

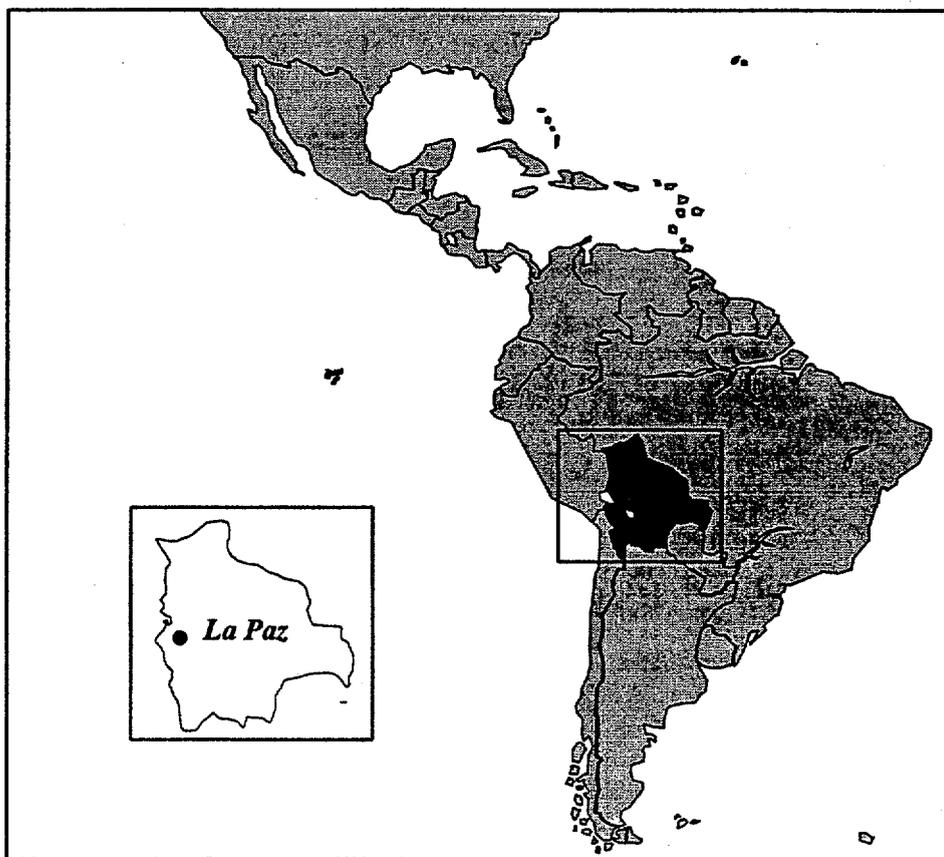
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A USAID Health Profile

93282

# BOLIVIA

## Health Situation & USAID Health Projects Descriptions 1993



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# BOLIVIA

## USAID Health Profile

**T**his is one of a series of USAID Health Profiles produced by the Center for International Health Information/ISTI (CIHI). Each profile contains descriptive information, tables, and graphs about the country's health and demographic conditions, health indicators and trends, and the health care system when available. The profile also provides an overview of USAID health assistance and descriptions of USAID-supported health activities. Profile information is compiled from CIHI's databases and reference library, as well as through analysis from additional data sources and reports.

The profiles are intended to provide current and trend data in a concise format to policy makers, consultants, evaluation teams, and other interested individuals and organizations. They are not intended to provide a comprehensive description of the total health sector of a country. Contact CIHI for information on the availability of other health profiles and standard reports.

This profile contains national level health and demographic statistics available in CIHI's databases as of the date noted in each section. In order to enable CIHI to report the most current health and demographic statistics, please provide any more recent or more accurate data by contacting the center at the address on the previous pages or through USAID, Bureau for Research and Development, Office of Health.

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## I: COUNTRY OVERVIEW

DECEMBER 1993

**B**olivia is a landlocked nation and the fifth largest in South America. The altiplano, a high mountain plateau, and the eastern lowlands divide Bolivia into two highly distinct regions. The snowy peaks of the Andean mountain range reach as high as 21,000 feet and reach their greatest width at 400 miles in Bolivia. In the northeast, the mountains drop sharply into the hot Amazon Basin and the valleys which cut into the mountains are fertile and semi-tropical. These valleys produce a wide variety of cereals and fruits, but transporting them to the cities of the altiplano is a formidable task. Even the lowland tropical plains which were once heavily populated, are now largely abandoned because of their inaccessibility.(LAC9301)

The Bolivian culture is comprised of pre-Colombian Aymara and Inca Indian traditions and a slight European influence. Bolivia's major cities and the bulk of its population are located on the altiplano. The population of the capital city of La Paz and the city of Potosi is about 70 percent Indian, 25 percent mestizo and 5 percent European.(LAC9301)

Bolivia gained independence from Spain in 1825 under the leadership of Gen. Antonio Jose de Sucre (Bolivia's first president) and Simon Bolivar, after whom the new republic was named. In the century following independence, political stability was achieved under a two-party system of conservatives and liberals who represented rural landowners and powerful mining interests. This stability essentially remained until 1935 when Bolivian forces were defeated soundly by troops from Paraguay in the Chaco War. The defeat brought upon disillusionment with the old political structures in Bolivia and a military government dominated the succeeding years.(PRB9204)

Recent political history has not been as stable in Bolivia, though elections continue to take place. In the early 1980s, a military junta took power and a ban was placed on all political activity. However, as the national economic crisis worsened and popular unrest spread, the government lifted the ban on the activities of political parties and labor unions. As a result, an election was held in late 1982 and Hernan Siles Zuazo was officially proclaimed president. In 1985, President Paz Estenssoro was elected and faced problems of social unrest, labor strikes and extremely high inflation. More problems arose for Bolivia in the late 1980s as heavy flooding left 150,000 people destitute and the bottom dropped out of the world's tin prices, leading to an unemployment rate of 32 percent. In June 1993, Gonzalo Sanchez de Lozada was elected President with 36 percent of the vote.(LAC9301)

Throughout its history, Bolivia's economy has been based on the extraction of its mineral wealth. In the early 20th century, the increasing world demand for tin made it Bolivia's chief export. The mining of tin became the key to Bolivia's economic success and for decades it provided the nation with substantial revenue.(PRB9204) But, by 1985, tin prices dropped dramatically due to a vast stock oversupply and the increased substitution of aluminum forcing Bolivia to market tin for less than one-third of the price of production. The nation turned its focus away from the tin mines to other sectors including energy development and agriculture. Between 1992 and 1993, the economy showed a modest improvement with a three percent growth.(LAC9301)

\* Sources in this profile are referred to by a seven-digit code. Generally, the first three letters refer to an organization, agency, etc., and the first two numbers indicate the year of the publication or other source document. A complete list of sources appears at the end of the profile.



## II: HEALTH & DEMOGRAPHIC OVERVIEW

### Health Sector Description

DECEMBER 1993

The major health care providers in Bolivia are the Ministry of Health (MOH), serving roughly one-third of the population, and the social security system, which covers approximately one-fourth of the population. Private non-profit and for-profit providers each serve roughly five percent of the population. An estimated 25-30 percent of the population lacks access to modern health care services.(LAC9202) Many Bolivians rely on traditional medicine, particularly in rural areas.

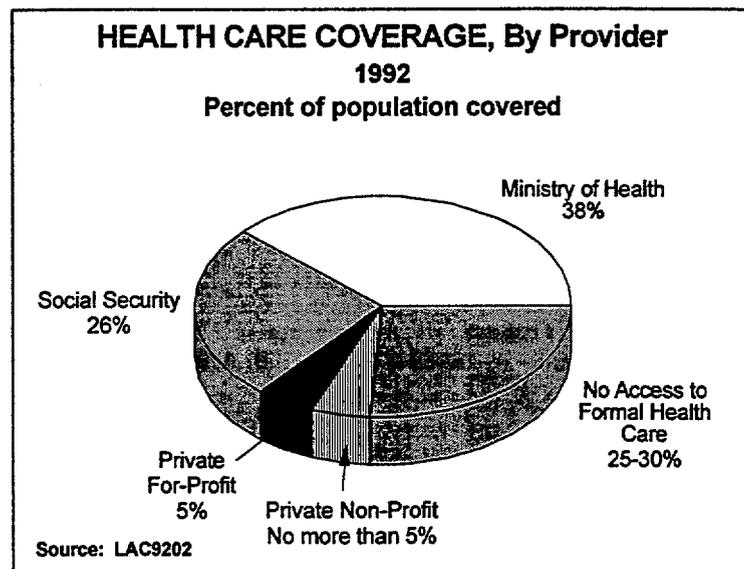
#### Ministry of Health

The Ministry of Social Provision and Public Health (*Ministerio de Previsión Social y Salud Pública /MPSSP*), through its Public Health Subsecretariat, provides curative and preventive care through 101 general and regional hospitals, 418 health centers, and 910 predominantly rural health posts. (LAC9202) Organized in 12 regional "sanitary units" and approximately 90 health districts, the MOH is officially responsible for providing services to 75

percent of the population, but estimates of real coverage, which is concentrated in urban areas, range from 30 percent (LAC9201) to 38 percent. (LAC9202) Rising prices for MOH health care are thought to be denying access to some Bolivians. (LAC9100) According to a recent evaluation of child survival activities in Bolivia, government policy favoring a shift in emphasis from urban hospital-based services to primary health care for more vulnerable groups has seen only limited programmatic change.(LAC9202)

#### Social Security System

The Bolivian Social Security Institute (*Instituto Boliviano de Seguridad Social / IBSS*), administered under the MOH's Subsecretariat of Social Security, offers pension, sickness and maternity, work injury and family allowance programs.(IDB9101) The sickness and maternity program provides curative care for households of insured wage earners employed in industry, commerce, mining and government, covering about 26 percent of the population, but rarely the poor.(LAC9202) While the IBSS operates its own health facilities in major urban areas, it also contracts with the MOH for use of some facilities and frequently purchases private services for affiliates outside of the cities.(IDB9101,LAC9100)



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## *II: Health & Demographic Overview*

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### **Regional and Local Governments**

Regional Development Corporations (RDCs) in some departments, such as Santa Cruz, have played a limited role in establishing and maintaining rural health facilities. Municipalities frequently own but rarely operate urban health facilities.(LAC9202)

### **Private Sector**

The private, for-profit sector is estimated to serve no more than five percent of the total population, a share which is shrinking due to impoverishment, particularly in rural areas. The MOH estimates that the private, nonprofit health care delivery system also covers about five percent of the total population, mostly in periurban and rural areas, through as many as 500 non-governmental organizations.(LAC9202)



## Health Situation Analysis

DECEMBER 1993

**H**ealth conditions in Bolivia are among the worst in South America. Although infant and under-five mortality rates have declined since 1980, these rates vary widely across regions, ethnic groups and socio-economic strata, and are among the highest in Latin America.(DHS9001) Infant mortality declined from 112 deaths per thousand live births in 1980 to 90 deaths in 1992 and, during the same period, under-five mortality fell from 170 to 125 deaths per thousand live births.(WBK9302, WOL9100)

The 1989 Demographic and Health Survey (ENDSA-1989) reports that large mortality differentials persist in Bolivia, with infant mortality in urban areas at 79 deaths, compared with 112 deaths in rural areas. Of the deaths among children born five years preceding the survey, 76 percent occurred at home, and half of the children who died were not taken to any health facility during the illness that led to death. For causes of death, the survey indicates that birth problems accounted for one-third of neonatal mortality (deaths among infants who have not yet reached one month of age) and diarrheal disease was the probable main cause of death for almost half the children who died at age one to 11 months. Acute respiratory infection was reported for 20 percent of children under five years of age during the two weeks preceding the survey.(DHS9001)

Only 19 percent of children aged 12 to 23 months are fully vaccinated, according to the ENDSA-1989, and extremely high dropout rates have limited coverage for vaccines requiring multiple doses.(DHS9001) Nonetheless, vaccination coverage rates have risen steadily for most antigens. From 1989 to 1992, coverage rates rose from 28 to 77 percent for DPT3, from 38 to 83 percent for Polio3, and from 58 to 80 percent for measles.(DHS9001, WHE9301)

During diarrheal episodes, about 50 percent of mothers gave their children more liquids. One in four mothers used a fluid prepared from a packet of oral rehydration salts (ORS) and one in nine mothers prepared a homemade solution of sugar and salt. A quarter of the children were taken to a health facility for treatment.(DHS9001)

Chronic malnutrition (low weight for age) affects more than one in three children under three years old. Substantial deterioration in nutritional status is reported to occur during the first two years of life and stunting (very short for age) increased significantly during both the first and second years of life. Over half of infants are breastfed exclusively for the first three months of life.(DHS9001)

Fertility-related variables also significantly impact child mortality; short birth intervals (less than two years) in particular were associated with a mortality rate three times higher than that for birth intervals of 48 months or longer. More than half of all pregnant women did not receive any prenatal care during the period 1984-88, and only one in five women received an injection to prevent tetanus in the newborn.(DHS9001)

The government of Bolivia has finalized a national program of action to guide its efforts in achieving basic World Summit for Children goals.(UNI9312) A National Plan for Child Survival and Maternal Health initiated in 1989 focuses on three major areas -- social management, primary health care, and the development of local health systems -- with integrated care for eligible women and children under five receiving the highest priority.(DHS9001)

II: Health & Demographic Overview

Current Demographic and Health Indicators

DECEMBER 1993

Demographic Indicators			
INDICATOR	VALUE	YEAR	SOURCE
Total Population	6,495,329	1993	CALXX02
Urban Population	4,099,400	1993	UNP9200
Women Ages 15-49	1,873,000	1993	UNP9200
Infant Mortality	90	1992	WOL9100
Under 5 Mortality	125	1992	WOL9100
Maternal Mortality	480	1991	AID9103
Life Expectancy At Birth	61	1993	UNP9200
Children Under Age 1	207,884	1993	CALXX01
Annual Infant Deaths	19,967	1993	CALXX01
Total Fertility Rate	4.9	1993	UNP9200

Child Survival Indicators			
INDICATOR	PERCENT	YEAR	SOURCE
<b>Vaccination Coverage</b>			
BCG	86	1992	WHE9301
DPT 3	77	1992	WHE9301
Measles	80	1992	WHE9301
Polio 3	83	1992	WHE9301
Tetanus 2	20	1989	WHE9001
DPT Drop Out	46	1989	DHS9001
<b>Oral Rehydration Therapy</b>			
ORS Access Rate	58.0	1991	WHD9201
ORS and/or RHF Use	34.0	1989	DHS9001
<b>Contraceptive Prevalence</b>			
Modern Methods (15-49)	12.2	1989	DHS9001
All Methods (15-49)	30.3	1989	DHS9001
<b>Nutrition</b>			
Adequate Nutritional Status	81.0	1989	DHS9001
Appropriate Infant Feeding	51.0	1989	DHS9001
A) Exclusive Breastfeeding	59.0	1989	DHS9001
B) Complementary Feeding	57.3	1989	DHS9001
Continued Breastfeeding	73.1	1989	DHS9001

