

MEMORANDUM OF DISTRIBUTION

I. OBLIGATION: This is a partial final award under
PIO/T No. 94 2-0102-3-1633/57. If final obligation, OP
has no objections to the derecording of any remaining funds.

II. DOCUMENT IDENTIFICATION/INFORMATION:

- a) Document No.: ANE 0102-2-00-1041-00
- b) Incremental funding action: YES NO
- c) Buy-in: YES NO
- d) Document has been transmitted to recipient/grantee for signature. Date transmitted: _____
- e) Method of Financing (check one only) _____
 Letter of Credit
 Periodic Advance
 Direct Reimbursement

III. FM DISTRIBUTION

- One original signed copy to FM for recording obligation. (PFM/FM/A/PPN, Rm. 612, SA-2)
- One copy to FM paying office. (Rm. 700, SA-2, PPM/FM/CMF)

IV. TECHNICAL OFFICE/MISSION DISTRIBUTION.

- Technical Office: A/PD/PCAP, Tom Marr, Rm 3320A, N.S.
(office symbol, name, rm & bldg #)

(specify)

- ~~APRE/PS/SOP copy of all documents including final assistance document signed by all parties.~~ ANE/PD/PCAP, Carrie Williams, Rm 3320A-N.S.
- APRE/PD, Carrie Williams, Rm 502 SA-2

V. OP DISTRIBUTION:

- OP/PS/SOP copy of all documents including final assistance document signed by all parties.

Copy of this form goes with each copy of the document distributed and one copy remains in the official file.

Contracting Officer: [Signature] Date: _____

Agency for International Development
Washington, D.C. 20523

SEP 6 1991

Dr. Philip Johnston
President
CARE
660 First Avenue
New York, NY 10016

Subject: Grant No. ANE-0102-G-00-1041-00

Dear Dr. Johnston:

Pursuant to the authority contained in the Foreign Assistance Act of 1961, as amended, the Agency for International Development (hereinafter referred to as "AID" or "Grantor") hereby provides to CARE (hereinafter referred to as "CARE" or "Grantee") the sum of \$1,172,588 to lower infant, child and maternal mortality and morbidity and to insure a better quality of life for persons with disabilities in Bakan District, Pursat Province.

This Grant is effective and obligation is made as of the date of this letter and shall apply to commitments made by the Grantee in furtherance of program objectives during the period beginning with the effective date and ending November 30, 1993.

This Grant is made with CARE on condition that the funds will be administered in accordance with the terms and conditions as set forth in Attachment 1, entitled "Schedule", Attachment 2, entitled "Program Description," and Attachment 3 entitled "Standard Provisions", which have been agreed to by your organization.

Please sign the original and copy of this Cover Letter to acknowledge your receipt of the grant, retain one copy for your files, and return the remaining copies to the undersigned.

Sincerely,



Judith D. Johnson
Grant Officer
Overseas Division-ANE
Office of Procurement

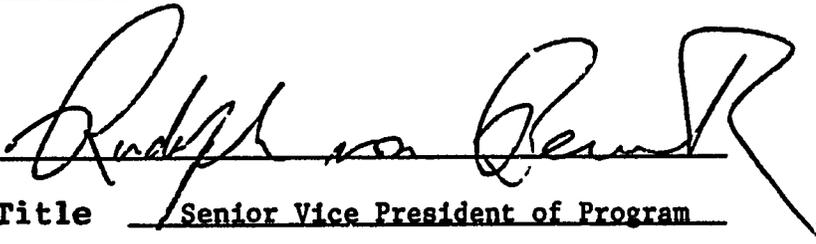
Attachments:

1. Schedule
2. Program Description
3. Standard Provisions

Acknowledged

CARE:

By



Name/Title Senior Vice President of Program

Date September 13, 1991

Fiscal Data

PIO/T No.:	442-0102-3-1633157
Appropriation No.:	72-1111021.7
Budget Plan Code:	QDCA-91-33442-IG-15
Duns No.:	00-179-3082
IRS Employer ID No.:	131685039
Total Estimated Grant Amount:	\$1,172,588
Total Amount Obligated:	\$1,172,588
Technical Office:	A/PCAP, Mike Feldstein

ATTACHMENT I

SCHEDULE

A. PURPOSE OF GRANT

The purpose of this Grant is to lower infant, child and maternal mortality and morbidity and to insure a better quality of life for persons with disabilities in Bakan District, Pursat Province, as more specifically described in Attachment 2 to this Grant entitled "Program Description".

B. PERIOD OF GRANT

1. This Grant is effective as of the date of the Grant Officer's signature on the cover letter of this Grant. The expiration date of this Grant is November 30, 1993.
2. Funds obligated hereunder are available for program expenditures from the effective date of the grant to November 30, 1993.

C. AMOUNT OF GRANT AND PAYMENT

1. The total estimated amount of this grant for the period shown in B.1 above is \$1,172,588.
2. AID hereby obligates the amount of \$1,172,588 for program expenditures during the period set forth in B.2. above and as shown in the Financial Plan below.
3. Payment shall be made to the Grantee in accordance with procedures set forth in Attachment 3 Standard Provision 1, entitled "Payment - Letter of Credit".

