these efforts.

II. Proposed Activity Objective

Under this current proposed activity for FY 1994, FY 1995, and FY 1996, DDM/Policytech, proposes to work with the counterparts listed above plus other counterparts, providing greater in-depth technical assistance to (1) strengthen their capacity to devise and analyze policy and programmatic alternatives; (2) build alliances for action; and (3) monitor and evaluate action

III. Proposed Activities

DDM/Policytech proposes to work closely with a team of Bolivian professionals to increase their capability to undertake policy-making activities. Specific activities proposed at this time include·

1. Information and Planning Unit in the Secretariat of Health

   Five activities are proposed to assist the Secretariat to evaluate all the information in the sector, propose strategies for strengthening each information subsystem, develop integrated systems which will allow high level policymakers to have direct access to key indicators of the sector, and allow policymakers to use this information in policy analysis, planning and evaluation. The proposed five activities include·

   a. Development of Executive Information Systems (EIS) that are designed specifically to meet the needs of high-level decision makers.

   b. Development of a Health Planning Resource Model (HPRM) based on previous experience in Peru and the region of Santa Cruz, Bolivia.

   c. Provision of a Long Term Advisor (Bolivian local hire) to work inside the Information and Planning Unit

   d. Assistance with priority setting using cost-effectiveness analysis to compare alternative control measures for the major health problems.

   e. Provision of Training, including the Leadership Forum at Harvard University for the Secretary of Health or other appropriate Ministers; short courses in health financing (10 weeks, 1

participant), and MPH training in international health policy and management (10 months, 1 participant)

2 Ministry of Human Development and Secretariat of Health, Ministry of Sustainable Development and the Environment

Three activities are proposed to build consensus for the health reform process and to make certain that key issues like costing and financing are treated adequately The proposed activities include

f Preparation of graphical presentations on Health Sector reform using simplified eye-catching formats and technology showing the importance of investing in health, key elements and options of reform with associated costs and financing, and presentation of elements of the de facto reform already in progress

g Preparation and presentation of at least three Policy Seminars (with approximately four consultants for each) -- in collaboration with PAHO when possible -- on social insurance schemes, economic and finance issues, responding to client demands, universal benefits packages, the political economy of decision making, or other experiences with health sector reform in other countries

h Assistance in mapping the process of decision making in the Bolivian health sector to identify the actors, interests, concerns, beneficiaries, potential losers, and influence points to develop tactics for achieving political consensus as the reform process moves forward

3 Non-Government Sector

Three activities are proposed to strengthen the policy analysis capabilities of non-government health institutions and help them gain greater visibility among the health and social sector authorities. The proposed activities include·

i Development of an Executive Information System for PROSALUD, a dynamic private sector alternative for provision of self-financing, high quality health services

j Technical assistance in information management and analysis for PROCOSI, a federation of 13 NGOs, to improve coordination

k An analysis of reproductive health cost-effectiveness with PROCOSI members as they introduce reproductive health programs into their child survival projects

SCOPE OF WORK
USAID BOLIVIA BUY-IN TO THE BASICS PROJECT

I. BACKGROUND

Health conditions in Bolivia for infants and children under five have generally improved since 1980, but child and infant mortality is still among the highest in Latin America To combat this problem, "Improved Family Health Throughout Bolivia" is one of USAID/Bolivia's four strategic objectives, and "Increased utilization of health and family planning interventions by Bolivian mothers and children under 5" is a specifically-targeted outcome.

The mission has been funding the extension of modern child survival technologies in Bolivia since 1988, including the control of diarrheal diseases (CDD), promotion of oral rehydration salts (ORS), treatment of acute respiratory infections (ARI) and expansion of programs to immunize children against childhood diseases (EPI)programs. These activities are supported principally through the bilateral "Community and Child Health" (CCH) Project

A health sector assessment and evaluation of CCH was conducted in October, 1993 This review occurred shortly after Bolivian national elections, and coincided with the implementation of a major reorganization of the GOB health sector into a Secretariat of Health (SOH) Decentralization and extension of basic health services to Bolivian municipalities is a primary mandate of the SOH. In response, the assessment identified a number of specific areas where USAID/Bolivia has a comparative advantage in promoting improved health services for children under the age of five These include:

- Communication and Social Marketing for Behavior Change in Support of Child Survival Interventions
- Commodities and Logistics Systems
- Training.
- Program Development, Management, Information and Evaluation Systems
- Service Utilization and Quality of Care
- Research.

The mission currently views these areas as providing a basic framework which will guide much of USAID/Bolivia assistance to child survival over the next three to five years.

II. OBJECTIVES

The major objective of activities to be funded through this PIO/T is support to ongoing child survival programs, particularly in areas which facilitate the reorganization and decentralization of health services Primary strategies for accomplishing this objective are improving the quality of care, strengthening health system management at the regional and municipal levels, identifying ways that communications can lead to behavior changes in different audiences, and extending the involvement of the private sector in better child health.