Other Health Indicators			
INDICATOR	PERCENT	YEAR	SOURCE
<b>HIV-1 Seroprevalence</b>			
Urban	NA		
Rural	NA		
<b>Access to Improved Water</b>			
Urban	79.7	1992	MRF9211
Rural	29.7	1992	MRF9211
<b>Access to Sanitation</b>			
Urban	35.3	1992	MRF9211
Rural	14.7	1992	MRF9211
Deliveries/Trained Attendants	42.0	1989	DHS9001

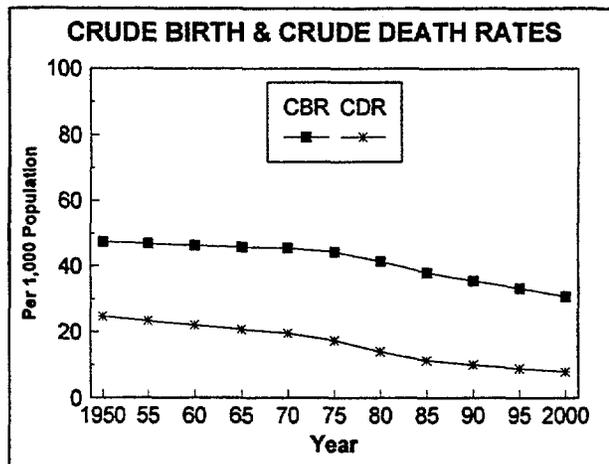
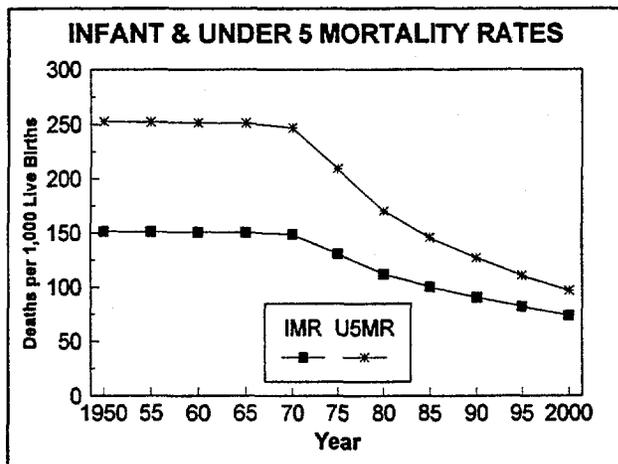
NA = Not available



## Trends in Selected Demographic and Health Indicators

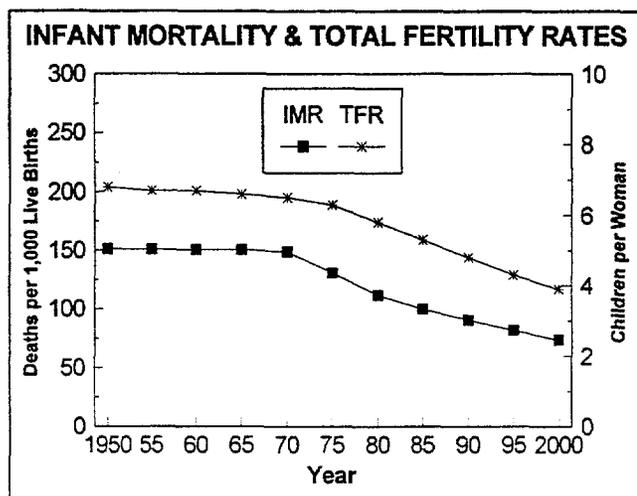
DECEMBER 1993

INDICATOR	1950	1955	1960	1965	1970	1975	1980	1985	1990	1995	2000	SOURCE
Infant Mortality	151.2	151.0	150.8	150.6	148.7	130.9	111.9	100.1	90.7	82.1	73.8	WBK9302
Under Five Mortality	252.5	252.0	251.5	251.1	246.9	209.3	170.0	145.8	126.9	110.7	96.7	WBK9302
Crude Birth Rate	47.4	46.9	46.3	45.8	45.5	44.4	41.4	38.0	35.5	33.2	30.8	UNP9200
Crude Death Rate	24.8	23.4	22.1	20.8	19.6	17.4	14.0	11.4	10.0	8.9	7.9	UNP9200
Avg. Annual Growth Rate	2.1	2.1	2.2	2.3	2.4	2.6	2.6	2.5	2.4	2.3	2.2	UNP9200
Total Fertility Rate	6.8	6.7	6.7	6.6	6.5	6.3	5.8	5.3	4.8	4.3	3.9	UNP9200



### IMR and TFR

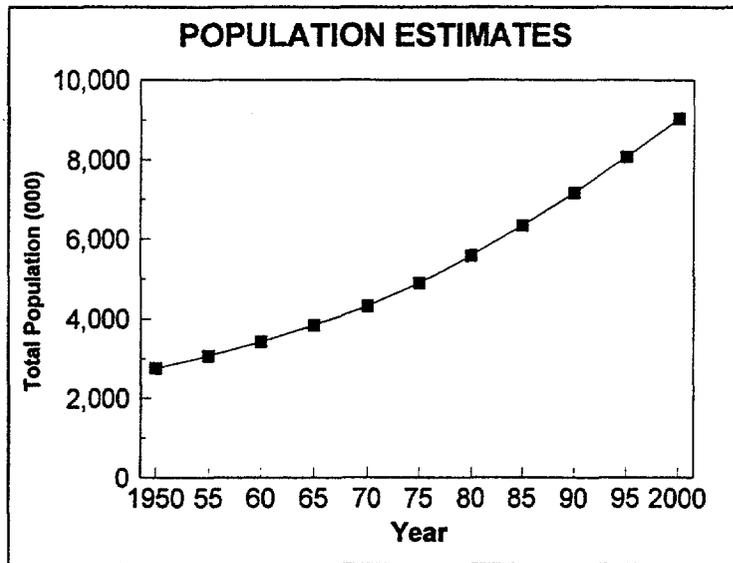
The relationship between IMR and TFR is currently a subject under review by the scientific community. While there is not conclusive evidence that the IMR and TFR are causally linked and necessarily decline together, there is empirical evidence for suspecting that such a reinforcing relationship exists as the pattern is observable in most countries.



Population Estimates/Pyramid

DECEMBER 1993

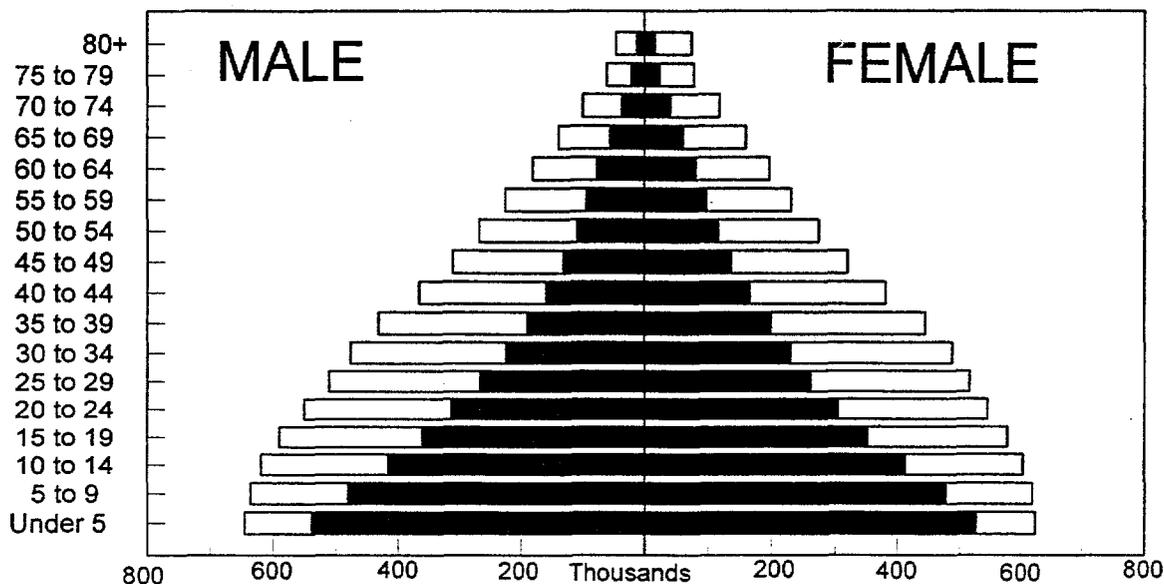
POPULATION ESTIMATES (000s)		
YEAR	VALUE	SOURCE
1950	2,766	UNP9200
1955	3,072	UNP9200
1960	3,428	UNP9200
1965	3,841	UNP9200
1970	4,325	UNP9200
1975	4,894	UNP9200
1980	5,581	UNP9200
1985	6,342	UNP9200
1990	7,171	UNP9200
1995	8,074	UNP9200
2000	9,038	UNP9200



CURRENT & PROJECTED POPULATION

By Age & Gender: 1990 - 2020

Total Population 1990: 6,988,893 Total Population 2020: 12,435,169



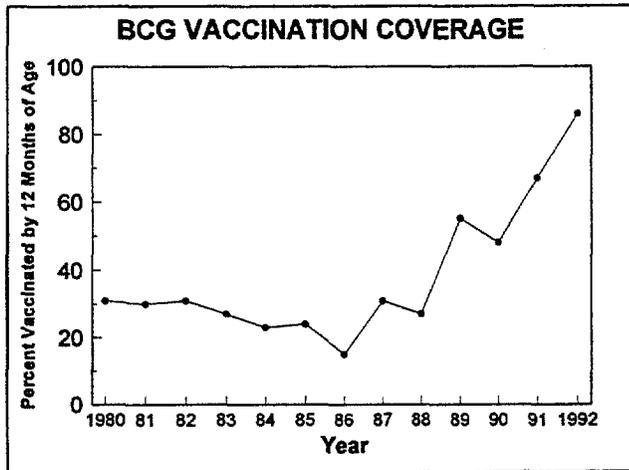
Source: BUC9105



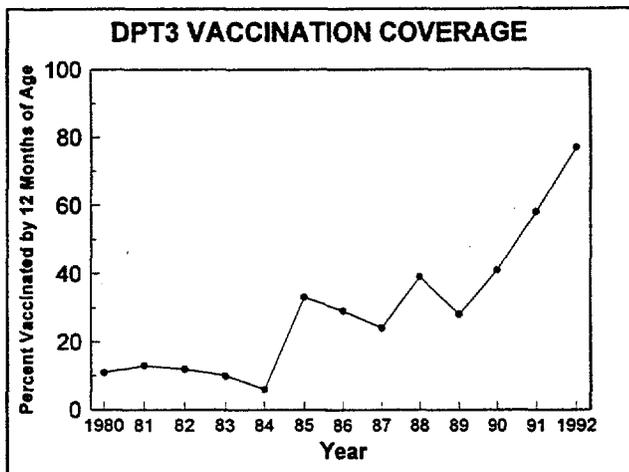
# Trends in Selected Health and Child Survival Indicators

## Vaccination Coverage Rates

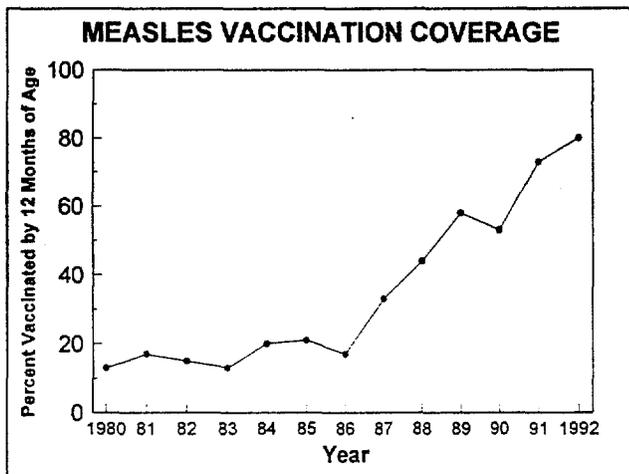
DECEMBER 1993



BCG COVERAGE		
YEAR	PERCENT	SOURCE
1980	31	WHE8700
1981	30	WHE8700
1982	31	WHE8700
1983	27	WHE8700
1984	23	WHE8700
1985	24	WHE8700
1986	15	WHE8800
1987	31	WHE8900
1988	27	WHE8900
1989	55	DHS9001
1990	48	WHE9100
1991	67	WHE9202
1992	86	WHE9301

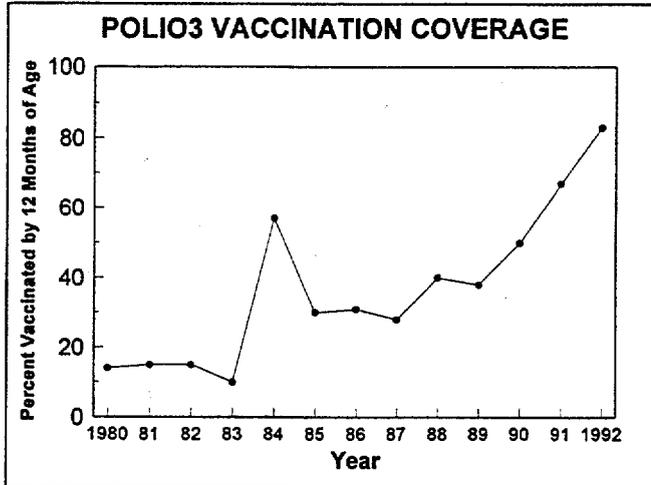


DPT3 COVERAGE		
YEAR	PERCENT	SOURCE
1980	11	WHE8700
1981	13	WHE8700
1982	12	WHE8700
1983	10	WHE8700
1984	6	WHE8700
1985	33	WHE8700
1986	29	WHE8800
1987	24	WHE8900
1988	39	WHE8900
1989	28	DHS9001
1990	41	WHE9100
1991	58	WHE9202
1992	77	WHE9301