D. FINANCIAL PLAN

The following is the Grant Budget. Revisions of this budget shall be made in accordance with the Standard Provision of this Grant, entitled "Revision of Grant Budget".

<u>Financial Plan</u>	<u>Year 1</u>	<u>Year 2</u>
Equipment	\$ 17,500	\$ 0
Project Activities	\$ 39,000	\$ 39,000
Services	\$ 22,000	\$ 22,000
Baseline Survey/Consultant	\$ 22,500	\$ 0
Project Salaries and Benefits	\$349,810	\$349,810
Operations	\$ 92,364	\$ 90,782
Evaluation	\$ 12,000	\$ 13,000
Audit	\$ 0	\$ 20,000
Indirect Costs	\$ 42,193	\$ 40,629
TOTAL PROJECT COSTS	\$597,367	\$575,221

The budget estimates for AID funded items are illustrative. In no event will total costs exceed the maximum amount of the Grant, \$1,172,588.

E. REPORTING AND EVALUATION

1. Project Reports

CARE shall submit quarterly reports to A/PCAP and A/PD. A standardized report format shall be provided to the Grantee by AID and this format shall be followed. AID may also request special reports on specific topics on occasion.

2. Final Report

A final evaluation report and a final report on the utilization of grant funds shall be submitted by CARE to A/PCAP within 90 days of the completion date of the Grant as set forth in paragraph B. This report shall summarize all activities undertaken under this grant and give an assessment of program results and achievements.

3. Fiscal Reports

a. Fiscal reports shall be submitted in accordance with the AID Optional Standard Provision 1, "Payment - Letter of Credit".

b. The original and two copies of all financial reports shall be submitted to A.I.D., Office of Financial Management, Program Accounting and Finance Division (PFM/FM/CMPD/DCB), Washington D.C. 20523. In addition, one copy of all financial reports shall be submitted to the Technical Office specified in the Cover Letter of this Grant.

F. SPECIAL PROVISIONS

1. The Grant Standard Provisions, appended hereto as Attachment 3, are considered applicable to this Grant.

2. The cost principle applicable to this Grant is OMB Circular A-122.

3. Direct compensation of personnel will be reimbursable in accordance with the established policies, procedures and practice of the grantee and the provision of the applicable cost principles, entitled, "Compensation for Personal Services". Such policies, procedures and practices shall be the same as used in contracts and/or grants with other Government agencies and accepted by the cognizant U.S. Government agency assigned primary audit responsibility, shall be in writing and shall be made available to the Grant Officer, or his/her designated representative, upon request. Compensation (i.e., the employee's base annual salary) which exceeds the maximum level of the Foreign Service 1 (FS-1) (or the equivalent daily rate), as from time to time amended, will be reimbursed only with the approval of the Grant Officer.

4. It is anticipated that AID shall engage the services of a contractor to work in Cambodia and act as a program and fiscal consultant over this and other grantees working in the Phnom Penh area. The contractor shall conduct site inspections, review reports, and make recommendations on vouchers. To enable the contractor to perform these functions, the Grantee shall make available to the contractor all records, accounts, documentation, inventories, and other relevant materials relating to this grant. The grantee shall also provide the contractor with copies of all reports and vouchers submitted to AID as required under this grant.

5. In signing this grant, the Grantee agrees to directly deliver services funded by AID to intended beneficiaries. The Grantee shall not serve as an intermediary which merely turns its commodity or other assistance over to the government or some other group for delivery to beneficiaries unless this has been specifically approved in writing by AID.

6. Marking Requirements

In accordance with AID policy, the contractor shall mark all AID-financed commodities and shipping containers, and project construction sites and other project locations with the AID red, white, and blue handclasp emblem. Marking is not required for raw materials shipped in bulk (such as coal, grain, etc.), or for semifinished products which are not packaged. In addition, all communications about this project shall identify AID and/or the U.S. Government (people of the United States) as the funder and the Grantee as implementor. Any deviation from this requirement must be requested by the Grantee and specifically approved by AID in writing.

7. AID Eligibility Rules for Goods and Services

a. It is anticipated that the total procurement of goods and services under this grant will be less than \$250,000.

b. All goods and services shall be purchased in accordance with the Optional Grant Standard Provisions #7, entitled "A.I.D. Eligibility Rules for Goods and Services." Priority of purchase shall start with authorized geographic country code 000. Procurement of goods and services shall be accomplished in the following order of precedence:

The United States (Geographic code 000),

Selected Free World (Geographic code 941),

Special Free World (Geographic code 935), Thailand,
and Japan,

Cambodia.

8. Procurement and Shipment of Pharmaceuticals/Medical Supplies

a. The Recipient shall obtain approval from the A.I.D. Grant Officer prior to the shipment of any procured pharmaceuticals/medical supplies or donated pharmaceuticals/medical supplies being shipped at grant expense. The following criteria shall apply:

The list of pharmaceutical/medical supplies submitted for approval shall contain product description, i.e., trade name and/or generic name, dosage form, potency/concentration, and unit package size, lot number, expiration date, and name of manufacturer.