In order to accomplish this, support is sought from the centrally-funded BASICS Project, which is specifically designed to address these and other issues related to institutionalization of child survival programs Activities described below are designed to serve as a first phase of a more comprehensive assistance effort by BASICS over the next three years Future activities will be defined in the Country Activity Plan (CAP) for Bolivia, which will be developed in late 1994 This document will provide a strategic framework for activities which will address USAID/Bolivia's long-term child survival goals

The described assistance will be undertaken in collaboration with other USAID/Bolivia funded activities, including the CCH Project The activities below directly support the GOB's "Plan Vida," which is aimed at a rapid reduction of maternal and child mortality and the malnutrition which underlies much of it They also complement the child survival activities of other international donors working in Bolivia

III. STATEMENT OF WORK

The BASICS Project will implement and support the activities described below between September 1994 and August 1995 The timing of sub-activities is expected to vary, but the approximate duration of each is indicated in the activity description.

1. Compendium of ARI/CDD studies

Many studies on ARI and CDD have been conducted in Bolivia; however, the findings have not been broadly disseminated among those who are in a position to develop and implement national policies.

Objective: To make available to health care providers, policy makers, medical and nursing school faculty and others the results of local research on ARI and CDD.

Activities:

1. Collect, summarize and distribute information on ARI and diarrheal diseases developed through clinical, community and ethnographic studies in Bolivia in the last ten years

Duration: Four months

Output: Publication and distribution of research results.

2 Mortality Survey in El Alto

Although the CCH Project, the DHS, and other organizations have collected information on specific causes of childhood mortality, there has not yet been a systematic analysis of the operational, family decision-making, and quality of care factors that contribute to children dying, especially with reference to those potentially preventable deaths which occur within the theoretical reach of existing health services

In order to better understand why children die, rather than of what, BASICS will work with local collaborators to carry out operations research on family behavior, decision-making, and quality of treatment provided for children in El Alto, a peri-urban area of La Paz, who have died from illnesses for which death is judged to be potentially preventable This research will draw upon the "Process Diagnosis" approach developed and implemented for study of maternal and early infant mortality in Bolivia.

Objective: Identify the operational points at which the process of recognizing, seeking care, and providing care for child illness breaks down, and the key determinants of failure of the process at these points.

Analysis of study results will lead to development of recommendations for interventions to improve this process and improve management of child illness at both the family and health provider levels. This work is preliminary to implementation of specific strategies to implement these recommendations

Activities

1 Identify consultants and local collaborators

2. Develop and execute operations research

3 Analyze results

4 Present and discuss findings and their implications to locally responsible public health and civil authorities

5 Initiate a process of collaborative identification of strategies which will address the behavioral and service delivery problems identified

Duration: One Year

Output: Study protocol, research instruments, completed study, data analysis and training and IEC strategies developed based on results

3. Barriers to ARI Compliance Study

Recent studies conducted in Bolivia demonstrate that compliance with ARI case management protocols by health workers is a problem. In order to improve ARI treatment compliance, BASICS will conduct operations research to identify barriers and benefits which these groups perceive to adherence to norms A set of specific recommendations to improve compliance will be developed based on the results of this operations research Results of study are expected to inform communication strategies and systemic interventions for improving standard case management by health workers and compliance by caretakers

This study is preliminary to proposed activities to improve ARI case management (activity 6, below).

Objective: To identify impediments to proper ARI standard case management by health workers and to compliance with treatment by caretakers (mothers)

Activities:

1 Identify appropriate consultants and develop study design.

2 Collect and analyze data.

3 Develop recommendations for improving compliance

4. Assist the SOH to design of a plan for implementing recommendations and to develop appropriate didactic materials (i e training and informational materials) for health workers and caretakers

Duration: Approximately one year

Output: Study protocol, completed study, report on results, recommendations and plan for future activities and development of appropriate IEC materials/activities

4 Health Sector Reform

The health sector in Bolivia is going through major structural changes, and the management of health services is being shifted to municipal governments In support of this reform, BASICS will provide technical assistance and training support to improve management and administrative skills necessary to this decentralization Because Bolivia is initiating reforms which are anticipated by other countries in the Latin American region, BASICS also plans to document the Bolivian experience in decentralization as a case study which may produce lessons learned for other countries in the region

Objective: Provide ad hoc assistance as required to support decentralization of the Bolivian health system.

Activities:

1. Assist the SOH to develop a plan for assistance in this area.

2 With CCH and local municipal authorities, design guidelines for facilitating decentralization.

2. Develop and carry out informational and training seminars for municipal authorities and community organizations.

3. Provide technical assistance to regional, district and municipal health authorities.

Duration: Continued assistance as needed throughout the period to August 1995.