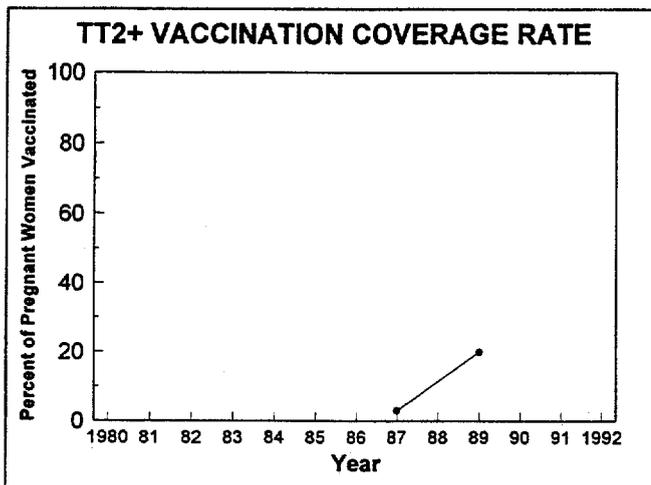


MEASLES COVERAGE		
YEAR	PERCENT	SOURCE
1980	13	WHE8700
1981	17	WHE8700
1982	15	WHE8700
1983	13	WHE8700
1984	20	WHE8700
1985	21	WHE8700
1986	17	WHE8800
1987	33	WHE8900
1988	44	WHE8900
1989	58	DHS9001
1990	53	WHE9100
1991	73	WHE9202
1992	80	WHE9301

Vaccination Coverage Rates, continued



POLIO3 COVERAGE		
YEAR	PERCENT	SOURCE
1980	14	WHE8700
1981	15	WHE8700
1982	15	WHE8700
1983	10	WHE8900
1984	57	WHE8700
1985	30	WHE8700
1986	31	WHE8800
1987	28	WHE8900
1988	40	WHE8900
1989	38	DHS9001
1990	50	WHE9100
1991	67	WHE9202
1992	83	WHE9301

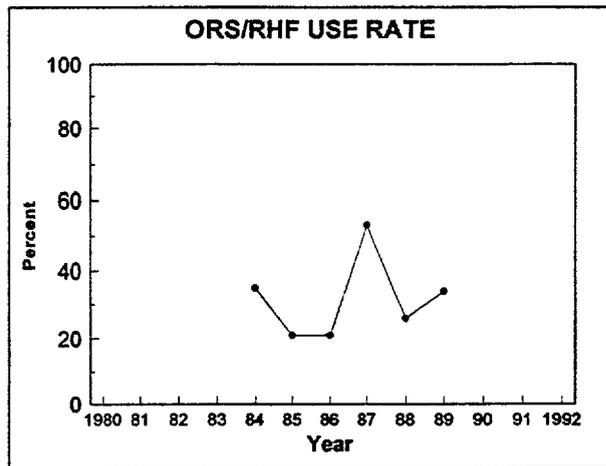
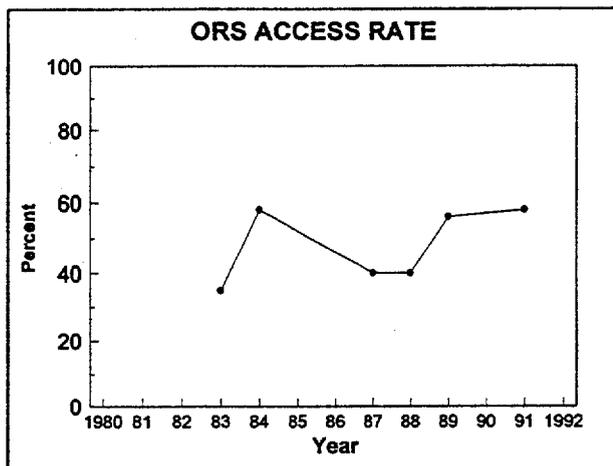


TT2+ COVERAGE		
YEAR	PERCENT	SOURCE
1985		
1986		
1987	3	WHE8900
1988		
1989	20	WHE9001
1990		
1991		
1992		



### ORS Access, ORS and/or RHF Use Rates

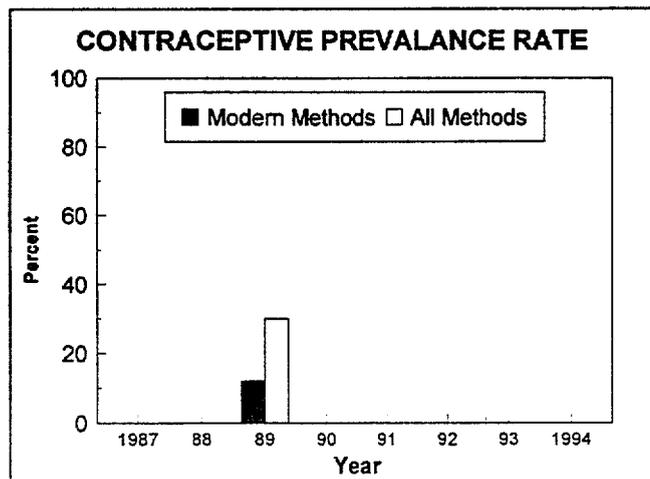
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INDICATOR	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992
ORS Access	35	58			40	40	56		58	
Source	WHD8500	WHD8601			WHD8900	WHD9000	WHD9100		WHD9201	
ORS/RHF Use		35	21	21	53	26	34			
Source		WHD8601	WHD8700	WHD8800	WHD8900	WHD9001	DHS9001			

### Contraceptive Prevalence Rate

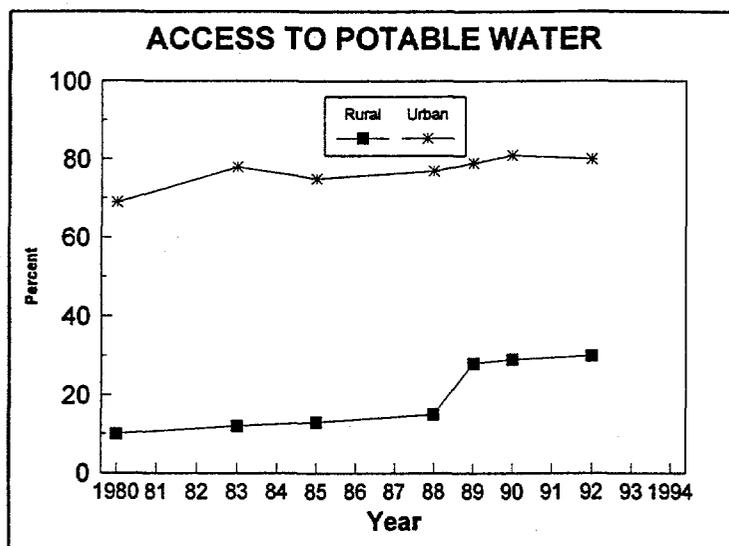
DECEMBER 1993



YEAR	MODERN METHODS	SOURCE	ALL METHODS	SOURCE
1987				
1988				
1989	12.0	DHS9001	30.0	DHS9001
1990				
1991				
1992				
1993				
1994				

### Access to Potable Water

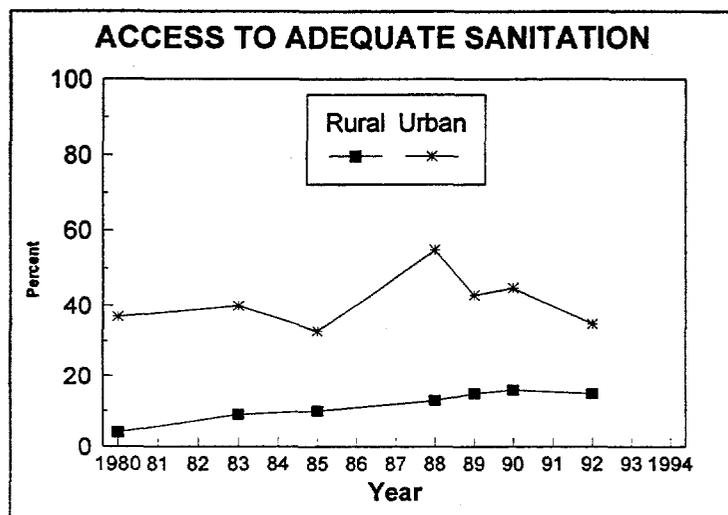
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YEAR	RURAL	SOURCE	URBAN	SOURCE
1980	10	AID9001	69	AID9001
1981				
1982				
1983	12	WHO9101	78	WHO9101
1984				
1985	13	WHO9101	75	WHO9101
1986				
1987				
1988	15	WHO9101	77	WHO9101
1989	28	AID9001	79	AID9001
1990	29	WHO9101	81	WHO9101
1991				
1992	30	MRF9211	80	MRF9211
1993				
1994				

### Access to Adequate Sanitation

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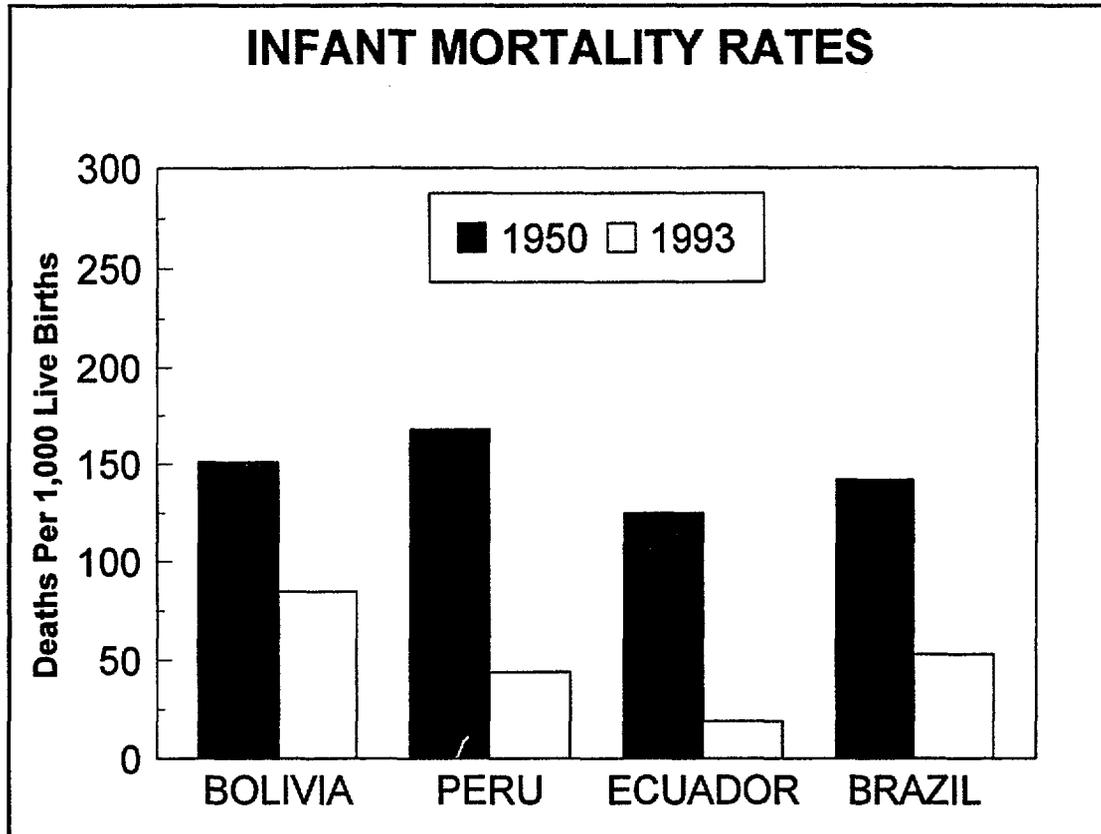
YEAR	RURAL	SOURCE	URBAN	SOURCE
1980	4	AID9001	37	AID9001
1981				
1982				
1983	9	WHO9101	40	WHO9101
1984				
1985	10	WHO9101	33	WHO9101
1986				
1987				
1988	13	WHO9101	55	WHO9101
1989	15	AID9001	43	AID9001
1990	16	WHO9101	45	WHO9101
1991				
1992	15	MRF9211	35	MRF9211
1993				
1994				



## Comparative Indicators

### Comparative IMR Rates

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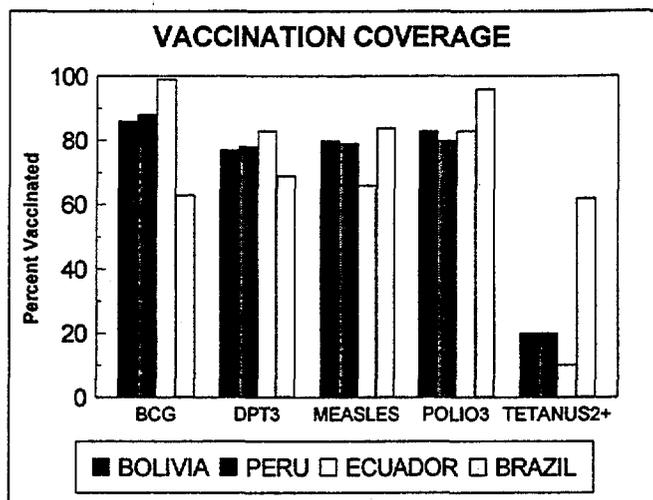


COUNTRY	1950	SOURCE	1993	SOURCE
BOLIVIA	151	WBK9302	85	WBK9302
PERU	168	WBK9302	44	WBK9302
ECUADOR	125	WBK9302	19	WBK9302
BRAZIL	142	WBK9302	53	WBK9302

## II: Health & Demographic Overview

### Comparative Vaccination Coverage Rates

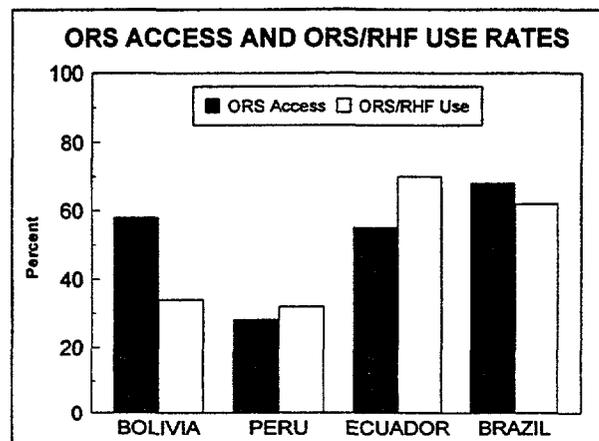
DECEMBER 1993



COUNTRY	INDICATOR	YEAR	VALUE	SOURCE
BOLIVIA	BCG	1992	86	WHE9301
	DPT3	1992	77	WHE9301
	Measles	1992	80	WHE9301
	Polio 3	1992	83	WHE9301
	Tetanus 2	1989	20	WHE9001
PERU	BCG	1991	88	DHS9207
	DPT3	1992	78	AID9202
	Measles	1992	79	AID9202
	Polio 3	1992	80	AID9202
	Tetanus 2	1991	20	DHS9207
ECUADOR	BCG	1992	99	WHE9301
	DPT3	1992	83	WHE9301
	Measles	1992	66	WHE9301
	Polio 3	1992	83	WHE9301
	Tetanus 2	1991	10	WHE9301
BRAZIL	BCG	1992	63	WHE9301
	DPT3	1992	69	WHE9301
	Measles	1992	84	WHE9301
	Polio 3	1992	96	WHE9301
	Tetanus 2	1987	62	WHE8900

### Comparative ORS Access, ORS and/or RHF Use Rates

DECEMBER 1993



COUNTRY	INDICATOR	YEAR	VALUE	SOURCE
BOLIVIA	ORS Access	1991	58	WHD9201
	ORS/RHF Use	1989	34	DHS9001
PERU	ORS Access	1992	28	WHD9300
	ORS/RHF Use	1991	32	DHS9207
ECUADOR	ORS Access	1991	55	WHD9201
	ORS/RHF Use	1991	70	WHD9201
BRAZIL	ORS Access	1991	68	WHD9201
	ORS/RHF Use	1991	62	WHD9201



### III: HIV / AIDS

DECEMBER 1993

*doesn't describe ongoing mission project, 511-0608*

According to reports to the World Health Organization (WHO), since 1990 Bolivia has had the lowest AIDS incidence rate of any nation in Latin America and the Caribbean, reaching a high of only 2.3 cases per million inhabitants in 1991.(PAH9301) Underreporting is evident in the fact that deaths attributed to AIDS represent nearly ninety per-cent of total cases recorded. Basic preventive measures emphasizing education and condom promotion are designed to help prevent the entry of HIV on an epidemic scale.