All U.S. source/origin pharmaceuticals and other products regulated by the Food and Drug Administration (FDA) to be procured and/or shipped must be in compliance with all applicable U.S. laws and regulations governing the interstate shipment of these products at the time of shipment. Pharmaceuticals donated from non-U.S. source/origin must meet the standards of the U.S. FDA. All items must be shipped properly packaged to preserve the quality of the product. This includes those products that require special temperature conditions during shipping and storage, e.g., refrigeration.

No product requiring expiration dating shall have less than three months shelf life on receipt in the benefiting country. The Recipient shall be responsible for determining that all dated products procured and/or shipped will have sufficient opportunity to be received, distributed, and used according to labeling directions by the end user prior to product's expiration date.

9. Local Cost Financing

This grant authorizes the use of local cost financing, provided such financing falls within the legitimate needs of the program description applicable to this Grant and does not exceed the following limitations:

1. Procurement locally of items of U.S. origin up to a per transaction limit of the local currency equivalent of \$100,000.

2. Procurement locally of items of non-U.S. origin up to a per transaction limit of the local currency equivalent of \$5,000.

3. Commodities and services available only in the local economy (no specific per transaction value applies to this category). This category includes the following items:

- a. utilities-including fuel for heating and cooking, waste disposal and trash collection;
- b. communications-telephone, telex, fax, postal, and courier services;
- c. rental costs for housing and office space;
- d. petroleum, oils, and lubricants for operating vehicles and equipment;
- e. newspapers, periodicals, and books published in the cooperating country, and
- f. other commodities and services (and related expenses) that, by their nature or as a practical matter, can only be acquired, performed, or incurred in the cooperating country.

In cases where local cost procurements are expected to exceed the above limitations, the Grantee must obtain approval from the Grant officer prior to proceeding with the procurement.

Except as otherwise changed by the above limitations, the conditions of the Optional Standard Provision entitled Local Cost Financing (November 1988), hereby incorporated into this Grant, apply, including paragraphs (b), (c), (d), (e), and (f).

The total estimated cost and the obligated amount of this Grant remain unchanged.

All other terms and conditions of this Grant remain unchanged.

G. Indirect Cost Rates

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

TYPE OF RATE: Provisional

RATE: Indirect Cost 7.6%

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

PERIOD: 7/1/91 until amended

H. Title to and Use of Property (Grantee Title)

Title to all property financed under this grant shall vest in the Grantee, subject to the conditions under the special provisions herein.

ATTACHMENT II

Program Description

The Bakan Integrated Rehabilitation and Child Health Project
A Proposal presented by CARE to USAID

Executive Summary

Part I

The largest private, non-sectarian, development and relief agency, CARE proposes to begin activities inside Cambodia, after a sixteen year absence. CARE's program efforts will address the crying need for humanitarian assistance in the areas of improving the chances of child survival and assisting those persons disabled by the strife that has racked Cambodia for more than a decade. CARE will work with community members of villages in Bakan District, Pursat Province in Western Cambodia. The entire population of the District is estimated to be 80,500, and in the first year of activities, CARE's work will directly benefit approximately one-tenth of the population in the Bakan Integrated Rehabilitation and Child Health (BIRCH) Project.

The project is designed to holistically address the health, nutrition and rehabilitation needs of children and civilian victims of the war - both the disabled and the widowed. BIRCH provides for active village involvement, and while some material input will be required of AID and CARE, participant decision-making and development of self-reliance will be emphasized. A substantial proportion of the project is devoted to training to strengthen the capabilities of the individuals and villages involved. Mechanisms will be established within the community which will enable it to solve problems more effectively in the future.

The BIRCH project will work with 40 villages to establish women's groups which will be encouraged to work with a Community Health Worker (CHW) to promote health protective interventions. Village water committees will be established to participate in the development of improved water sources planning. In ten of these villages, water supply improvement projects will be undertaken. With the technical assistance of our collaborating partner, the Hilton/Perkins International Program, the BIRCH project will assist in the development of community-based rehabilitation programs which highlight the integration of persons with disabilities into the community life. CHWs will also be trained to work with mothers of children with disabilities to help them adopt appropriate rehabilitation efforts within the family.

In this first six months, project systems and structures will be put into place, community organizing activities will begin and a baseline survey will be completed. The second six month period will involve the curriculum design, training sessions and additional community motivation by the trained community members themselves. A mid-term evaluation of the implementation process, and the progress on the described activities and indicators will be conducted at the end of the year. As experience is gained and lessons are learned, more specific project objectives and activities will be defined for replication in other communities in Bakan during year two. At the end of the two-year period, well developed, replicable and sustainable strategies for rural water supply, child survival (CS) interventions, health and nutrition education and women's development activities will be in place in Bakan.

The total budget for the first year of activities is \$737,408, and the second year of activities \$575,180. We are requesting the United States Agency for International Development to provide \$1,172,588 and CARE will contribute \$140,000.

PART II. The Project

1. Perceived Problems

The tragic legacy of over two decades of devastating events, including the horrors of Pol Pot, has left Cambodia an impoverished country. Through the Cambodian people's resilience and determination, some achievements have been made, even in the face of relative international isolation and absence of needed development assistance. While the Khmers struggle to return a degree of normalcy to their lives, the country remains one of the poorest in Asia. UNICEF estimates GNP per capita to be \$160.