Outputs: Quarterly reports on health reform process, training seminars at regional, district or municipal levels completed based on needs assessment

5. Strengthening National IEC Capacity

As BASICS develops the activities described above, the project will draw upon a local cadre of communication specialists and social science researchers to help shape protocols and conduct research, as well as craft and disseminate messages that are likely to influence behaviors in specific audiences In this phase, BASICS will increase national skills by working side-by-side with Bolivian professionals, and by offering formal training in communications methodologies as needed.

Objective: Promote national capability in health communication for behavior change and for managing the technologies associated with them.

Activities:

1 Identify Bolivian resources for conducting communication research and communication activities

2 Identify government and NGO personnel who could benefit from training and who will be in a position to apply communication skills to child survival programs.

3 Work with Bolivian professionals in designing and implementing formative research and the resulting communication strategies

4 Conduct the first of a series of training workshops in communications using materials previously developed through HEALTHCOM

Duration: BASICS will provide support for strengthening IEC capacity throughout the year covered by this PIO/T to August 1995.

Output: Cadre of trained personnel who will carry out BASICS' communication strategy, within the SOH and through NGOs. As results of proposed studies are received and processed, BASICS will assist in developing IEC strategies to address problems identified.

Activities:

1 Assist the SOH to review and refine plans for improving DD/ARI services based on findings from the Health Facilities Survey, the Compliance Study and other information

2 Identify and implement short and/or simple analytic activities to better define the strengths and weaknesses of DD/ARI service delivery in primary health care facilities (e g , review of existing curricula, training strategies, program operations, etc.)

3 Develop a strategy for improving clinical DD/ARI services, particularly in the areas of provider performance, training, and supervision

4 Design an evaluation methodology with indicators which will measure changes in DD/ARI treatment compliance by health care providers and permit evaluation of the effectiveness of the strategy developed.

Outputs: Review of SOH proposals for DD/ARI Training and supervisory systems, analyses of current strengths and weaknesses in delivery of DD/ARI clinical services, strategy for improving services and evaluation methodology

7. BASICS/W Operations Division Staff Support to BASICS/Bolivia Program

It is anticipated that two trips will be made during the period of September 1994-August 1995 by BASICS/W Operations Division staff members to support the activities described herein, including programmatic, financial, and administrative support, and for the purpose of conducting supervisory visits

Output: Central administrative support to facilitate in-country BASICS staff and country work plan, Trip reports.

SCOPE OF WORK
BOLIVIA BUY-IN
DATA FOR DECISION MAKING MAKING PROJECT
CENTERS FOR DISEASE CONTROL AND PREVENTION
PASA

A. Background

The first phase of the Data for Decision Making (DDM) Project, implemented by the Centers for Disease Control and Prevention (CDC), in collaboration with the National Secretariat of Health, Ministry of Human Development, the Child and Community Health Project (CCH), and USAID Bolivia, culminated with the First National Data for Decision Making Conference held in La Paz March 21-23, 1994 Participating Bolivian health officials and representatives of international partner agencies agreed that the program in applied epidemiology, management, and communications had been successful in building the capacity of Bolivian health officials and program managers at national, regional, and district levels to use data for identifying problems in their health programs, and to take a rational approach towards solving those problems The methodology allowed them to identify key determinants of the problem, explore possible interventions, develop a plan of action, identify and allocate available resources, develop evaluation plans and budgets, and communicate their plans and consequences of implementing their plans to decision and policy makers in a clear and understandable way.

On March 23, 1994, the National Secretariat of Health requested technical assistance from international partner agencies, including USAID, in 11 priority areas defined by the Secretariat's Task Force on Health Sector Reform Among the eleven areas, technical assistance was requested to develop, strengthen, and support a) mechanisms to implement policies in the context of decentralization; b) the establishment of a management program in health including training for groups who will implement health reform; and c) information systems for monitoring, evaluation, and management[1]

B. Objective

To provide technical assistance to the Bolivian National Secretariat of Health through the Child and Community Health Project to consolidate and institutionalize the technical capacity to plan, implement, and evaluate the program of in-service training piloted successfully during DDM Phase I.