The information below is based on reports to WHO through Mar. 31, 1993: (PAH9318)

Total reported AIDS cases	60
Deaths attributed to AIDS	45
1992 incidence rate (per 1 million population)	1.0
Male/female ratio (1992)	1.8:1
Pediatric cases	1 (1.7% of total)
Perinatal cases	1 (1.7% of total)

### National AIDS Control Program

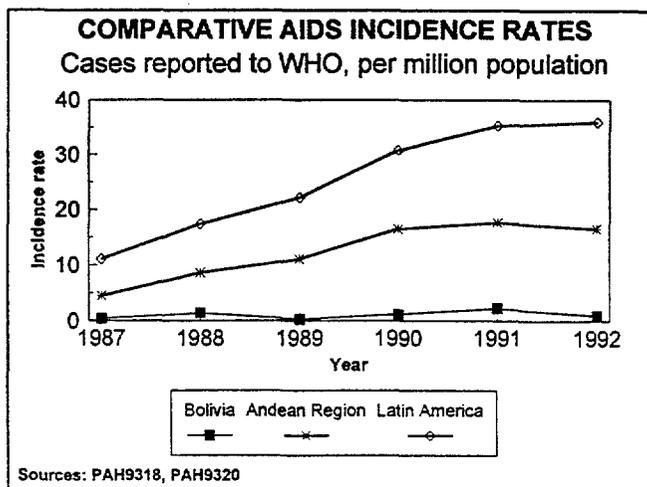
**Programa Nacional de Vigilancia y Prevención del SIDA, Ministerio de Previsión Social y Salud Pública.** The national AIDS program stresses epidemiological surveillance, sexual education in schools under the Ministry of Education, and the promotion of condom use in high-risk groups.(PAH9305) Assistance from USAID's AIDSTECH project helped the health ministry upgrade sexually-transmitted disease (STD) clinic services and surveillance systems and more effectively manage blood bank/laboratory testing centers.(AID0002)

Year	New cases	Comparative incidence rates (per million)		
		Bolivia	Andean Region	Latin America
Through 1986	3			
1987	3	0.4	4.5	11.1
1988	10	1.4	8.6	17.4
1989	2	0.3	11.1	22.2
1990	9	1.2	16.5	30.8
1991	17	2.3	17.7	35.3
1992	8	1.0	16.6	36.0

### Local Non-Governmental Organizations with HIV/AIDS Activities

(WHO9102,PAH9305,AID0002)

**Centro de Investigación, Educación y Servicios (CIES).** CIES operates STD clinics for women in La Paz and has conducted research, outreach and educational services for female sex workers through a network of professional, clinic-based health educators and volunteer peer educators.



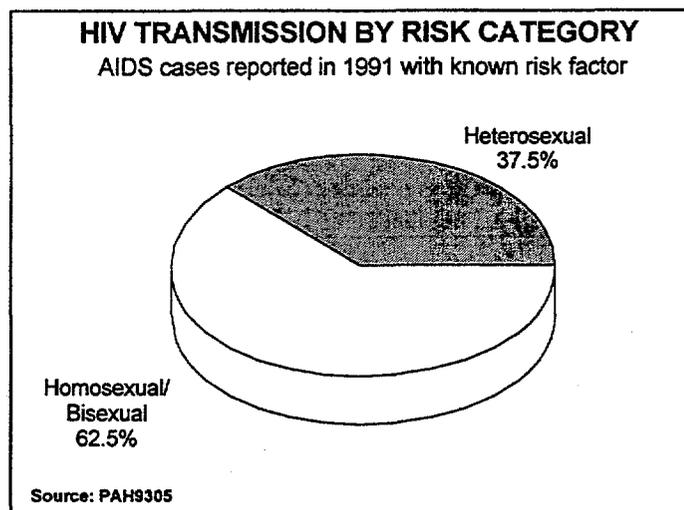
### III: HIV / AIDS

HIV-1 Seroprevalence from selected studies (BUC9301)				
Population sampled	Sex	Year	% HIV-positive	Sample size
Blood Donors	B	1988	0.1%	1235
Individuals Requesting Test	B	1988	0.0%	425
Various Groups	B	1985-89	0.1%	23622
Prostitutes, Santa Cruz City	F	1987	0.0%	295
Prostitutes	F	1988	0.0%	1094
Prostitutes, Other Risk Groups, Santa Cruz City	B	1989	0.8%	399
Homosexuals & Bisexuals	M	1988	10.3%	68
Prisoners	B	1988	0.1%	1539

**Consultora de Investigación y Educación (CIE), Cochabamba.**

**Fundación para la Atención Médica y Educación Sexual (FAMES).**

**Programa de Salud (PROSALUD).** PROSALUD integrates HIV/AIDS prevention services into its primary health care operations in Santa Cruz.



**Voluntarios en Acción (VEA), La Paz.** VEA organizes volunteers to conduct HIV-testing.

#### International NGOs with AIDS-related Activities in Bolivia (NCI9201, QUE9200, WHO9102)

Academy for Educational Development

American Red Cross

Centro Italiano di Solidarieta, Rome

Esperança

Johns Hopkins University/Population Communication Services

Partners of the Americas

Plan International

Terre des Hommes Deutschland

#### International Agencies supporting HIV/AIDS Activities in Bolivia

(PAH9305, UNF9200)

European Economic Community (EEC)

Pan-American Health Organization (PAHO)

Swedish International Development Agency (SIDA)

United Nations International Children's Educational Fund (UNICEF)

United Nations Population Fund (UNFPA)

United States Agency for International Development (USAID)

World Health Organization / Global Programme on AIDS (WHO/GPA)



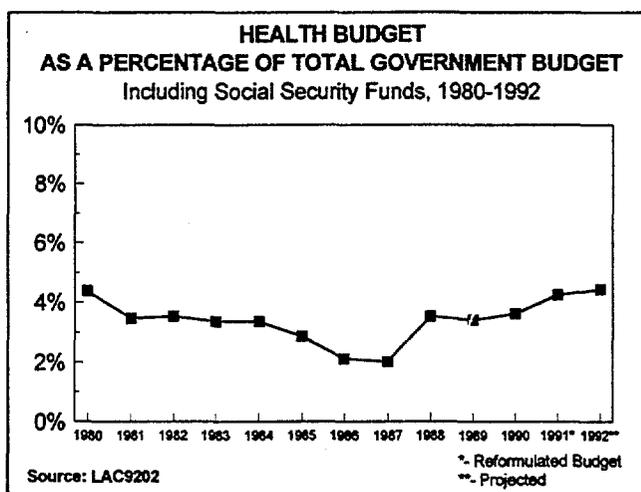
## IV: HEALTH CARE FINANCING

DECEMBER 1993

According to the World Bank, total health expenditures in Bolivia amounted to four percent of Bolivia's gross domestic product (GDP) in 1990, roughly 60 percent of which corresponded to public spending.(WBK9303) Official foreign aid provided over one-fifth of health care funding in Bolivia in 1990, the highest share in the Latin America and Caribbean (LAC) region.(WBK9303) The major sources of external financing are the United States Agency for International Development (USAID), the World Bank and the United Nations Development Programme (UNDP).(LAC9202)

### Public Sector

The public health sector's share of the national budget, including allocations to the Ministry of Health (MOH) and the social security system, declined during the economic crisis of the 1980s, reaching a low of two percent before beginning a mild recovery in



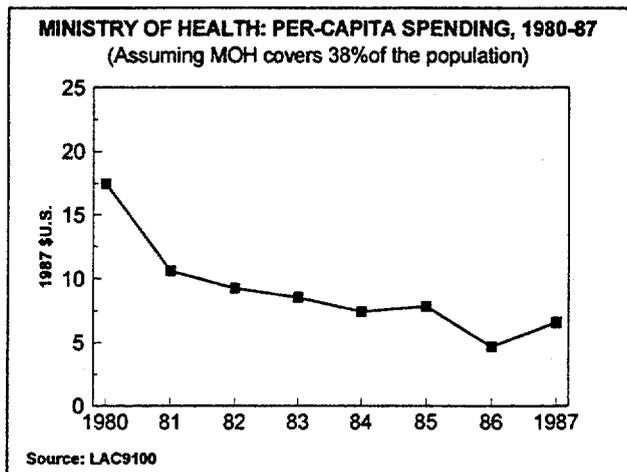
Health Budget as Percentage of Total Government Budget	
Year	Percentage
1980	4.38%
1981	3.47%
1982	3.53%
1983	3.36%
1984	3.36%
1985	2.87%
1986	2.11%
1987	2.01%
1988	3.53%
1989	3.41%
1990	3.62%
1991	4.25%
1992	4.43%

1988.(LAC9202)(See figure above) Measured in constant Bolivianos, the size of the health budget remained roughly the same from 1988-1990, increased by 24 percent in 1991, and was projected to remain at a similar level for 1992.(LAC9202)

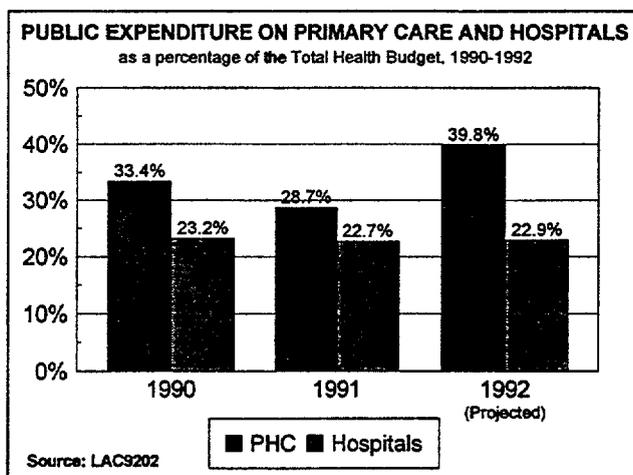
### Ministry of Health

The MOH experienced a 75 percent decline in per-capita spending between 1980 and 1986.(LAC9100) (See figure at top of next page) Partial recovery starting in the late 1980s was facilitated through external funding, enhanced cost recovery and an increased share of the overall national health budget, growing from 50 percent in 1988 to over 60 percent in 1991.(LAC9202) The sharp decline in domestic funding in the 1980s brought about a recurrent cost crisis which produced shortages of materials and supplies and placed severe limits on personnel expenditures, which consumed roughly 90 percent of treasury-

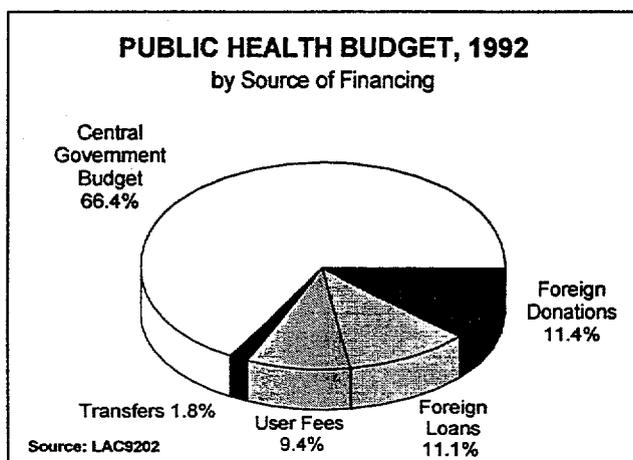
## IV: Health Care Financing



YEAR	1987 \$U.S.
1980	17.47
1981	10.60
1982	9.23
1983	8.54
1984	7.43
1985	7.84
1986	4.69
1987	6.59



provided funds between 1987 and 1991.(LAC9100) As indicated in the figure on the left, expenditures on primary health care increased to nearly 40 percent of the total health budget by 1992, according to the MOH. (LAC9202)



The figure at the bottom of the page illustrates the relative shares of various public health funding sources in 1992. While treasury outlays routinely made up 90-95 percent of the MOH budget prior to 1985, reductions in central allocations signified an increased role for alternative sources such as user fees and external financing, which respectively financed an average of 24 percent and 21 percent from 1985-1989.(LAC9201) User fees are determined, collected and spent on a facility-specific basis, but revenues are generally used for medicines, supplies and personnel "bonusses." (LAC9201) An assessment of health financing in Santa Cruz found that

user fees provided over 50 percent of total income for the MOH's Regional Health Unit there.(LAC9100) The World Bank estimates that user fees' share of total revenues in selected public hospitals grew from 13 percent to 40 percent between 1984 and 1988.(HPP9000)

Contributions from USAID provided over five percent of total central government health financing in 1991.(LAC9202) Other foreign aid is provided for public health programs



through the Social Investment Fund, created by the government of Bolivia in 1991 to take over health and education programs financed by the World Bank and the UNDP under the Emergency Social Fund. (WBK9202)

### **Social Security System**

Expenditures on health care by the Bolivian Social Security Institute (IBSS), financed through 10 percent of employer's payrolls, (IDB9101) amounted to over 40 percent of the national health budget in 1992. (LAC9202) High administrative costs - 14.5 percent of total expenditures from 1983 to 1986 - reflect multiplicity of management at IBSS, which consists of 12 major funds, 20 complementary funds, and five health programs. (IDB9101)

### **Regional and Local Governments**

Regional Development Corporations and municipalities generally allocate less than one percent of their budgets for health-related services. (LAC9202)

### **Private Sector**

According to the World Bank, private expenditures accounted for roughly 40 percent of total spending on health in 1990. (WBK9303) A USAID evaluation found that health spending in the private, non-profit health sector amounted to \$20 million in 1988, accounting for an astonishing 28 percent of total health expenditures that year. (LAC9202) Some private contractors and non-governmental organizations (NGOs) receive funding for construction of health posts and water and sanitation systems from the externally-financed Social Investment Fund. (WBK9202)

The only prepaid health plans in evidence in the late 1980s involved health services provided by some large employers in extractive industries. (LAC8900) Experiments in local financing of NGO health activities include an in-kind community financing program in Cochabamba in which beneficiaries supplied an annual quota of wheat or potatoes to remunerate health promoters. (AID8702) More recently, PROSALUD, a USAID-supported primary health care network serving 125,000 in Santa Cruz, has had limited success with prepaid plans (LAC8900) but has achieved 85 percent self-financing through users' fees. (LAC9100)

# V: USAID PROJECT ASSISTANCE

## TIMELINE: USAID Activities Related to Health & Population

DECEMBER 1993

Project Information					Fiscal Year																	
Project #	Project Name	Life-of-Project	Begin FY	PACD	Pre 85	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	200	
511-0000	Program Development and Support	*	1974	1993**																		
511-0569	Self-Financing Primary Health Care	\$2,300,000	1983	1990																		
511-0543	Chapare Regional Development	\$38,500,000	1983	1990																		
511-0536	Tiwanacu Rural Health (San Gabriel)	\$300,000	1983	1987																		
511-0590	ORT and Child Growth Monitoring-OPG	\$1,236,000	1985	1990																		
938-0510	FY85 Child Survival Grant to Project Concern International	\$1,375,000	1985	1991																		
938-0502	FY85 Child Survival Grant to Save the Children Federation	\$6,695,000	1985	1989																		
938-0261	Matching Grant to Meals for Millions	\$165,000	1985	1988																		

(Timeline continued on next page)

This chart contains USAID-funded projects active since 1980 known to contain a child survival, HIV/AIDS, other health, or population component. The Life-of-Project (LOP) column indicates total authorized funding planned for all project activities from the beginning until the conclusion of the project, and not an amount allocated to a specific project component. The project beginning year and project completion date (PACD) appear after the LOP. OPG is the abbreviation for Operational Program Grant. Please see Data Notes.