The consequences of over 20 years of civil strife have altered the demographics of the country. Now 64% of the adult population are women who head 35% of households. In Cambodian's agrarian society, 60% of farmers are women working in adverse socio-economic conditions. The decimation and scattering of families in the 1970s left women shouldering heavy responsibilities without the support of the traditional extended family. They and their children are susceptible to severe hardship. Meanwhile, an inordinate number of persons are affected by disabilities, having fallen prey to land mines, polio, or being caught in the internal fighting.

Pursat, one of Cambodia's 21 provinces, is located in the western part of the country where the standard of living is lower than in other areas. It is one of the provinces where security in certain areas is often disrupted by Khmer Rouge insurgency. Communications and road networks are lacking. It suffers from chronic rice production shortages. Agriculture is precarious and subsistence-based constrained by poor soil, unstable rainfall and periodic droughts, irregular flood receding patterns from the Tonle Sap (Great Lake) and inefficient farming technologies.

Based on annual rice deficiencies, low standard of living, lack of health care and other services, low NGO presence and observed need, CARE chose Pursat Province for development of its Bakan Integrated Rehabilitation and Child Health (BIRCH) Project. Initially, the project will limit itself to one district, Bakan (pop. 80,500), to ensure that proposed activities and monitoring are feasible given the security situation. Later, the project can be modified and expanded to other districts.

While there is little reliable information available and no comprehensive national information base, UNICEF estimates that 20% of all Cambodian children die before their fifth birthday. The 1989 infant and child mortality rates (IMR and CMR) of 127/1,000 and 200/1,000. The Ministry of Health (MOH) lists the ten principal causes of infant and child morbidity as diarrheal diseases, protein energy malnutrition, pneumonia and other acute respiratory illnesses, typhoid fever, anemia, TB, dysentery, dengue hemorrhagic fever, malaria and accidents. Based on this list, the majority of health problems are connected to poor environmental conditions, inadequate health, nutrition, and hygiene education and under-utilization of available services.

During a CARE assessment visit, mothers in Bakan District reported diarrheal episodes in children as the most common illness. Measles epidemics, as well as cases of whooping cough, polio and neonatal tetanus, also occur frequently. Women indicated that nightblindness was common among their children. Malnutrition was identified (and observed) as another problem. The combined effects of diarrhea, vaccine-preventable diseases and malnutrition threaten the survival of children in Bakan. Further discussions indicated that women who knew about oral rehydration treatment during diarrhea thought only ORS packets, which in Bakan had to be purchased, could be used. They did not know that an effective rehydration solution

could be made at home with household staples, nor did they know that nightblindness was caused by insufficient consumption of certain types of foods.

While no national nor district-level statistics exist, a growing number of children and adults are learning to live with disabilities, including those born with a disability, those who have lost sight, hearing or limbs due to mines and warfare, those whose limbs have not fully developed due to polio, and those who have developed disabilities due to nutritional deficiencies. Many of these persons are coping, but without the appropriate training and support of their families and communities.

Discussions in the villages of Bakan indicated that providing simple, low cost technologies (such as ORT and immunizations), enhancing knowledge (hygiene and sanitation, nutrition management), improving access to water, training local persons in the appropriate support for children and adults with disability, improving community attitudes regarding the integration of persons with disability, and increasing food at the household level, could not only save lives, but greatly improve the quality of life as well. This will be the aim of the Bakan Integrated Rehabilitation and Child Health (BIRCH) project.

In designing this project, CARE was cognizant of the Congressional appropriation for aiding civilian war victims and providing humanitarian assistance to children in Cambodia. This project will further USAID's objectives in the region by assisting those affected by the war, without providing any material assistance to the Khmer Rouge and without strengthening the Phnom Penh regime. From CARE's perspective, this project inside Cambodia will invigorate CARE's dedication to the health and well-being of the Cambodian people which we have served both in Thailand and in Cambodia in the past.

2. Relevant Background and Experience

CARE has a long commitment to the Khmer people both in Cambodia, and on the Thai-Cambodian border. In 1975 CARE was forced to cease operations in Cambodia when the Khmer Rouge took power. CARE re-established an in-country presence in 1980 but was unable to maintain operations due to monitoring difficulties. In November 1990, CARE-International opened a Phnom Penh office to establish new initiatives to assist the Cambodian people.

From 1979 to the present CARE has been involved in relief and humanitarian assistance projects for the Khmers who fled to the border area next to Thailand. CARE continues to provide the logistics, warehousing and monitoring of rations distributions in a United Nations High Commissioner for Refugees (UNHCR) camp and has worked in collaboration with the UN Border Relief Organization (UNBRO). CARE's program became the model feeding and nutrition/health education program in the camps. Because of CARE's experience working with Khmers, CARE has a number of well-trained, Khmer-speaking staff, many of whom have expressed an interest in working with CARE inside Cambodia.

Since November 1990, a program manager fielded by CARE/Australia has been conducting a series of nutritional surveys in the geographic region surrounding Phnom Penh. Funding for their project has been provided by the Government of Australia's development agency, AIDAB.