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[1]The areas cited here are those to which DDM/CDC could respond and are not all inclusive

C. **Statement of Work**

1 Assist CCH in identifying a core staff of trainers in applied epidemiology, basic biostatistics, computer use, data analysis and presentation, applied management, and effective written and oral communication These trainers will join the Bolivian presently working in CCH who was responsible for the first phase of DDM in Bolivia, and who will become the DDM/Bolivia Director

2 Provide the core staff of trainers with additional technical support in their respective areas of expertise to increase their capacity to train in the areas of 1 above at the same level of quality that was maintained during the first phase of DDM

3. Under the direction of the DDM/Bolivia Director, and with support from CDC, the core staff of trainers will·

a. conduct a <u>Training Needs Assessment</u> for area medical doctors and nurses in rural and periurban areas, and develop a curriculum for training this target audience in the relevant topic areas identified during the assessment The curriculum will respond to professional and educational priorities established by the Human Resources Management Office of the National Secretariat of Health The training needs assessment will include an inventory and analysis of other similar "management" training programs currently being implemented in Bolivia (specifically through the World Bank's PROISS project, the Interamerican Development Bank's PSF project, and others), and will determine, with the Human Resources Management Office, priority target audiences, programmatic or geographic areas for the DDM training Agreement will be reached on the role and function of each training program, and appropriate target audiences for each

a. review existing materials developed during Phase I to <u>Revise and Adapt the Curriculum</u> as appropriate for use in training the target audience identified above.

b <u>Teach the Curricula</u> to selected area doctors and nurses.

c. <u>Follow-up trainees on-the job</u> after their formal two week courses to assess progress, assist with problems, and to make the training realistic to the job situations of the trainees

d. <u>Evaluate</u> the quality of the program and its effectiveness in increasing the use of data at local

levels for improved program performance and impact

4. Provide technical assistance to the DDM staff in the design and production of a public health bulletin to increase the dissemination and use of public health information at area, district, regional, and central levels [2]

5. Provide support for semi-annual national meetings of former and new participants of the DDM/Bolivia training in order to promote continuity with the first DDM training group, and provide a forum for discussion of DDM issues

6. Explore mechanisms and funding sources, and develop a plan for full institutionalization of "DDM" training and technical assistance activities in Bolivia This will include exploring possible collaborative options with existing public and/or private training institutions Potential future funding sources include UNICEF, PAHO, IDB, and other local and international donor agencies.

D. Anticipated Accomplishments

The duration of this activity is one year The following outputs are expected to be accomplished by the end of the buy-in period

1. A DDM unit will be established within the Child and Community Health Project which can plan, implement, and evaluate in-service training programs in the areas noted in C 1 above The unit will provide technical assistance to the Secretariat of Health in its efforts to train public health professionals to plan, implement and evaluate public health programs

2. A cadre of trainers will be identified and hired to staff the DDM unit in CCH These trainers will receive advanced training in their respective technical areas and in training methodology

3. A training needs assessment defining specific target audiences, and identifying their needs in the proposed areas will be carried out

4. Training curricula in applied epidemiology, management, and communications will be developed for specific target audiences

5. Training programs for public health professionals (to be identified in collaboration with the Office of Human

[2]The first several issues might include results of project plans and outcomes by the first group of participants

Resources Management of the National Secretariat of Health) comprising 4 courses will be implemented (One training program will be developed under the funding for this agreement A second program will be developed if sufficient additional funding is identified.)

6. Methodologies and instruments for follow-up of trainees will be developed

7 A public health bulletin will be designed, piloted, and evaluated

8 A counterpart institution from the university post-graduate or other public or private training system will be identified Agreements will be reached on post-graduate academic accreditation for DDM training, potential university or private faculty participation in DDM training programs, and future transfer of training methodologies to the institution

ATTACHMENTS

H PROJECT'S STATUTORY CHECK LIST

(26 pages)

Updated Assistance Checklist for
Community and Child Health Project
(USAID Project No 511-0594) ("CCH"),
Supplement No 2

5C(2) - ASSISTANCE CHECKLIST

Listed below are statutory criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to receive assistance This section is divided into three parts Part A includes criteria applicable to both Development Assistance and Economic Support Fund resources Part B includes criteria applicable only to Development Assistance resources Part C includes criteria applicable only to Economic Support Funds

CROSS REFERENCE IS COUNTRY CHECKLIST UP TO DATE?	Yes Country checklist for Bolivia was updated for FY 1995 in the Project Paper for Community and Child Health (USAID Project No 511-0594)
A CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS	
1 **Host Country Development Efforts** (FAA Sec 601(a)) Information and conclusions on whether assistance will encourage efforts of the country to (a) increase the flow of international trade, (b) foster private initiative and competition, (c) encourage development and use of cooperatives, credit unions, and savings and loan associations, (d) discourage monopolistic practices, (e) improve technical efficiency of industry, agriculture, and commerce, and (f) strengthen free labor unions	These issues are generally applicable to the CCH Because it will foster private-public partnerships and competition, will encourage the development of alternative health care finance mechanisms and will discourage public monopolic health care services
2 **U S. Private Trade and Investment** (FAA Sec 601(b)) Information and conclusions on how assistance will encourage U S private trade and investment abroad and encourage private U S participation in foreign assistance programs (including use of private trade channels and the	Project will only indirectly encourage U S private trade and investment abroad Project has used and will continue using the services of U S firms in providing technical assistance

services of U S private enterprise)