\* Total LOP is not available

\*\* Fiscal year of final obligation

\*\*\* Project is ongoing

Source: AID0000



Project Information					Fiscal Year																	
Project #	Project Name	Life-of-Project	Begin FY	PACD	Pre 85	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	200	
938-0503	FY85 Child Survival Grant to CARE	\$625,000	1985	1988		■	■	■	■													
511-0589	Priv. Agriculture Organ.(Nutrition)	\$6,700,000	1986	1992		■	■	■	■	■	■	■	■	■	■							
511-0599	Child Survival/Rural Sanitation	\$5,000,000	1986	1990		■	■	■	■	■	■											
938-0045	FY86 Vitamin A Grant to Save the Children Federation	\$118,000	1986	1990		■	■	■	■	■	■											
938-0520	FY86 Child Survival Grant to Esperanca	\$500,000	1986	1989		■	■	■	■	■												
938-0521	FY86 Child Survival Grant to Project Concern International	\$500,000	1986	1989		■	■	■	■	■												
938-0522	FY86 Child Survival Grant to Plan International	\$500,000	1986	1989		■	■	■	■	■												
511-0600	ORS Packets	\$450,000	1987	1989				■	■	■	■											
938-0528	FY87 Child Survival Grant to Freedom from Hunger	\$460,000	1987	1991				■	■	■	■	■	■									
511-0594	Community and Child Health	\$20,394,000	1988	1995					■	■	■	■	■	■	■	■	■	■	■	■	■	■
511-0597	Radio Education	\$1,908,000	1988	1992					■	■	■	■	■	■	■							
511-0578	Planning Assistance-OPG	\$1,635,000	1988	1991					■	■	■	■	■									
511-0601	Child Survival PVO Network-OPG	\$1,777,000	1988	1991					■	■	■	■	■									

(Timeline continued on next page)

Project Information					Fiscal Year																	
Project #	Project Name	Life-of-Project	Begin FY	PACD	Pre 85	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	200	
511-0608	AIDS Prevention and Control	\$4,000,000	1988	1995					■	■	■	■	■	■	■	■						
938-0510	FY88 Child Survival Grant to Project Concern International	\$850,000	1988	1991					■	■	■											
938-0ESP	FY89 Child Survival Grant to Esperanca	\$640,000	1989	1992					■	■	■											
938-0SCF	FY89 Child Survival Grant to Save the Children Federation	\$600,000	1989	1992					■	■	■											
938-0FFH	FY89 Child Survival Grant to Food for the Hungry Int'l	\$500,000	1989	1992					■	■	■											
511-0568	Reproductive Health International	\$9,300,000	1990	1995							■	■	■	■	■	■						
511-0607	Self-Financing Primary Health Care II	\$6,500,000	1990	1996							■	■	■	■	■	■	■					
938-PLAN	FY90 Child Survival Grant to Plan International	\$875,000	1990	1993							■	■	■	■								
938-0AND	FY90 Child Survival Grant to Andean Rural Health Care	\$700,000	1990	1993							■	■	■	■								
511-0618	CARE/Water and Health II	\$7,000,000	1991	1995								■	■	■	■	■						
511-0619	Interactive Radio Learning	\$5,000,000	1991	1996								■	■	■	■	■	■					
511-0620	PVO Child Survival II	\$8,000,000	1991	1996								■	■	■	■	■	■					
511-0617	Cochabamba Regional Development	\$80,000	1991	1996**								■	■	■	■	■	■					

(Timeline continued on next page)



# Fiscal Year Obligations for USAID-funded Projects Related to Health

DECEMBER 1993

Project #	Project Name	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
511-0000	Program Development and Support (PD&S)	90	200	200	630	192	375	237	0
511-0543	Chapare Regional Development	0	0	0	0	0	1,212	0	0
511-0568	Reproductive Health	0	0	0	0	0	1,000	584	0
511-0569	Self-Financing Primary Health Care	550	112	1,000	90	200	0	0	0
511-0578	OPG:Planning Assistance	0	0	0	200	500	120	0	0
511-0590	OPG:ORT and Child Growth Monitoring	384	52	400	400	0	0	0	0
511-0594	Community and Child Health	0	0	0	2,700	2,282	6,309	0	1,235
511-0597	Radio Education	0	0	0	34	200	0	0	0
511-0599	OPG:Child Survival/Rural Sanitation	0	2,486	1,550	0	464	500	0	0
511-0600	ORS Packets	0	0	450	0	0	0	0	0
511-0601	OPG:Child Survival PVO Network	0	0	0	1,000	677	100	0	0
511-0607	Self-Financing Primary Health Care II	0	0	0	0	0	0	564	1,486
511-0608	AIDS Prevention and Control	0	0	0	100	225	175	504	1,000
511-0617	Alternative Development	0	0	0	0	0	0	718	1,016
511-0618	CARE/Water and Health II	0	0	0	0	0	0	2,000	1,250
511-0619	Interactive Radio Learning	0	0	0	0	0	0	415	0
511-0620	PVO Child Survival II	0	0	0	0	0	0	3,165	3,000
511-0623	Special Development Activities	0	0	0	0	0	0	90	45
931-0045	SCF:PVO Vitamin A Intervention Program	0	0	84	0	0	0	0	0
936-3057	Central Contraceptive Procurement	0	0	0	0	0	0	120	0
938-0502	FY 85 Child Survival Grant	669	0	0	0	0	0	0	0
938-0503	FY 85 Child Survival Grant	625	0	0	0	0	0	0	0

(Fiscal Year Obligations continued on next page )

Funding is based on reported attributions for child survival, HIV/AIDS and other health activities from all funding accounts, except population account funding in FY 1985-91. FY 1985-92 funding figures are actual. Please see Data Notes.

Source: AID0000, AID9308



Project #	Project Name	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
938-0510	FY 85 Child Survival Grant	525	0	0	0	0	0	0	0
938-0510	FY 88 Child Survival Grant to PCI	0	0	0	850	0	0	0	0
938-0520	FY 86 Child Survival Grant to Esperanca	0	550	0	0	0	0	0	0
938-0521	FY 86 Child Survival Grant to PCI	0	500	0	0	0	0	0	0
938-0522	FY 86 Child Survival Grant to PLAN	0	500	100	0	0	0	0	0
938-0528	FY 87 Child Survival Grant to FFH	0	0	460	0	0	0	0	0
938-0531	FY 87 Child Survival Grant to ANDEAN	0	0	220	0	0	0	0	0
938-0535	FY 87 Child Survival Grant to SCF	0	0	700	0	0	0	0	0
938-0AND	FY 90 Child Survival Grant to ANDEAN	0	0	0	0	0	700	0	0
938-0ESP	FY 89 Child Survival Grant to Esperanca	0	0	0	0	640	0	0	0
938-0PCI	FY91 Child Survival Grant to PCI	0	0	0	0	0	0	675	0
938-0PCI	FY91 Vitamin A Grant to PCI	0	0	0	0	0	0	25	0
938-0SCF	FY 89 Child Survival Grant to SCF	0	0	0	0	600	0	0	0
938-FFHI	FY 89 Child Survival Grant to FFHI	0	0	0	0	500	0	0	0
938-PLAN	FY 90 Child Survival Grant to PLAN	0	0	0	0	0	450	0	0
938-PLAN	FY 90 Child Survival Grant to PLAN	0	0	0	0	0	425	0	0
<b>TOTAL (000s):</b>		<b>\$2,843</b>	<b>\$4,400</b>	<b>\$5,164</b>	<b>\$6,004</b>	<b>\$6,480</b>	<b>\$11,366</b>	<b>\$9,097</b>	<b>\$9,032</b>

# USAID-Funded Health Projects Active During Fiscal Year 1992

DECEMBER 1993

Project #	Project Name	U.S. Contractor/Grantee
511-0568	Reproductive Health	National Population Council, Ministry of Planning
511-0594	Community and Child Health	Ministry of Health
511-0597	OPG:Radio Education	Education Development Center, Inc.
511-0607	Self-Financing Primary Health Care II	PROSALUD
511-0608	AIDS Prevention and Control	Ministry of Health, Department of Health and Human Services/Centers for Disease Control and Prevention
511-0618	CARE/Water and Health II	CARE
511-0619	Interactive Radio Learning	Education Development Center, Inc.
511-0620	PVO Child Survival II	Program of Coordination of PVO's Working in Child Survival in Bolivia
511-0624	Displaced Children	Peace Corps
938-0535	FY87 Child Survival Grant to SCF	Save the Children Federation
938-0AND	FY90 Child Survival Grant to Andean	Andean Rural Health Care
938-0ESP	FY89 Child Survival Grant to Esperanca	Esperanca
938-0PCI	FY91 Child Survival Grant to PCI	Project Concern International
938-0PCI	FY91 Vitamin A Grant to PCI	Project Concern International
938-0SCF	FY89 Child Survival Grant to SCF	Save the Children Federation
938-FFHI	FY89 Child Survival Grant to Food for the Hungry, International	Food for the Hungry International
938-PLAN	FY90 Child Survival Grant to PLAN (Sucre)	PLAN International (CHILDREACH)
938-PLAN	FY90 Child Survival Grant to PLAN (Altiplano)	PLAN International (CHILDREACH)

Please see Data Notes.

Source: CIH0001



## Descriptions of USAID-Funded Child Survival, HIV/AIDS, and Other Health Projects

DECEMBER 1993

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### Bilateral Projects

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**Project Number:** 511-0568  
**Project Title:** Reproductive Health Services  
**Country:** Bolivia  
**Project Area:** La Paz, Cochabamba, Santa Cruz, Oruro, Potosi and selected rural areas  
**Project Duration:** FY 1990 - 9/30/95  
**Implementing Organization(s):**  
**Host country:** Ministry of Health (MOH), Caja Nacional de Salud (CNS), Unidad de Politica de Poblacion (UPP)  
**U.S.:** Population Communication Services of Johns Hopkins University (JHU/PCS), The Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO), Management Sciences for Health/Family Planning Management Development (MSH/FPMD), The Population Council, The Pathfinder Fund, John Snow Inc./MotherCare, Development Associates, The Futures Group (RAPID, OPTIONS, SOMARC), Macro International

#### Project Overview:

The broad goal of the five-year Reproductive Health Services (RHS) project is to improve maternal and child health in Bolivia. The project purpose is to increase access to and the quality of reproductive health services. RHS operates in primarily urban areas targeting recent migrants to the cities, women of reproductive age (15-45), pregnant and lactating women, and high-risk women. The project strategy supports three elements: 1) the Government of Bolivia reproductive health program; 2) non-governmental (NGO) activities; and 3) social marketing of contraceptives. Crossing this sectoral framework, the project supports five technical activities: services provision; information, education, and communication (IEC); training; research and evaluation; and policy development. USAID provides direct funds to three public entities: the Ministries of Health and Planning and the Caja Nacional de Salud. Technical assistance is provided by ten U.S. cooperating agencies.

Having spent the first two years setting the stage, the project now plans to accelerate services. For example, existing IEC, training, and indirect NGO support may expand to include three more cities. This would extend RHS to most of Bolivia's urban and peri-urban centers, representing 89 percent of Bolivia's urban population.

#### Project Highlights:

Although it is too soon to measure statistical output, RHS has achieved significant progress in all project components in the two years of project operation. These efforts include:

- A National Coordinating Committee for Reproductive Health has been established by the MOH, UPP, CNS, the Bolivian Society of Gynecology and Obstetrics, the Pan American Health Organization and USAID. Technical subcommittees for services, IEC, training, research and evaluation and policy were also formed.
- CNS has launched a major effort to include reproductive health services throughout its national system of hospitals and clinics. The program is developing in Santa Cruz and Cochabamba and is expanding in La Paz and El Alto.

## V: USAID Project Assistance

- The MOH has established systems for aggregating services statistics and facilitating contraceptive delivery. The OPTIONS project has provided technical assistance in developing these systems.
- The IEC subcommittee, with assistance from Population Communication Services, has produced a national logo and printed materials that are being used throughout the country. The MotherCare project in Cochabamba has launched a mass media project that will cover all aspects of maternal and child health.
- Two training centers for clinical methods have been established by JHPIEGO and have begun training programs. A training of trainers program is now incorporating reproductive health into the curriculum of auxiliary nursing schools. Training has focused on both the private and public sectors.
- In support of the research and policy component, UPP has produced a large array of detailed and comprehensive studies. With assistance from MotherCare, the Center of Health Research, Consultation, and Education conducted a study to determine why mothers prefer to give birth at home. Some of the reasons mothers did not use facilities include the fact that the facilities were too cold, husbands were not permitted to be present, lack of privacy, refusal to return the placenta to the family for ritual disposal, and the birthing position. The findings of this study were presented to a group of health care providers who are now adopting new practices to make the facilities more appealing to pregnant women.
- Close to a dozen local NGOs have received direct or indirect (commodities or training) assistance under this project. One NGO will run one of the national training centers.
- The Social Marketing program managed by PROSALUD, a local NGO, has already surpassed planned or projected sales targets. The program also launched a television campaign with technical assistance from SOMARC.