Lastly, CARE's worldwide experience in similar village-based health, nutrition, child survival, water supply and women's development projects. The expertise gained, and of perhaps greater importance, the lessons learned from these experiences, will be drawn upon in development and implementation of BIRCH.

3. Project Goal and Purpose

The problems, highlighted above in Section 1, include high infant, child and maternal morbidity and mortality due to the poor environment, lack of clean water, malnutrition, and prevalence of communicable diseases. The project purpose is to lower infant, child and maternal mortality and morbidity and to insure a better quality of life for persons with disabilities in Bakan District, Pursat Province. The specific measurable goals to be accomplished are presented in the Logframe, Annex A.

4. Project Elements

a. Nature and Scope of Inputs

The BIRCH project will utilize AID and CARE resources to fund baseline needs assessment, training activities, community motivation, technical assistance and materials development. A significant input into the project will be the staff of persons familiar with work on the Thai-Cambodian

border to manage the project, design the training curriculum, define the appropriate messages, and assist in community organization. These inputs will assist in the accomplishment of the major aims of the project. Following baseline data collection, the project will consist of four main components designed to have an impact upon the health, nutrition and well-being of vulnerable women, their children, and persons with disabilities. These components include:

1. Developing village water supply, including training on proper maintenance, hygiene and sanitation.

Within the scope of this project, two areas of local water supply development are envisioned: construction or rehabilitation of traditional hand dug wells and increased village capacity for rainwater catchment and storage. CARE will employ a water systems engineer on a consultancy basis for a four-week period to assess the project area (ground water levels, existing wells, locally-available resources) and develop strategies to carry out project objectives within the scope of village capabilities.

2. Training CHWs for the purpose of promoting village level maternal and child health interventions and providing health and nutrition education.

CARE will, with the input of the community, identify and then train 40 CHWs, including 10-16 immunizers (one for each district commune containing project villages), to promote and provide basic CS interventions (EPI services, ORT training, Vitamin A distribution) and health, hygiene and nutrition education. Health workers will also be trained to report common causes of morbidity and mortality in their communities so that a surveillance system can be developed over time. Thirty midwives and TBAs, trained by Medecin Sans Frontier (MSF) will receive supplementary training to enable them to reinforce the activities of the CHWs and immunizers.

3. Establishing women's groups for the purpose of increasing home gardening capabilities as well as training group members in improved health and nutrition practices.

The health status of the child is intrinsically linked with the health and knowledge of the mother. Therefore, CARE will work with women's groups to train them to better care for their families. CARE will enlist the assistance of village leaders to identify women interested in forming groups of 10-15 members. The aim of these groups will be to increase access to resources through home vegetable gardening (and

possibly, through other activities to generate income) and thus, to improve the health and nutrition knowledge and practices of group members and other village members through education and increased food availability. With an improved local water supply, women will be able to grow vegetables during the dry season. More food will be available for consumption and any surplus can be sold to supplement income.

4. Community training in the integration and rehabilitation of persons with disability.

Working with the Hilton/Perkins International Program (HPIP), CARE will work with persons with disability to facilitate the design of appropriate training sessions for community members. The integration of persons with disability into the community is dependent upon a number of factors. The attitude of the community toward persons with disability is one factor that can be influenced through community education. Behaviors adopted in the homes of persons with disability to allow maximum freedom of activity will be a second area of training. This will be fostered by the participation of persons with disability in the design and implementation of programs for the disabled. CARE and HPIP, an organization well-versed in the issues surrounding the community integration of persons with disability, will work at the village level with training and outreach activities which will facilitate community acceptance and integration of disabled members in the community development process.

b. Anticipated Outputs

Managerial/Administrative Structures:	YR 1	YR 2
Establish Pursat Field Office	X	
Proj. villages selected/assessments made	20	20
Baseline Survey/Rehab. Needs Assessment completed	X	
Survey of additional villages for inclusion in program		X
Project monitoring system set up	X	
Water system engineer consultancy	X	
Water committees established	10	10
Training in financial management for water committees		X
Villages with water systems in place	5	10
Village health and nutrition education plan developed	X	
Community Rehabilitation Training Plan designed	X	
Women's Groups established	20	30
Women's group organizers trained	20	30
Women's groups receive training and are functional	20	30
Women's group members establish home gardens		20
Community Health Workers (CHWs) identified and trained	X	X
Training of parents of children with disability		X
Referral of persons with disability for prosthetic devices		X
Educational gatherings in villages scheduled and held	X	X
EPI outreach sites established	10	10

Program Outputs:

Under-ones fully immunized	400	1,000
Under-sixes receive Vitamin A capsules	600	1,200
Women 15-45 years old receive Tetanus Toxoid	1,000	3,500
Women receive ORT training	400	1,000
Mid-term evaluation/process review	X	
Final Evaluation		X
Audit		X

c. Project Units and Sites

All villages to be covered by project activities will be located within Bakan District, Pursat Province. The

community members themselves will be both the project participants (as health and water committee members, as women's group members) and the beneficiaries of the increased means of protecting the health of their children and integrating their disabled members into community life.

d. Project Management

The Project Manager, who was part of the initial project design team, will have overall responsibility for project execution. She will be assisted by a team of Field Officers with specific skills necessary for program implementation, including a Water Systems Field Officer, two Child-Nutrition Training Officers, a Community-Based Rehabilitation Training Officer, a Maternal Health/Women's Development Officer, and an Administrative Officer. Technical assistance will be provided, as required for the water systems assessment, and the baseline survey. Also the Hilton Perkins International Program will provide technical assistance in the design and use of educational materials for the integration of persons with disability into community life.