3 **Congressional Notification**

a **General requirement** (FY 1995 Appropriations Act Sec 515, FAA Sec 634A) If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified (unless the Appropriations Act notification requirement has been waived because of substantial risk to human health or welfare)?	Congress has been notified in accordance with standard Agency procedures
b **Special notification requirement** (FY 1995 Appropriations Act Sec 520) Are all activities proposed for obligation subject to prior congressional notification?	No special notification is required for obligations for Bolivia
c **Notice of account transfer** (FY 1995 Appropriations Act Sec 509) If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures?	Not applicable
d **Cash transfers and nonproject sector assistance** (FY 1995 Appropriations Act Sec 536(b)(3)) If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U S interests to be served and a description of any economic policy reforms to be promoted?	Not applicable
4 **Engineering and Financial Plans** (FAA Sec 611(a)) Prior to an obligation in excess of $500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance, and (b) a reasonably firm estimate of the cost to the U S	Yes

of the assistance?

5 **Legislative Action** (FAA Sec 611(a)(2)) If legislative action is required within recipient country with respect to an obligation in excess of $500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?	No special action is required
6 **Water Resources** (FAA Sec 611(b)) If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U S C 1962, et seq)?	Not applicable, at this point in the project because all water systems construction has been completed as of December 31st 1994
7 **Cash Transfer/Nonproject Sector Assistance Requirements** (FY 1995 Appropriations Act Sec 536) If assistance is in the form of a cash transfer or nonproject sector assistance	Not applicable
a **Separate account.** Are all such cash payments to be maintained by the country in a separate account and not commingled with any other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)?	Not applicable
b **Local currencies:** If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies	Not applicable
(1) Has A I D (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by	

agreement the responsibilities of A I D and that government to monitor and account for deposits into and disbursements from the separate account?

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

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

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

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

Not applicable

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

Project focuses on selected rural areas in Bolivia

10 **U S Private Trade** (FAA Sec 601(b)) Information and conclusions on how project will encourage U S private trade and investment abroad and encourage private U S participation in foreign assistance programs (including use of private trade channels and the services of U S private enterprise)	See item 2 above
11 **Local Currencies**	
a **Recipient Contributions** (FAA Secs 612(b), 636(h)) Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U S are utilized in lieu of dollars	PL 480 funds and newly established municipal funds - authorized through the popular participation of 1994 - will contribute local currency to meet local costs
b **U S.-Owned Currency** (FAA Sec 612(d)) Does the U S own excess foreign currency of the country and, if so, what arrangements have been made for its release?	No, not applicable
12 **Trade Restrictions**	
a **Surplus Commodities** (FY 1995 Appropriations Act Sec 513(a)) If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U S producers of the same, similar or competing commodity?	Not applicable
b **Textiles (Lautenberg Amendment)** (FY 1995 Appropriations Act Sec 513(c)) Will the assistance (except for programs in Caribbean Basin Initiative countries under U S Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U S -made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in,	No

or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U S exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?	
13 **Tropical Forests** (FY 1991 Appropriations Act Sec 533(c)(3)(as referenced in section 532(d) of the FY 1993 Appropriations Act) Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas?	No
14 **PVO Assistance**	
a **Auditing and registration** (FY 1995 Appropriations Act Sec 560) If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A I D , and is the PVO registered with A I D ?	No
b **Funding sources** (FY 1995 Appropriations Act, Title II, under heading "Private and Voluntary Organizations") If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?	Not applicable
15 **Project Agreement Documentation** (State Authorization Sec 139 (as interpreted by conference report)) Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A I D LEG within 60 days of the agreement's entry into force with	No agreement covered by the Case-Zablocki Act guidance is anticipated

respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision)

16 **Metric System** (Omnibus Trade and Competitiveness Act of 1988 Sec 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec 2, and as implemented through A I D policy) Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A I D specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

The metric system will be used to the extent practicable

Bulk purchases are not anticipated

Metric units of measurement have been used from the earliest programmatic stages

17 **Abortions** (FAA Sec 104(f), FY 1995 Appropriations Act, Title II, under heading "Population, DA," and Sec 518)

a Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? (Note that the term "motivate" does not include the provision, consistent with local law, of information or counseling about all pregnancy options including abortion)

No

b Are any of the funds to be used to pay for the performance of involuntary sterilization as a method