### Sources:

AID0001, AID9211, QUE9100, QUE9200

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**Project Number:** 511-0594  
**Project Title:** Community and Child Health  
**Country:** Bolivia  
**Project Area:** National  
**Project Duration:** FY 1988 - 9/30/95  
**Implementing Organization(s):**

**Host country:** Ministry of Health (MOH)  
**U.S.:** JSA Healthcare, CIENTIFICA, Coopers & Lybrand, Medical Services Corp. International (MSCI), Centers for Disease Control (CDC), Project Concern International

### Project Overview:

The objective of the Community and Child Health project is to reduce infant, child, and maternal mortality by supporting three national child survival programs, improving the capacity of the MOH to provide child survival services in six districts in the project areas, and providing water and sanitation in rural communities. The major emphases of the project are institution building and service delivery at the district level. Efforts began in four districts and have gradually expanded. Working closely with the MOH, the project also seeks involvement and cooperation from private voluntary organizations (PVOs).



At the national level, USAID supplies vaccines, drugs, and cold chain equipment to the MOH for its regular immunization activities at fixed centers and for large-scale vaccination campaigns which target at-risk rural populations. The project works through the Immunization Interagency Coordinating Committees with the MOH and other donors. In other Expanded Programme of Immunization (EPI) areas, the project designed a user-friendly computerized system which tracks costs and logistics for the EPI program. The system is used by the MOH and all donor agencies contributing to EPI.

At the institutional level, the project conducts workshops, providing a wide range of formal and informal training with priority given to auxiliary nurses in charge of central sanitary posts and to district-level administrators. Training in health education and community participation techniques is emphasized.

The Chagas' disease control component provides information from operations research to the National Chagas Program. A team of Chagas' control experts work directly with the MOH to develop action programs in 1) surveillance of Chagas' disease, 2) regional laboratory capability, 3) basic and operations research, 4) training, 5) pesticide spraying, 6) house improvement, 7) local animal control, 8) education program in primary schools, and 9) partnerships with other donors.

**Project Highlights:**

- The project has assisted the MOH's lowest- and mid-level administrative units in working through community participation. This is a first for Bolivia, and it is hoped that these levels will be self-sufficient in many aspects before the end of the project.
- Research activities supported by the project include "Impact of Community Health Programs" and "Diagnosis of Health Education in District Communities." The project has also worked with the CDC on a collaborative study at the children's hospital in La Paz to determine the magnitude of persistent diarrhea and dysentery presenting to the hospital. Potential predictors for progression from acute to persistent diarrhea were also examined. This study, which had been supported by PRITECH since May 1991, ended in May 1992 and was followed by data analysis.
- A recent evaluation of the Bolivian Chagas' Disease Control project found that "remarkable" progress has been made in the field-testing of community-based control methods. During the first two years of this project, over 1,000 homes in 13 communities were improved, making the houses and animal shelters inhospitable to triatomine bugs. This two-year effort has been extended an additional two years in order to continue research and strengthen communication and coordination between project sites.
- A two-year in-service training program for 42 epidemiologists began, with assistance from the Data for Decision Making Project.

**Sources:**

AID0001, AID9211, CAB9108, CAB9204, QUE9100, QUE9200

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**Project Number:** 511-0607  
**Project Title:** Self-Financing Primary Health Care II  
**Country:** Bolivia  
**Project Area:** La Paz city and El Alto city  
**Project Duration:** FY 1991 - 5/08/96  
**Implementing Organization(s):**  
Host country: PROSALUD, Pro-Mujer  
U.S.: No organizations

**Project Overview:**

As a follow-on to the Self-Financing Primary Health Care I project (#511-0569), this project assists the regional health care systems in Bolivia's La Paz and Beni departments to be financially self-sufficient. The Santa Cruz model, developed under the initial project, will be replicated for the establishment of primary health care systems in two regions -- the city of El Alto and its surrounding areas and the city of Trinidad in Beni Department and nearby rural areas. These two regions currently report some of the highest infant, child, and maternal mortality rates in the country and in Latin America and also lack adequate health services.

The goal of the project is to have all health centers cover all recurrent costs and be self-sufficient by using a combination of fee-for-services, pre-payment, and deferred payments for the health services provided. The project will contribute to the institutionalization of PROSALUD as a nationwide primary health care organization with autonomous regional branches.

**Project Highlights:**

■ In 1992 the project trained physicians, nurses, community health workers, mothers, and health managers. Topics covered include reproductive health, quality assurance, self-financing, women's health, child survival, community relations and outreach, strategic planning, and the development of educational materials.

**Sources:**

AID0001, QUE9100, QUE9200

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**Project Number:** 511-0618  
**Project Title:** CARE/Water and Health II  
**Country:** Bolivia  
**Project Area:** Seven provinces in the La Paz department and the Campero province in Cochabamba department  
**Project Duration:** FY 1991 - 3/28/95  
**Implementing Organization(s):**  
  **Host country:** Ministry of Health (MOH)  
  **U.S.:** CARE, Departmental Development Corporations

**Project Overview:**

This project serves as a follow-on to the Child Survival/Rural Sanitation project. It is designed to improve infant and child nutrition and vaccination among 48,000 people in 160 rural villages in several provinces of the La Paz and Cochabamba departments. The project helps develop community capabilities in the areas of primary health care, water and sanitation, agriculture, and community organization. End-of-project targets include an 80 percent child vaccination coverage, a 20 percent decrease in child malnutrition, and a 50 percent usage rate of oral rehydration therapy for children with diarrhea. CARE implements the project in coordination with Bolivia's regional Departmental Development Corporations.

Primary health care efforts are implemented through village health workers. These efforts include health promotion, vaccination, oral rehydration therapy, growth promotion, nutrition, hygiene, and, in 20 pilot villages, diagnosis and treatment of acute respiratory infections, prenatal care, and the supply of appropriate or essential medicines.



Water and sanitation efforts to provide potable water and sanitation services rely heavily on village cash and in-kind contributions. In addition, a subsidy for villagers interested in building latrines provides incentive. Over 1,100 latrines had been built by the end of fiscal year 1992.

The project's agricultural component complements other interventions, particularly by ensuring appropriate use of the water and an increased food supply. Other activities include animal vaccination and de-parasitization, and instruction and assistance in vegetable gardening. Almost 40 percent of families in the project area now have vegetable gardens which will ultimately improve health by meeting the critical dietary deficiencies in vitamin A, calcium, iron, and folic acid.

The project addresses sustainability of its interventions through grassroots enthusiasm and participation. A full-time CARE employee works in every fifth village to help establish community organizations. By the close of 1992, 112 community organizations had been established, 40 percent of which included at least one woman. Sub-committees of the organizations supervise community-selected health, water, and agricultural workers. Village workers receive training in their respective project areas and responsibility for project services is gradually transferred to the workers and village organizations.

Another key element in sustaining activities is the development of mechanisms to pay community workers. One way workers are being compensated is with funds generated from health service fees. A community pharmacy pilot activity is also planned which would help reduce the turnover of health workers and provide a supply of essential medicines in villages not served by the MOH.

Due to continued outbreaks of cholera, the project will intensify its training activities for community workers and communities.

**Project Highlights:**

- During 1992 all community workers received training in cholera treatment. They were also trained in vaccination, the control of diarrheal diseases and acute respiratory infection, nutrition, and the identification of high-risk pregnancies. Almost half of the trained community health workers are women, thus making the health care system more approachable to pregnant women.

- Nutrition-related activities are highly important in an area where almost three-quarters of the children 12-23 months of age and over two-thirds of children three to four years old are malnourished. The project is working to improve the nutritional status of the children through the cultivation of family vegetable gardens, the introduction of iodized salt (over 70 percent of families now use iodized salt), and the monthly weighing of children under two years of age (40 percent of these children are now weighed monthly).

**Sources:**

AID0001, QUE9100, QUE9200

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**No Longer Funded**

**Project Number:** 511-0597  
**Project Title:** OPG: Radio Education  
**Country:** Bolivia  
**Project Area:** Departments of La Paz, Cochabamba, Santa Cruz, and Tarija  
**Project Duration:** FY 1988 - 5/12/92  
**Implementing Organization(s):**  
Host country: Programa de Educacion por Radio Fe y Alegria  
U.S.: Education Development Center, Inc. (EDC)

## V: USAID Project Assistance

### Project Overview:

This project was designed to: (1) improve the quality and efficiency of primary education in Bolivia by using interactive radio to teach mathematics and language, (2) build on Bolivia's successful use of radio to convey health messages to children, and (3) increase Fe y Alegría's institutional capacities.

Under the project, Fe y Alegría was to develop, promote, and broadcast an interactive radio program series for Bolivian primary schools. The radio program was to present and explain primary school curriculum material and concepts, thus reinforcing the presentation of curriculum material by teachers. It also was to provide intensive written and oral practice in basic core curriculum skills. Participation in the program was to be voluntary and the program was expected to reach 10 percent of Bolivian children in grades 1-3.

Specific goals of the program included adapting a full radio mathematics curriculum for grades 1-3, adapting the entire grade 1 Spanish language curriculum developed under project #936-5818 in Honduras, and transmitting 450 half-hour radio lessons in mathematics and 150 half-hour radio lessons in Spanish language studies. A core group of 15 specialists was to be trained in interactive radio curriculum adaptation, script-writing, materials development, teacher training, lesson production, and project administration. Fe y Alegría was to make available radios and educational materials to participating schools and communities at an affordable price.

By implementing the program, it was projected that Fe y Alegría would strengthen its capabilities in several areas. The program would:

- Develop a capacity to adapt, produce, and transmit educational radio programs at the primary school level; in 1990, a weekly radio program, "Diarrhea Prevention and Oral Rehydration Therapy," was aired.
- Experiment with different transmission modes, including donated transmission time on existing private radio stations and/or networks and assembling an ad hoc network of local stations around the country which would be contracted to re-transmit at a low cost; and
- Develop an Agreement of Cooperation with other private organizations administering schools and with the Ministry of Education to work jointly on promoting effective use of the interactive radio broadcasts by primary school teachers.

### Sources:

AID0001, AID9105, QUE9100

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**Project Number:** 511-0619  
**Project Title:** Interactive Radio Learning  
**Country:** Bolivia  
**Project Area:** Departments of La Paz, Cochabamba, Santa Cruz, and Tarija  
**Project Duration:** FY 1991 - 9/30/96  
**Implementing Organization(s):**  
Host country: Ministry of Education and Culture (MEC), Ministry of Health (MOH), Programa de Educacion por Radio Fe y Alegría  
U.S.: Education Development Center, Inc. (EDC)



**Project Overview:**

This purpose of this project, which is a follow-on to the OPG: Radio Education project (#511-0597), is to institutionalize the use of interactive radio instruction (IRI) to improve health and math education in Bolivia's basic education system. The MEC implements the project with help from EDC, a U.S. contractor. The project objectives include 1) development of a health curriculum for grades 3 to 5; 2) institutionalization of math curricula for grades 2 to 5; 3) implementation of related monitoring and evaluation; and 4) extension of IRI to out-of-school children and adults.

EDC and participating non-governmental organizations (NGOs) are developing health curriculum modules and teachers' guides for grades 3 to 5. The project conducts baseline studies for the development of the health modules, operations research to measure behavioral outcomes, and formative and summary evaluations based on both formal testing and classroom observations.

These modules will be tested in 200 schools and, upon validation, implemented in all schools receiving math broadcasts. Since one of the units covers first aid, the project offers training to teachers in this area and provides each pilot school with a first aid kit. In areas where there are no health workers, motivated teachers are encouraged to provide both first aid and primary health measures such as distributing oral rehydration salts packets. To extend the effects of IRI health education into the communities, private voluntary organization and MOH health promoters are invited to listen to the IRI broadcasts and are given teachers' guides which they can adapt for use with their adult clients.

While the health curriculum modules are being developed, the IRI math curriculum developed under the Radio Education project for grades 2 to 3 is being institutionalized in at least seven of the country's nine departments. A key activity in this process is the development of a training of trainers program. First, Ministry supervisors and teachers are trained in IRI methodology; then, this latter group trains school directors, who in turn are responsible for training additional teachers. Other goals of this part of the project include producing teachers' guides, making agreements with radio stations for transmitting the lessons, establishing a system for distributing and maintaining radios, and training supervisors to evaluate the IRI lessons.

A pilot program will be undertaken to make IRI broadcasts available to out-of-school children and to interested adults. Potential activities include publicizing broadcast times, possibly broadcasting at alternative times of day when working people are able to listen, and developing study guides.

An extensive operations research activity was scheduled to begin in 1993 to validate behavior change that can be attributed to the program. Fifty additional programs were planned to be developed and field-tested at the third and fourth grade levels during the 1993 school year.

**Project Highlights:**

- "Radio Health" was inaugurated in August 1992 by the Minister of Education, the U.S. Ambassador, and USAID officials.
- During the month of September 1992, 566 teachers were trained in the use of the instructional methodology, and 19,277 students participated in the weekly health lesson through the close of the 1992 school year. Some of the topics covered in the training included the use of oral rehydration therapy, how to differentiate between common diarrhea and cholera, vaccination promotion, nutrition, malaria, acute respiratory infection, and water and sanitation. Evaluation tests are being administered in a sample of the project classrooms to verify student learning of the basic health messages.

**Sources:**

AID0001, QUE9100, QUE9200

**No Longer Funded**

**Project Number:** 511-0601  
**Project Title:** OPG: Child Survival PVO Network  
**Country:** Bolivia  
**Project Area:** Entire country  
**Project Duration:** FY 1988 - 7/31/91  
**Implementing Organization(s):**  
Host country: PROCOSI (Secretaria Ejecutiva)  
U.S.: Save the Children Federation

**Project Overview:**

This project supported Save the Children Federation's (SCF) efforts to develop a child survival PVO network in rural Bolivia and to improve collaboration between PVOs and the Ministry of Health (MOH).

USAID funds were used to provide subgrants to national and international PVOs for approximately 20 community-based subprojects in such areas as vaccination, diarrheal disease control, growth monitoring, birth spacing, acute respiratory infection, and maternal/child health. The project also financed technical assistance for participating PVOs in the technical and managerial aspects of child survival programs. The project was implemented through the existing PROCOSI PVO Rotation Executive Committee in Bolivia, and all proposals were reviewed by a panel which included members of the SCF, USAID/Bolivia, and the MOH.

**Project Highlights:**

- In August 1990 a vitamin A component was added to the project. This component provided subgrants to PVOs for vitamin A activities and promoted vitamin A interventions by producing educational materials and mass media messages and by conducting workshops.
- Since the project's inception, project staff and several communities in the project area carried out a retrospective case-control study of perinatal and neonatal deaths, as well as a participatory problem identification exercise known as the "autodiagnostico" with women's groups in eight communities. Both investigations identified similar serious maternal, perinatal, and neonatal health problems.