Additional technical support will be provided by the Regional Technical Advisor for Primary Health Care in Dhaka, the Regional Technical Advisor for Training in Bangkok, the Training and Primary Health Care Units in CARE Headquarters, and the CARE Thailand staff. Administrative support and management backstopping will be provided by CARE Thailand, the CARE Australia staff in Phnom Penh and the Asia Regional Management Unit in CARE Headquarters.

e. Project Beneficiaries

Project beneficiaries will be the community members of the 40 villages in Bakan District in which CARE will initiate activities. During the initial design team visit, men and women from these communities participated in discussions of their needs and the lack of available services. With the beginning of the project, a more detailed look at the communities, including problem identification and the design of project activities to address these needs will be undertaken with the participation of the local community members.

The direct beneficiaries will be all the community members in the villages, as all will benefit from increased availability of potable water, and the improved health of their children. Women, as care-takers and often the head of household in many Cambodian families will receive special

attention to bolster their confidence in their ability to provide for and protect the health of their families.

While the specific communities have not yet been chosen, from available statistics and the initial site visit conducted by CARE, the villages within Bakan District are among those with the poorest service delivery and sorry health conditions. Communities will be chosen based on need and feasibility of beginning service provision within the first year. A more detailed picture of the beneficiaries and their socio-economic status will be available after the baseline survey.

f. Collaboration

Collaboration with other institutions and organizations working in Cambodia has already begun. To avoid duplication of efforts, CARE had discussions with many NGOs working in Cambodia. The number of NGOs working in Cambodia has more than doubled in the last two years and presently stands at 60. Inter-agency coordination has become a problem, as has the government's capacity to coordinate agencies' activities to prevent duplication of services. CARE has carefully assessed NGO activity in Pursat Province and specifically Bakan District. MSF, the International Committee of the Red Cross (ICRC) and the French Red Cross (FRC) are the only agencies presently involved in health programs. ICRC provides assistance for the provincial hospital surgical ward and FRC provides assistance for TB and malaria programs. MSF assists the provincial hospital in developing other curative services. MSF is also providing technical training and medical supplies and equipment in district health centers and assists the MOH in a midwifery and TBA training program. CARE has discussed its proposed project with MSF staff in Pursat and Phnom Penh.

The Hilton/Perkins International Program of the Perkins School for the Blind in Watertown, Massachusetts, seeks in international program efforts to improve the quality of life of youth with visual impairment, and multiple disabilities. This work is carried out through community-oriented efforts that are driven by local determination of needs and ownership of efforts to meet those needs, active participation of persons with disability and their families, and, collaboration with local resources and organizations. The HPIP staff have extensive experience in Asia, including work in refugee camps in Thailand with the Khmer and Lao populations.

American Refugee Committee (ARC) intends to begin a health program in Kandieng, another district of Pursat. While ARC will not be active in Bakan District, CARE and ARC have discussed their respective ideas with a view towards future collaboration in training and information sharing. CARE and ARC worked together on the Thai-Cambodian border and developed an excellent relationship which will be built upon inside Cambodia.

CARE has also consulted with UNICEF concerning the proposed project and with respect to technical and material assistance. UNICEF was very supportive of the project and suggested areas in which CARE might wish to become more involved in the future, such as an expanded role promoting the national EPI program and development of a family spacing program.

While HPIP will provide the training expertise in issues related to community rehabilitation of persons with disability, physical rehabilitation and the local production of prosthetic devices will not be undertaken by BIRCH at this point. For this vital contribution, CARE has been in consultation with Operation Handicap, International (OHI). OHI is working to renovate a prosthetic device workshop in Pursat town. The BIRCH project will collaborate with OHI for a referral network for persons in need of prosthetic devices. Integrating these persons more fully into the community will be the role played by CARE and HPIP.

g. Cost per direct beneficiary

With approximately 18,000 beneficiaries, the total cost per beneficiary will be about \$75 per direct beneficiary. This excludes the CARE contribution for non-expendable capital assets. These direct beneficiaries are the women and children that will receive services in the first year of the project. The broader community will benefit from the provision of water, the use of oral rehydration therapy, and the integration of persons with disability into the productive life of the community. The project elements are directly linked to the project objectives and community members themselves will participate in directing project activities to those at-risk in the community.

h. Governmental Approval

During their visit to Cambodia in early 1991, CARE's project assessment team discussed the viability of BIRCH with

local health representatives through an intermediary responsible for PVO Affairs. After reaching Bakan, the CARE team participated in two days of meetings with local health workers and women's groups. A short summary of CARE's planned activities in Cambodia will be forwarded to the Ministry of Foreign Affairs for their comment. CARE does not foresee any objections to implementing the BIRCH project in Cambodia.