No

of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?	
c Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?	No
d Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? (As a legal matter, DA only)	Yes
e In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? (As a legal matter, DA only)	No
f Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?	No
g Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization?	No
18 **Cooperatives** (FAA Sec 111) Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life?	Yes, the project will promote sustainable health and sanitation institutions at the rural areas
19 **U S.-Owned Foreign Currencies**	

a **Use of currencies** (FAA Secs 612(b), 636(h), FY 1995 Appropriations Act Secs 503, 505) Are steps being taken to assure that, to the maximum extent possible, foreign currencies owned by the U S are utilized in lieu of dollars to meet the cost of contractual and other services	See answers to previous questions relating to local currencies, above
b **Release of currencies** (FAA Sec 612(d)) Does the U S own excess foreign currency of the country and, if so, what arrangements have been made for its release?	No, not applicable
20 **Procurement**	
a **Small business** (FAA Sec 602(a)) Are there arrangements to permit U S small business to participate equitably in the furnishing of commodities and services financed?	Procurement will be conducted by recipient organization under standard HB 11 provisions U S small business will not be excluded
b **U S procurement** (FAA Sec 604(a) Will all procurement be from the U S , the recipient country, or developing countries except as otherwise determined in accordance with the criteria of this section?	Yes, see answer to previous item
c **Marine insurance** (FAA Sec 604(d)) If the cooperating country discriminates against marine insurance companies authorized to do business in the U S , will commodities be insured in the United States against marine risk with such a company?	Not applicable
d **Insurance** (FY 1995 Appropriations Act Sec 531) Will any A I D contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U S insurance companies have a fair opportunity to bid for insurance when such insurance is necessary or appropriate?	Yes
e **Non-U S. agricultural procurement** (FAA Sec 604(e)) If non-U S procurement of agricultural commodity or product thereof is to be financed, is there provision against	Procurement of agricultural products is not anticipated under the Project

such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U S)

f **Construction or engineering services** (FAA Sec 604(g)) Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries)

No, construction engineering services will be a very small component of the project Services as they are required would likely be procured from local or U S sources

g **Cargo preference shipping** (FAA Sec 603)) Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U S flag commercial vessels to the extent such vessels are available at fair and reasonable rates?

Project will comply with cargo preference requirements in accordance with relevant standard provisions of USAID Handbook 11 instruments

h **Technical assistance** (FAA Sec 621(a)) If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

Yes, project will not utilize facilities and resources of other Federal agencies

i **U S. air carriers** (International Air Transportation Fair Competitive Practices Act, 1974) If air transportation of persons or

Yes, in accordance with standard provisions of applicable USAID Handbook 11 instruments

property is financed on grant basis, will U S carriers be used to the extent such service is available?	
j **Consulting services** (FY 1995 Appropriations Act Sec 559) If assistance is for consulting service through procurement contract pursuant to 5 U S C 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)?	Expenditures under any direct contract for consulting services financed under this Project will be a matter of public record and available for public inspection
k **Metric conversion** (Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec 2, and as implemented through A I D policy) Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A I D specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?	See previous answers to questions relating use of metric system above
l **Competitive Selection Procedures** (FAA Sec 601(e)) Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	Yes
m **Notice Requirement** (FY 1995 Appropriations Act Sec 568) Will project agreements or contracts contain notice consistent with FAA	Yes, in accordance with standard provisions on procurement in USAID Handbook 11 instruments

section 604(a) and with the sense of Congress that to the greatest extent practicable equipment and products purchased with appropriated funds should be American-made?

21 **Construction**

a **Capital project** (FAA Sec 601(d)) If capital (e g , construction) project, will U S engineering and professional services be used?

Most construction work took place in previous project phases such as water systems and housing improvements At this stage of the project, except for minor renovations and isolated health centers, there will be no major construction work However, procurement of these small services will be done in accordance with FAA and USAID Handbook provisions

b **Construction contract** (FAA Sec 611(c)) If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

Yes

c **Large projects, Congressional approval** (FAA Sec 620(k)) If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U S not exceed $100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress?

Not applicable

22 **U S. Audit Rights** (FAA Sec 301(d)) If fund is established solely by U S contributions and administered by an international organization, does Comptroller General have audit rights?

Not applicable

23 **Communist Assistance** (FAA Sec 620(h) Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of

Yes

the Communist-bloc countries?

24 **Narcotics**

a **Cash reimbursements** (FAA Sec 483) Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated?	Yes
b **Assistance to narcotics traffickers** (FAA Sec 487) Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances), or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance?	Yes, new regulations under FAA Section 487 will be implemented as soon as they are issued
25 **Expropriation and Land Reform** (FAA Sec 620(g)) Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President?	Yes
26 **Police and Prisons** (FAA Sec 660) Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs?	Yes
27 **CIA Activities** (FAA Sec 662) Will assistance preclude use of financing for CIA activities?	Yes
28 **Motor Vehicles** (FAA Sec 636(i)) Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U S , unless a	Yes

waiver is obtained?