**Sources:**

AID0001, CAB9109, QUE9100

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**Project Number:** 511-0620  
**Project Title:** PVO Child Survival II  
**Country:** Bolivia  
**Project Area:** Entire country  
**Project Duration:** FY 1991 - 5/30/96  
**Implementing Organization(s):**  
Host country: PROCOSI, Ministry of Health (MOH)  
U.S.: No organizations

**Project Overview:**

PROCOSI, an association of U.S. and Bolivian private voluntary organizations (PVOs), implements this project which is designed to strengthen the technical, management, and service delivery capacity of PVOs



working in health, child survival, and community development, as well as to enhance the coordination of development activities among these PVOs. The project is a follow-on to the OPG: Child Survival PVO Network project (#511-0601).

In addition to providing technical assistance, training, coordination, and child survival materials, PROCOSI makes up to 50 subgrants to members through an executive secretariat governed by a rotating executive committee of PVO directors. USAID/Bolivia is considering using project funds for a debt-for-development swap to establish an endowment to permit PROCOSI to cover future operation costs.

**Project Highlights:**

■ The Government of Bolivia recently authorized PROCOSI to participate in the conversion of Bolivian debt and to receive a 50 percent premium on PROCOSI's investment of US \$5 million. This is the first major step towards establishing the endowment that will permit PROCOSI to cover future operating costs. PROCOSI is the only PVO in Bolivia to participate in a debt-for-development program and to be authorized a premium by the Bolivian Government to finance child survival and maternal health activities.

**Sources:**

AID0001, QUE9100, QUE9200

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**Project Number:** 511-0608  
**Project Title:** AIDS Prevention and Control  
**Country:** Bolivia  
**Project Area:** La Paz, Santa Cruz, Cochabamba, Sucre  
**Project Duration:** FY 1988 - 9/30/95  
**Implementing Organization(s):**  
    **Host country:** Ministry (MOH), Centro de Investigacion, Education y Servicios (CIES)  
    **U.S.:** Centers for Disease Control/DHHS, Johns Hopkins University/Population Communication Services, Academy for Educational Development

**Project Overview:**

The project is designed to:

1. Collect reliable epidemiological data to define and track the extent of the STD/HIV/AIDS problem in Bolivia;
2. Detect, treat and/or counsel STD/HIV/AIDS patients;
3. Develop, disseminate and target information and education to high risk groups directed at promoting safe sexual behaviors and avoidance of injecting drug abuse and
4. Promote use of and make condoms accessible on demand.

By the end of the project, the following are planned to be operational: (1) the formation of a national coordinating committee to review strategies developed under the project and ensure coordination and consistency among all sectors involved; (2) strengthening of three STD/HIV/AIDS reference laboratories in La Paz, Santa Cruz and Cochabamba; (3) development and operation of three model STD/HIV/AIDS clinics in the same cities; (4) development of a sentinel surveillance system; (5) training of health workers in detection, treatment and counseling; (6) provision of STD/HIV/AIDS counselling and outreach services;

(7) development and implementation of information, education and communication programs, and (8) marketing of 2.7 million condoms.

Project activities are focused on high risk groups -- commercial sex workers and their clients, conscripts, transportists, and street children. In La Paz, an epidemiological survey with registered commercial sex workers was initiated in February of 1992 and intervention strategies were designed based on the study findings. A similar study was undertaken in Santa Cruz and was to be replicated in two other Bolivian cities during 1993.

**Sources:**

QUE9200

■ **U.S. Private Voluntary Organizations/FDC/PVC Projects**

**Project Number:** 938-PLAN.02 (Sucre) and 938-PLAN.03 (Altiplano)  
**Project Title:** Child Survival Grants to PLAN (Sucre and Altiplano)  
**Country:** Bolivia  
**Project Area:** Sucre Subproject - City Sucre, Chuquisaca Department, Provinces of Oropeza, Yamparuez and Potosi Department, Provinces of Chayanta and Cornelio Saavedra  
Altiplano Subproject - La Paz Department, Provinces of Ingavi, Los Andes, Manco Kapac, and Jose Manuel Pando  
**Project Duration:** FY 1990 - 8/31/93  
**Implementing Organization(s):**  
**Host country:** Ministry of Health (MOH)  
**U.S.:** PLAN International, Inc., PLAN International/Sucre, PLAN Internationals/Altiplano

**Project Overview:**

PLAN implemented child survival and maternal health activities in two locations through two separate grants. Both subprojects worked toward the goals of community empowerment and institutional decentralization.

■ **Sucre Subproject**

The Sucre area comprises two rural provinces in the Chuquisaca and Potosi departments and the peri-urban city of Sucre, serving a total population of 53,000. In 1992, the project concentrated on educating community health workers (CHWs), traditional birth attendants (TBAs), and mothers. A secondary effort reached community leaders, especially within the agrarian syndicate (local governing bodies). PLAN initiated an intensive training program for community leaders teaching them how to design, implement, and administer their own development projects. Activities included building health posts, community centers for acute respiratory infections (ARI) and oral rehydration therapy (ORT), schools, and meeting halls, as well as initiating water and sanitation projects, agricultural improvement, and income generation activities. CHWs in the Sucre area attended syndicate meetings at which they gave progress reports and helped make decisions concerning health issues. In turn, the syndicate leaders attended regional training and evaluation workshops for CHWs.

CHWs from different project areas worked to make the drug supply system sustainable through service fees and other cost recovery activities. Some CHWs were involved in the purchase and supply of ARI drugs. They received training in financial management, and the local bank has assigned a special Quechua-speaking employee to work with the volunteers.



■ **Sucre Subproject Highlights**

■ PLAN reported improvement in its intervention activities, not only in higher vaccination coverage and ORT use rates, but in the transfer of responsibilities to the community and the MOH. PLAN successfully transferred the responsibility of providing vaccination services to the MOH in an effort to ensure sustainability at the completion of the project. In July 1992, a midterm evaluation survey reported that coverage rates for children under one year were 84 percent for BCG, 54 percent for DPT3, 54 percent for Polio3, and 52 percent for measles. Almost 80 percent of mothers had received two doses of tetanus toxoid.

■ Nutrition interventions in the Sucre region have been greatly enhanced by the training of five women called "madres vigilantes" (watching mothers) in each community as growth monitoring and promotion (GM/P) volunteers. Babies are weighed bi-monthly and mothers receive encouragement and instruction in nutrition as well as vaccination, pre-natal care, safe birthing, diarrheal disease, and acute respiratory infection control. Now implemented in 21 communities, the GM/P program has attracted so much attention in the Rio Chico Health District that MOH officials requested PLAN health staff to expand the program to all communities in the district.

■ PLAN has developed an excellent ARI control program in the Sucre area by establishing 114 community ARI units staffed by 169 CHWs. These volunteers are trained to diagnose and treat respiratory infections with basic medicines such as aspirin for non-pneumonia cases and penicillin or cotrimoxazol for pneumonia cases. Although pneumonia cases are referred to health posts, the early treatment given by the CHW serves as a protection until the child can be transferred.

■ **Altiplano Subproject**

The Altiplano subproject area consists of four primarily rural provinces of the La Paz department targeting a population of 21,000 families, 61 percent of which have children under five years of age.

The project extended its vaccination coverage into 18 new communities in the Altiplano region since August 1990. Although PLAN was unable to reach the vaccination coverage objective set in the implementation plan for 1992, the midterm evaluation survey indicated that complete coverage for children aged 12 to 23 months has increased at least 21 percent since 1991. Coverage for BCG was found to be 72 percent, 62 for Polio3, 60 for DPT3, and 58 for measles. In addition, the evaluation survey found that 60 percent of women with children under two years of age had received two or more doses of tetanus toxoid, and 47 percent had received three or more doses.

With a strategy that reinforces the MOH's policy on diarrheal disease control, PLAN's objective focused on increasing mothers' knowledge of appropriate prevention and treatment techniques, as well as increasing their ability to take appropriate action based on that knowledge. While the ORT use rate was reported by the evaluation survey to be 69 percent, only 50 percent were using ORT correctly for their children's diarrhea. Likewise, while less than half of the targeted 76 percent of diarrhea cases were treated by the MOH or a CHW, this percentage represents a 44 percent increase in cases treated by these workers since 1991. In addition, nearly all mothers now continue to breastfeed and feed children during diarrheal episodes.

While PLAN has succeeded in improving both the CHW's and the MOH's capacity to address health problems in the project area, gaps in capacity still exist. The project also addressed the current lack of systematic supervision, support, and education of the CHWs.

■ **Altiplano Subproject Highlights**

■ About 190 CHWs attended a conference in 1992 to exchange information and experiences, and many CHWs decided to create a formal CHW organization as a way to solicit incentives, benefits, and training from the MOH and other organizations.

## V: USAID Project Assistance

■ As of June 1992, nutrition and growth monitoring activities were implemented in all of the 184 communities in the Altiplano area, 33 of which were added since 1990. PLAN supported growth monitoring and promotion in 67 percent of these communities, while the MOH and other non-governmental organizations supervised the remaining ones. The challenge has been to transfer GM/P supervision and logistic support to the MOH or other NGOs by project completion. Efforts to improve the nutritional status of children included the promotion of exclusive breastfeeding and community gardens. At the time of the midterm evaluation, 89 percent of children under two years were breastfeeding; all children who were not breastfeeding were over the age of 15 months. During 1992, a total of 19,480 pounds of vegetables and 7,820 pounds of legumes were grown in community gardens by target area families.

■ In the Altiplano region, PLAN has extended ARI diagnostic, treatment, and referral services into 91 percent of the 184 communities it serves. A substantial shift has occurred in the utilization for ARI treatment since 1991. The percentage of mothers visiting the CHW for treatment of ARI has increased from 1.7 percent to 18.1 percent, while the percentage visiting an MOH facility for ARI treatment decreased from 40 to 21.3 percent. This drop may be attributed to the distance required to reach a MOH facility and that the MOH is now charging for medications previously dispensed free of charge to children under five years of age. Mothers' practices in treating ARI vary from excellent in some areas, to adequate or deficient in others, suggesting mixed results from the community education program.

■ To reduce high-risk births and improve maternal health, PLAN staff provided training, supervision, and logistic support to TBAs. The staff also trained family members and CHWs to perform clean births and recognize signs of complications that require referral. The project trained 80 TBAs between July 1991 and June 1992. PLAN also provided clean birth kits to pregnant women and paid for high-risk deliveries in MOH facilities.

### Sources:

BOL9201, BOL9202, QUE9200

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**Project Number:** 938-0535.01 and 938-0SCF.01  
**Project Title:** Child Survival Grants to Save the Children Federation (SCF)  
**Country:** Bolivia  
**Project Area:** Department of La Paz, Inquisivi Province  
**Project Duration:** FY 1987 - 1/31/93, 1989 - 8/31/94  
**Implementing Organization(s):**  
    **Host country:** Ministry of Health (MOH), SOPACPF  
    **U.S.:** SCF, Mothercare

### Project Overview:

SCF supports child survival and maternal health services in two areas of the La Paz department, reaching approximately 27,000 people in isolated rural communities in Inquisivi province. The project was originally designed to run through January 1993 and serve about 11,000 people with several key interventions including the promotion of oral rehydration therapy (ORT), vaccinations, growth monitoring, vitamin A, breastfeeding, and the control of acute respiratory infection. In 1989 the project area was expanded to reach an additional 16,000 people in the province. With support from MotherCare and SOPACPF, a Bolivian non-governmental organization, additional activities to improve maternal and neonatal health are being implemented.

Through activities with MotherCare and SOPACPF, 50 women's groups work with SCF staff to carry out maternal and neonatal health diagnoses and to conduct a baseline epidemiological study. Since mothers have



principal roles in the community and in their families' health, this collaborative effort has created a strong basis for outreach into the community and has assured greater application of child survival interventions. In addition, this effort has improved SCF's ability to identify and follow-up high-risk pregnancy cases. Family planning activities include training in available methods and distribution of contraceptives to interested individuals.

Integrated Development Fairs are held in individual communities for two to three days once every two months. Field staff and community members work together on local problems and interventions, including vaccinations, control of diarrheal diseases, growth monitoring, prenatal care, and training. At the end of the fair, the health information is consolidated and shared with the community.

Although some activities (such as community rosters, a computerized health information system, and blanket vaccination coverage) may not be sustainable, the project has strongly emphasized training community members with the hope that knowledge, attitudes, and practices related to preventative health care will remain.

**Project Highlights:**

■ Outcomes thus far have been positive. The number of isolated projects has been reduced, management responsibilities have been delegated to the field level, and the follow-up on programs has improved. Community participation has increased and the project has received greater support from community leaders. In addition to training volunteer health workers, SCF now emphasizes training groups, such as women's groups, with the expectation that basic health knowledge will remain in the community after the project ends or individuals move from the area.

■ In FY 1992, SCF implemented a new "Save the Children Present" strategy to achieve closer contact with project communities and bring child survival activities into an integrated program of community development. Toward this end, SCF staff who are known as field health supervisors now remain in the communities for extended periods of time and are gradually expanding their activities to include education, sustainable agriculture, and economic development to be integrated with current child survival interventions. This new strategy also incorporates "quality circles" to improve management at the zonal and central levels and to work toward the goal of integrated development. This process brings together staff from all levels of the project to make programmatic, operational and administrative decisions, thus ensuring the participation of individuals in the field who have the most frequent contact with the communities.

**Sources:**

QUE9200

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**No Longer Funded**

**Project Number:** 938-0AND.01  
**Project Title:** Child Survival Grant to Andean Rural Health Care, Inc. (ARHC)  
**Country:** Bolivia  
**Project Area:** La Paz and Cochabamba Departments  
**Project Duration:** FY 1990 - 9/29/93  
**Implementing Organization(s):**  
Host country: Consejo de Salud Rural Andino  
U.S.: ARHC

**Project Overview:**

## V: USAID Project Assistance

ARHC delivered key child survival interventions through an integrated primary health care system reaching about 42,000 people in 109 communities in the La Paz and Cochabamba departments. Although the geography and cultures of the regions vary considerably, high levels of poverty and migration affect both areas.

The project began its work in the Carabuco Health Area on the Altiplano through a 1986 Child Survival grant. Under the current grant begun in 1990, the project area was expanded to reach the Mallco Rancho Health Area in Cochabamba; two other sites, Ancoraimes in the Altiplano and Sipe in Cochabamba, were incorporated in 1992.

Using a census-based primary health care approach, ARHC provided interventions in vaccination, nutrition improvement, and control of diarrheal diseases and acute respiratory infections. This approach was based on five major elements:

- A family census and service record for all community households, providing a sound demographic and epidemiological base;
- Volunteer community health educators training;
- Regular home visitations by auxiliary nurses and/or volunteer educators;
- An integrated system of community health posts and an area referral hospital; and
- Outreach activities supervised by rural health technicians -- experienced auxiliary nurses who have management and supervision training.