5. Expected Achievements and Accomplishments

The final goal of the BIRCH project is to lower infant, child and maternal mortality and morbidity in Bakan District, Pursat Province, by the end of the two-year project period.

a. During the project cycle among the target population in 40 villages:

Objective 1: Increase by 50% (above baseline) the number of mothers able to practice improved management of diarrheal disease.

Objective 2: Increase by 50% (above baseline) the number of children under one who have received complete immunization coverage through regular, permanent immunization services.

Objective 3: Increase by 50% (above baseline) the number of women aged 15-45 years who have received complete tetanus toxoid coverage through regular, permanent immunization services.

Objective 4: Increase by 30% (above baseline) the number of women practicing improved nutritional management for themselves and their children under two.

Objective 5: Increase by at least ten, the number of villages with improved access to a local water supply.

Objective 6: Increase by 20% (above baseline) the number of family members able to carry out developmentally appropriate activities for children with disabilities.

Objective 7: Increase by 30% (above baseline) the number of persons with disability actively participating in family and community life.

b. Basic Information

Basic information collected in the baseline survey will provide data to be compared at the end of the first year and at the end of the project to assess project impact. The baseline will include measurement of current levels of knowledge and practices related to the home-based control and treatment of diarrheal diseases; nutritional and feeding practices for children under two; and attitudes related to the integration of persons with disability into community life. The baseline survey will also assess current levels of immunization among all children and under-ones; levels of tetanus toxoid delivery among women 15-45; current water supply systems and water use practices; and the numbers and activities of disabled persons within the communities.

→ The baseline and knowledge, attitudes and practices (KAP) surveys will be completed during the first quarter of year one. The information provided will be instrumental in the development of a project implementation plan as well as form the basis for determining project progress based on the mid-term and final evaluations. The mid-term evaluation will be conducted at the end of the first year and the final evaluation during the final quarter of the project. CARE's internal planning, implementation and evaluation reports will be prepared twice per year and annual progress reports for USAID will be submitted as required.

On-going project monitoring will be process oriented including EPI sessions held (versus planned), numbers of children attending immunization sessions, numbers of children receiving vaccines at the appropriate age, mothers in attendance at training sessions, number of family members of disabled persons at training sessions, numbers of mother's groups and water committees established, community contributions to water supply development, etc. Impact will be measured using an instrument similar to the baseline survey and through qualitative data collection techniques. Data will be collected by the project staff with local assistance for the baseline and will be carried out by community members with training by the staff to evaluate the progress.

c. Local Counterparts

CARE will be working with community groups in the Bakan District as our main partners in the implementation of the

project. Other organizations active in Cambodia and specifically in Pursat Province are described in Section 4.f. CARE, with many years of community organization and development experience, began efforts with communities during the design team visit by assisting community leadership in a problem identification. Community leaders and other community members will be active participants in activity planning for the 40 villages in which activities will be undertaken. The specific counterparts for moving the community organizing to community action will be in the form of the women's groups, water committees and the collected group of CHWs. These three local organizations will actually carry out much of the training and motivation as needed.

With the complex internal political situation in Cambodia, CARE feels that the wise course of action is to work with community groups drawn from a broad cross section of community members. Our work with these persons and the villages as a whole, will lead to a cadre of persons involved in the development of their own communities. In the initial year of this project, establishment of these groups and committees may be all that is feasible. Institutional strengthening will be limited to working with these groups and assisting water committees in the financial management of any water users fees if collected.

6. Program Management

a. Organization

CARE will place a team of qualified technical persons and administrative officers inside Cambodia who will be directly responsible for managing the program. The Project Manager, Nutrition Training Officers, Maternal Health/Women's Development Officer, Rehabilitation Specialist, Administrative Officer and Administrative Assistant will all be full-time staff with the project.

Administrative and management backstopping will be provided by the CARE Thailand office (5% of the Country Director and Assistant Country Director's time and 30% of the Administrative Officer's time). In-country logistical support will be provided by the CARE-Australia office in Phnom Penh.

(This reporting relationship is presented as an organizational chart, attached as Annex B. Qualifications for project positions and proposed candidates are attached as Annex C.)

Short-term consultation will be provided by CARE's Technical Advisors for Primary Health Care and Training. At least one consultation by a water systems engineer will also be provided. The Hilton/Perkins International Program will provide periodic technical assistance with materials development and training for the rehabilitation component of the project.