29 **Export of Nuclear Resources** (FY 1995 Appropriations Act Sec 506) Will assistance preclude use of financing to finance--except for purposes of nuclear safety--the export of nuclear equipment, fuel, or technology? Yes

30 **Publicity or Propaganda** (FY 1995 Appropriations Act Sec 554) Will assistance be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? No

31 **Exchange for Prohibited Act** (FY 1995 Appropriations Act Sec 533) Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law? No

32 **Commitment of Funds** (FAA Sec 635(h)) Does a contract or agreement entail a commitment for the expenditure of funds during a period in excess of 5 years from the date of the contract or agreement? No

33 **Impact on U S. Jobs** (FY 1995 Appropriations Act, Sec 545)

a Will any financial incentive be provided to a business located in the U S for the purpose of inducing that business to relocate outside the U S in a manner that would likely reduce the number of U S employees of that business? No

b Will assistance be provided No

for the purpose of establishing or developing an export processing zone or designated area in which the country's tax, tariff, labor, environment, and safety laws do not apply? If so, has the President determined and certified that such assistance is not likely to cause a loss of jobs within the U S ?

c Will assistance be provided for a project or activity that contributes to the violation of internationally recognized workers rights, as defined in section 502(a)(4) of the Trade Act of 1974, of workers in the recipient country, or will assistance be for the informal sector, micro or small-scale enterprise, or smallholder agriculture? — No

B CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY

1 **Agricultural Exports (Bumpers Amendment)** (FY 1995 Appropriations Act Sec 513(b), as interpreted by conference report for original enactment) If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U S exporters of a similar agricultural commodity, or (2) in support of research that is intended primarily to benefit U S producers? — Not applicable

2 **Tied Aid Credits** (FY 1995 Appropriations Act, Title II, under heading "Economic Support Fund") — No

Will DA funds be used for tied aid credits?	
3 **Appropriate Technology** (FAA Sec 107) Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?	Yes, related to primary health care, family health care and prevention
4 **Indigenous Needs and Resources** (FAA Sec 281(b)) Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country, utilizes the country's intellectual resources to encourage institutional development, and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government	The project's annual operational plan is based on annual plans prepared at the municipal level by the local level representatives Project aims at the establishment of local health systems with regional and central government Education and training for effective demand of health services and citizen participation in local health systems is a key project component
5 **Economic Development** (FAA Sec 101(a)) Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?	Yes, with the establishment of sustainable health care financing systems and local networks of health care providers
6 **Special Development Emphases** (FAA Secs 102(b), 113, 281(a)) Describe extent to which activity will (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U S institutions, (b) encourage democratic private and local governmental institutions, (c) support the self-help efforts of developing countries, (d) promote the	CCH attempts to reach with health services to rural and dispersed population, which are also poor It will develop adequate and sustainable technology for health care services in rural areas The participation of organized community groups in the governance of local health systems (public-private partnerships), the use of social marketing for health, and, intensive health education problems for community children and women, are important components of the project

participation of women in the national economies of developing countries and the improvement of women's status, and (e) utilize and encourage regional cooperation by developing countries	
7 **Recipient Country Contribution** (FAA Secs 110, 124(d)) Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?	Yes
8 **Benefit to Poor Majority** (FAA Sec 128(b)) If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?	Yes, whereas one of the main objectives is the institutional development of the National Secretary of Health, the project also aims at strengthening private and voluntary health care providers that work at local levels
9 **Contract Awards** (FAA Sec 601(e)) Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	Yes, it will follow HB 11 procedures
10 **Disadvantaged Enterprises** (FY 1995 Appropriations Act Sec 555) What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?	The project will follow procedures that do not discriminate against these enterprises
11 **Biological Diversity** (FAA	Not applicable

161

Sec 119(g) Will the assistance (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity, (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats, (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection, or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas? (Note new special authority for biodiversity activities contained in section 547(b) of the FY 1995 Appropriations Act)	
12 **Tropical Forests** (FAA Sec 118, FY 1991 Appropriations Act Sec 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act)	Not applicable
a **A I D Regulation 16** Does the assistance comply with the environmental procedures set forth in A I D Regulation 16?	Yes
b **Conservation** Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible (1) stress the importance of conserving and sustainably managing forest resources, (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas, (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management, (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices, (5) help conserve forests which have not yet been degraded by helping to	Not applicable

increase production on lands already cleared or degraded, (6) conserve forested watersheds and rehabilitate those which have been deforested, (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing, (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation, (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas, (10) seek to increase the awareness of U S Government agencies and other donors of the immediate and long-term value of tropical forests, (11) utilize the resources and abilities of all relevant U S government agencies, (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

c **Forest degradation** Will assistance be used for (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems, (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce

Not applicable

exotic plants or animals into such areas, (3) activities which would result in the conversion of forest lands to the rearing of livestock, (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands, (5) the colonization of forest lands, or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?	
d **Sustainable forestry** If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry?	Not applicable
e **Environmental impact statements** Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A I D regulations requiring an environmental impact statement for activities significantly affecting the environment?	This project does not include activities that significantly affect the environment
13 **Energy** (FY 1991 Appropriations Act Sec 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act) If assistance relates to energy, will such assistance focus on (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases?	Not applicable

14 **Debt-for-Nature Exchange** (FAA Sec 463) If project will finance a debt-for-nature exchange, describe how the exchange will support protection of (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves, or describe how the exchange will promote (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management	Not applicable
15 **Deobligation/Reobligation** (FY1995 Appropriations Act Sec 510) If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified?	Not applicable
16 **Loans**	
a **Repayment capacity** (FAA Sec 122(b)) Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest	This is a bilateral grant, therefore item 16 is not applicable
b **Long-range plans** (FAA Sec 122(b)) Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?	
c **Interest rate** (FAA Sec 122(b)) If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter?	
d **Exports to United States** (FAA Sec 620(d)) If assistance is	

for any productive enterprise which will compete with U S enterprises, is there an agreement by the recipient country to prevent export to the U S of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

17 **Development Objectives** (FAA Secs 102(a), 111, 113, 281(a)) Extent to which activity will (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U S institutions, (2) help develop cooperatives, especially by technicalassistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions, (3) support the self-help efforts of developing countries, (4) promote the participation of women in the national economies of developing countries and the improvement of women's status, and (5) utilize and encourage regional cooperation by developing countries?

The project aims at increasing access coverage, quality and sustainability of health services among rural populations It also promotes the use of improved traditional health services This will mean support for appropriate technology in ways that are sensitive to local culture Community based organizations will insure the participation of the rural poor, women and children, specially those in school age

18 **Agriculture, Rural Development and Nutrition,** and **Agricultural Research** (FAA Secs 103 and 103A)

a **Rural poor and small farmers** If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor, or if assistance is being made available for agricultural research,

This project aims at improving the health status of rural population, therefore, it will indirectly contribute to increase the productivity and income of the rural poor A distinct activity in the project is nutrition both for child survival and maternal

has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made	health The project does not include any assistance in crop production but insists in nutrition education, growth monitoring and reduction of malnutrition
b **Nutrition** Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value, improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs, and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people	
c **Food security** Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution	Not applicable
19 **Population and Health** (FAA Secs 104(b) and (c)) If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach	The CCH aims the integrated provision of essential health services, which include community health services, child survival services and reproductive health Nutrition covers both community and child health activities The project attempts to increase the utilization of existing health care facilities (improved supply of services) and the mobilization of community

	demand for health (outreach)
20 **Education and Human Resources Development** (FAA Sec 105) If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development, and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities	Non-formal health education in health nutrition and environmental sanitation is a major component of the CCH for community participation The project also includes management training and an important training line in regard to data for decision making that includes epidemiological, managerial and communication training
21 **Energy, Private Voluntary Organizations, and Selected Development Activities** (FAA Sec 106) If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is	Not applicable
a concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production, and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment,	
b concerned with technical cooperation and development, especially with U S private and voluntary, or regional and international development, organizations,	
c research into, and evaluation of, economic development	

processes and techniques,

d reconstruction after natural or manmade disaster and programs of disaster preparedness,

e for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U S assistance,

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

22 **Capital Projects** (Jobs Through Export Act of 1992, Secs 303 and 306(d)) If assistance is being provided for a capital project, is the project developmentally sound and will the project measurably alleviate the worst manifestations of poverty or directly promote environmental safety and sustainability at the community level?

Not applicable

C CRITERIA APPLICABLE TO ECONOMIC SUPPORT FUNDS ONLY

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

Not applicable because the project is DA funded

2 **Military Purposes** (FAA Sec 531(e)) Will this assistance be used for military or paramilitary purposes?

3 **Commodity Grants/Separate Accounts** (FAA Sec 609) If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? (For FY 1995, this

ATTACHMENTS

I. ENVIRONMENTAL WAIVER

(1 page)

U S AGENCY FOR
INTERNATIONAL
DEVELOPMENT

LAC-IEE-95-46

REQUEST FOR A CATEGORICAL EXCLUSION

Project Location	:	Bolivia
Project Title	:	Community and Child Health (amendment)
Project Number	:	511-0594
Funding	:	$26 million (as amended)
Life of Project	:	FY 95-FY 98 (as amended)
IEE Prepared by	:	Caroline Stem, USAID/Bolivia
Recommended Threshold Decision	:	Categorical Exclusion
Bureau Threshold Decision	:	Concur with Recommendation
Comments	:	None

Date 9/25/95

Jeffrey J. Brokaw
Chief Environmental Officer
Bureau for Latin America
and the Caribbean

Copy to	:	Lewis Lucke, Acting Director USAID/Bolivia
Copy to	:	Caroline Stem, USAID/Bolivia
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