* b. Implementation Plan

The implementation plan will be more clearly defined after the baseline survey when a true work plan can be developed. At this point, CARE projects that the following tasks are feasible for completion in years 1 and 2:

	YR 1	YR 2
Establish Pursat Field Office	X	
Proj. villages selected/assessments made	20	20
Baseline Survey/Rehab. Needs Assessment completed	X	
Survey of additional villages for inclusion in program		X
Project monitoring system set up	X	
Water system engineer consultancy	X	
Water committees established	10	10
Training in financial management for water committees		X
Villages with water systems in place	5	10
Village health and nutrition education plan developed	X	
Community Rehabilitation Training Plan designed	X	
Women's Groups established	20	30
Women's group organizers trained	20	30
Women's groups receive training and are functional	20	30
Women's group members establish home gardens		20
Community Health Workers (CHWs) identified and trained	X	X
Training of parents of children with disability		X
Referral of persons with disability for prosthetic devices		X
Educational gatherings in villages scheduled and held	X	X
EPI outreach sites established	10	10
Under-ones fully immunized	400	1,000
Under-sixes receive Vitamin A capsules	600	1,200
Women 15-45 years old receive Tetanus Toxoid	1,000	3,500
Women receive ORT training	400	1,000
Mid-term evaluation/process review	X	
Final Evaluation		X
Audit		X

7. Sustainability

The reduction of morbidity and mortality of children and women can only be assured by better health service delivery and improved health protective behaviors in the home. While CARE will seek to improve the impact of the UNICEF EPI program, the greater impact on children and women's health is to be made through the adoption of the health practices encouraged by the Community Health Workers. It is CARE's belief that community motivation is best fostered by community members. New ideas regarding weaning foods for children, appropriate prenatal care, the importance of immunization, the possibilities for productive work for the disabled and the treatment of dehydrating diarrhea are advocated by respected community members who will continue to represent and impart these messages after the project's end.

In the same way, water committees that participate in the selection of the site of the water source, the construction of the water source, and the maintenance of the water source feel a greater degree of ownership than mere "recipients" of assistance. CARE's approach is to involve community members in each step of the process to encourage the feeling of ownership and an awareness of a community's own ability to ameliorate some of the conditions which cause high infant, child and maternal morbidity and mortality.

8. Evaluation

CARE's Asia Regional Technical Advisor for Primary Health Care will assist in the baseline survey and both evaluations, as well as development of monitoring activities. CARE has found that a team approach to evaluation produces the best results. An outside consultant with NGO experience in health, nutrition and rural development will, therefore, be requested to participate in the mid-term and final project evaluations. Project staff, CHWs and community members will all participate in these activities.

Monitoring will be developed for each of the three project components and will be conducted monthly during the life of the project. For example, for monitoring progress of the health and nutrition objectives, certain key indicators will be tracked. Tier I indicators (quantitative indicators

of project implementation) will be recorded by CHWs on a monthly basis. Mechanisms for tracking Tier I indicators will include community census and registers, CHW reports, project training and activity reports, project staff checklists and monthly reports, periodic mini-surveys and focus group discussions. Tier II indicators (quantitative and qualitative indicators of attainment of project objectives) will be tracked through baseline and follow-up KAP, EPI coverage, ORT use and access surveys, nutritional assessments, sentinel sites and participant observation, group discussions and interviews.

All project field staff are responsible for oversight, collection and compilation of monitoring and sentinel site data. There will also be team leaders for survey activities. CHWs will be included in these endeavors so that the processes of data collection, analysis and utilization are understood and sustainable after project completion.

9. Reporting

CARE projects typically report progress at least semi-annually and for this project, we would expect two reports in the first year, and two in the second year. Progress on the above activities (See section 6.b.) will be reported in the progress reports - although the first progress report will include the description of the establishment of systems and community groups rather than the impact of the program on the population. The verifiable indicators for reporting progress are detailed in the attached logframe, Annex A.

10. Budget

CARE's total budget requested from USAID is \$1,172,588. A detailed description of the budget follows.

11. Non-AID Contribution

While the estimate of the community contribution to this project can not be provided at this time, CARE will provide approximately \$140,000 for vehicles, generators, and computer equipment to the project.

12. Financial Plan

The BIRCH project's budget has been designed to reflect direct project management from the local office in Bakan, and administrative support from CARE/Thailand. CARE/Thailand assist in recruiting and selecting project staff and in

setting up field operations in Bakan during the early phase of the project. After the project commences, administrative assistance will continue to be provided by CARE/Thailand, and logistical support will be provided by CARE/Cambodia's representative in Phnom Penh. The financial management of the grant will take place in Cambodia by the Administrative Officer with the input of the Project Manager and the oversight of the CARE Thailand Administrative Officer.

Estimated Country Project Budget

1. **Equipment:** CARE's major contribution to the project will be three landcruisers, computer equipment, generators, and two motorcycles. All capital assets valued at more than \$500 will be purchased with CARE funds.

2. Project Activities

2.2 **Water Resource Systems:** Supplies and equipment for water system construction have been budgeted under this line item.

5. Project Salaries and Benefits

5.1 **Project Management Staff:** Salary and benefit levels were set with the aim of recruiting highly qualified technical staff for the project. CARE is recruiting worldwide for these positions.

5.3 **Administrative and Management Support:** Approximately 5% of the Country Director's time and an estimated 30% of the administrative officer's time have been charged to the BIRCH project. The administrative officer will likely spend more than 30% of his time during the early phase of the project setting up an office and administrative mechanisms in Bangkok and Bakan. During the second year, administrative activities will involve less than 30% of his time.

6.0 Operations

6.5 **Travel out of the Thailand Office** has been budgeted for CARE/Thailand's Administrative Officer's travel to Bakan.