The home visitation component provided an opportunity for systematic education, treatment, referral, data gathering, and monitoring activities. It resulted in very favorable child survival indicators, including vaccination coverage rates that exceed national levels by 30 to 45 percent for all antigens. Although measles outbreaks occurred in other parts of the country, no measles cases were reported in the project area for the past several years.

ARHC plans included a systematic strengthening of family planning, prenatal care, and other factors affecting high-risk births. The organization worked to develop a family planning policy to promote basic education services to at-risk women, interested couples, and community leaders. Simultaneously, ARHC strove to achieve financial sustainability of family planning services. At the same time, the project continued to face issues of poverty and the communities' inability to contribute toward services, as well as limited governmental resources at the national level.

### Project Highlights:

- According to household surveys taken in July 1992, vaccination coverage for children 12 to 23 months ranged from 89 to 97 percent in the Carabuco Health Area where ARHC operated. In the nearby and comparable area of Ancoraimes, however, a baseline survey conducted in May 1992 indicated that only 1.5 percent of the children 12 to 23 months had received the complete schedule of vaccinations. With the incorporation of this area into the project, ARHC worked toward reducing this wide coverage gap.
- Improvement was reported in other intervention areas such as the frequency of growth monitoring and adequate weight gain, oral rehydration use in cases of diarrhea, breastfeeding practices, mothers seeking attention for ARIs, and knowledge of home remedies. Home visitations increased the mothers' level of trust placed in community health workers and other health staff; consequently, mothers are now more likely to seek appropriate treatment. For example, although less than 10 percent of ARI cases in the Carabuco and Mallco Rancho Health Areas were being treated by ARHC project staff in 1990, by 1992 about 53 percent of mothers with children with ARI reported seeking treatment.
- Education on diarrheal disease control was emphasized in much of the project area. When cholera struck in February 1992, education activities by community health workers were integral in controlling the spread of the disease.



■ Although funding for maternal health was not requested for this child survival grant, ARHC began responding to the large unmet needs for maternal health and family planning services. Maternal health was promoted during home visits and group education activities with women. Emphasis was placed on prenatal care, particularly given the low proportion of pregnant women receiving this service (7 to 39 percent across the four project service areas) and the varying percentage of births attended by health professionals (4 to 58 percent).

**Sources:**

QUE9200

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**No Longer Funded**

**Project Number:** 938-0ESP.01  
**Project Title:** Child Survival Grant to Esperanca Inc.  
**Country:** Bolivia  
**Project Area:** Gran Chaco Province, Tarija Department  
**Project Duration:** FY 1989 - 7/31/93  
**Implementing Organization(s):**  
  **Host country:** Unidad Sanitaria - Tarija  
  **U.S.:** Esperanca Inc.

**Project Overview:**

Esperanca worked closely with the local districts of the Ministry of Health (MOH) to promote primary health care interventions in the Gran Chaco province of the Tarija department. The project served a mixed urban/rural population of about 62,000.

**Project Highlights:**

- Several interventions resulted in positive outcomes. Based on a June 1992 survey of project areas, vaccination coverage rates for children under 12 months exceeded national levels, with 93 percent coverage for BCG, 76 percent for DPT3, 77 percent for Polio3, and 66 percent for measles. Tetanus toxoid coverage for women was 96 percent, compared to a 1989 national level of 20 percent.
- Nutrition-related activities implemented by mothers' clubs were so successful that mothers are now assuming greater program management responsibilities. The project's nutrition component was also enhanced by the cooperative efforts of a sister project which worked with mothers' clubs to implement/promote demonstration gardens. As with other project interventions, the prospects for sustainability of these efforts is high due to the continued involvement of local MOH personnel.
- In mobilizing communities in the project area to respond to the 1992 cholera outbreak, Esperanca helped to end the epidemic rapidly and bring about an increased appreciation of the benefits of oral rehydration therapy on the part of private physicians, health district officials, and the general population.
- The project worked toward the sustainability of its achievements by maintaining close collaboration with local MOH districts in the majority of activities. This relationship was mutually beneficial. The Bolivian MOH requested assistance from Esperanca in a number of management decisions and sought the organization's assistance in developing projects to strengthen the nation's health services network. With Esperanca's assistance, the MOH approved 12 mini-projects that will result in the construction of eight health posts, three communal centers for community health workers, and one health center in an economically depressed barrio.

■ Over the last three years of the project, Esperanca created and perfected a health package that includes an information system and a strategy for analyzing health programs in local MOH districts. To the credit of Esperanca's work, this health package is now being replicated nationally by the MOH.

**Sources:**

QUE9200

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**No Longer Funded**

**Project Number:** 938-FFHI.01

**Project Title:** Child Survival Grant to Food for the Hungry International (FHI)

**Country:** Bolivia

**Project Area:** La Paz Department - Pacajes Province Potosi Department - Alonso de Ibanez, Bustillos, and Tomas Frias Provinces

**Project Duration:** FY 1989 - 7/31/93

**Implementing Organization(s):**

Host country: Ministry of Health (MOH)

U.S.: FHI

**Project Overview:**

FHI delivered child health interventions through mothers' centers and volunteer health promoters to a widely scattered population in extremely isolated and impoverished areas of Bolivia's high plains. Project activities were located in the Pacajes province of the La Paz department and Alonso Ibanez, Bustillos, and Tomas Frias provinces of the Potosi department.

Although the project collaborated with the MOH to provide vaccinations and distribute packets of oral rehydration salts (ORS), iodized salt, and vitamin A capsules, FHI's main focus was community participation and education. Through the establishment of 137 mothers' centers and the training of 433 volunteer health promoters, the project achieved a high level of community involvement and promoted major health interventions. These achievements exceeded the project's three-year targets of 120 mothers' centers and 240 trained health promoters.

At the mothers' centers, innovative approaches to health education such as socio-dramas, puppet shows, games, and health fairs were used to convey health messages. Meetings at the centers provided opportunities for mothers to participate in healthful practices such as personal hygiene and preparation of healthy meals. PL-480 food distribution supplemented the diet of children and mothers and also served to motivate membership in the mothers' centers. In some centers, husbands asked to be involved. Consequently, training sessions were held in the evening so that the men could attend after returning from the fields.

A major activity at the centers was the implementation of a community-level health information system that enables mothers to collect, record, and interpret useful information on their children's health status. Large graphic charts on the walls of the centers were designed so that even illiterate mothers could use and understand them. Mothers actively participated in determining the nutritional status of children, progress in vaccination, and cases of diarrhea in children, how they were treated and the results. The charts were updated as appropriate and discussed during the regular weekly or bi-weekly meetings of the mothers' groups with their health promoter supervisor.

Committees within the mothers' groups were responsible for a variety of activities, including maintaining records of disease, child births and deaths, malnutrition, and home visits. Community participation greatly increased due to the sense of pride, purpose and ownership gained by belonging to a committee.



The collection of this pertinent health and demographic information through the mother's centers serves as a basis for a data collection/health information system created by FHI. The system simultaneously enables mothers to monitor community health status and progress while providing data for project management. The data are also passed on to the MOH at the national level. The computerized data tracking was expanded to include coverage of child mortality and probable cause, growth monitoring, vaccinations, vitamin A, iodized salt, diarrhea and ARI incidence and treatment, pregnancy, and births.

Throughout the life of the project, the issue of sustainability remained top priority. Finding methods to maintain the volunteer health promoters who live and work in individual communities will be crucial to sustaining key child survival activities.

**Project Highlights:**

- An improvement in the health status of the project population was in large part attributed to the implementation of messages learned through the mothers' centers and the high level of community participation achieved by the project.
- There was a steady decline in all types of malnutrition, with overall child malnutrition decreasing from 30 percent in December 1991 to 27 percent by March 1992 and then to 19 percent by June 1992. This improvement occurred despite the continued drought and crop failures.
- Vaccination coverage for children under six years old increased to 78 percent in 1992, exceeding a project goal of 70 percent. Seventy percent of children 12 to 23 months old were completely vaccinated. Tetanus toxoid coverage rose during the final year of the project, reaching 66 percent of registered mothers.
- Although mothers who participated in the mothers' centers know how and when to use ORS packets and how to prepare a home mix, the packets are only available through the centers and the cost of sugar prohibits preparing a home solution. Nonetheless, the incidence of diarrhea in children under six years of age was reduced from 14 to 4 percent during the month preceding an MOH survey. Cases of diarrhea treated with ORT rose from 35 to 93 percent, exceeding the third year target of 65 percent.
- A continuing drought created a significant increase in migration out of the project areas, making it difficult for the project to attain its original population targets. Since the total project population fell from 58,502 to 32,164, the geographic area was expanded to increase the number of targetted beneficiaries and three new health promoter supervisors were hired.

**Sources:**

QUE9200

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**Project Number:** 938-0PCI.07 (Child Survival) and 938-0PCI.08 (Vitamin A)  
**Project Title:** Child Survival and Vitamin A Grants to Project Concern International (PCI)  
**Country:** Bolivia  
**Project Area:** Cochabamba department - Ayoapya province Potosi department - barrios in the city of Potosi and rural areas in the provinces of Linares, Norchichas, Norlizep, and Baldivieso  
**Project Duration:** FY 1991 - 8/31/94  
**Implementing Organization(s):** FHI  
**Host country:** Ministry of Health (MOH)  
**U.S.:** FHI

## V: USAID Project Assistance

### **Project Overview:**

Working in the rural area of the Cochabamba department and both the rural and urban areas of the Potosi department, the project reaches a population of over 146,000 people, including almost 3,000 children less than one year old and over 21,000 women of childbearing age.

In both departments, PCI provided extensive training and educational sessions to over 2,000 individuals, including volunteer community health workers (CHWs), rural auxiliary nurses (RANs), traditional birth attendants (TBAs), health professionals, and the general population. The project has trained 189 CHWs in appropriate skills, thus achieving 104 percent of its training target. Training lessons are reinforced through radio messages broadcast in Potosi. These culturally sensitive messages, which are written for the general public to understand, have been met with wide approval.

Although PCI is not involved in the direct delivery of vaccinations, it provides training to health personnel at the district and local levels for vaccination planning and implementation activities.

To help improve low vaccination coverage rates in the urban areas of Potosi, PCI has employed a new strategy which utilizes youth group organizations in a house-to-house sweeping method to detect children with incomplete vaccination schedules.

Vitamin A related activities are incorporated in nutrition interventions and PCI collaborates with the MOH in its bi-annual capsule distribution scheme for one to five year old children. PCI is also collaborating with PROCOSI, a local private voluntary organization, in a study to examine the effectiveness of vitamin A as a protective agent.

In the rural areas in both the Cochabamba and Potosi departments, educational sessions and home visits conducted by CHWs and TBAs have permitted the project to increase the early detection of high-risk pregnancies. In the majority of cases, the CHWs and TBAs now accompany high-risk pregnant women to referral centers during their visit one to two weeks prior to the women's due dates. These efforts have significantly improved the channels of referral in the project areas.

The Potosi urban project area is facing the challenge of meeting the needs of urban poor. With both parents needing to work, older siblings are often left responsible for caring for infants. PCI is learning that these street children are both the beneficiaries of the project's efforts as well as actual health promoters among the street children.

### **Project Highlights:**

- In the rural area of Potosi, vaccination coverage has increased by 7 percent, while in the urban area coverage has increased by 10 percent over the baseline survey.
- In the urban areas of Potosi, vaccination coverage rates have doubled for children under one year old, and there has been a significant increase in total coverage for children under three years old.
- In August 1992, according to the MOH's health information system, one third of children 12 to 23 months of age were malnourished. In an effort to reduce malnutrition, PCI is engaged in a number of activities. Attendance at growth monitoring sessions is promoted and follow-up visits are made to homes of malnourished children by CHWs and supervision by RANs. Children suffering from second and third degree malnutrition (using weight-for-age as the identifying criteria) are referred to the health area or district hospital where they are treated and mothers receive further nutrition education. Agricultural production is also included in project activities to increase the nutritional level of rural communities by improving crop yield and crop diversification.
- PCI is achieving its objectives to control diarrheal disease through training CHWs and RANs to be trainers and providing community education. Serious outbreaks of cholera in both departments motivated PCI to re-evaluate its diarrheal activities to include education targeting adults as well as children. In response to



the epidemic, PCI began an aggressive radio campaign in Potosi which sent messages to a larger proportion of the target population than were reached by traditional educational activities. In both departments, the project established an immediate notification system for cholera cases. In addition, PCI is part of inter-institutional emergency teams which travel to rural cholera outbreak areas with supplies of oral rehydration solution (ORS), IV liquids, and antibiotics to treat cases and manage contacts. As a result of the epidemic, diarrhea is now a mandatory reportable illness, a change which has led to the development of a related surveillance and notification system.

- An impressive increase in basic sanitary and latrine building activities has also occurred following the government's declaration that potable water and basic sanitation are now main national health priorities. Since early 1992, a total of 180 self-financed community projects have been implemented in the isolated communities between Morochata, Independencia, and Cocapata in the Cochabamba department.

- Community participation has increased through the formation of health committees and the incorporation of CHWs into 84 local community governments in the Cochabamba department. PCI also signed a contract with the provincial farmers union of Ayopaya in order to receive the cooperation of the institution, which includes among its membership most of the area's population. In addition, PCI is encouraging each CHW to sign a health contract with their own communities; the goal for March 1993 is 90 contracts signed with community organizations.

- The project has not been as successful in achieving community participation in the rural areas of the Potosi department, due in part to factors of distance, uncertain transportation, and associated costs. In an effort to rectify this, PCI has established a strong working relationship with Bolivia's Departmental Health Committee and has been a catalyst in undertaking events in collaboration with the committee's health personnel. PCI works with the committee in forming local health committees.

- Unexpected benefits have come from research studies conducted as a result of PCI's inter-institutional coordination with various U.S. and Bolivian universities. This coordination has enabled PCI to implement investigation activities at very low costs but with a high degree of technical quality. Cooperation with other agencies such as PAAC in Cochabamba and Food for the Hungry in Potosi has strengthened PCI's nutrition and agricultural production projects.

**Sources:**

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**USAID/Washington Support (AID9300)**

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■ **Regional Projects**

**Accelerated Immunization** supported efforts to reduce malaria, neonatal tetanus and other vaccine-preventable diseases.

**Health and Nutrition Technical Service:** LAC Cholera provided technical and material assistance to help the MOH combat cholera. LAC Health and Nutrition Sustainability analyzed recurrent costs of MOH primary health care services, provided health management assistance to PROCOSI and PROSALUD, and contributed to a national assessment of breastfeeding practices.

■ **Bureau for Research and Development Projects**

**Mothercare (Breastfeeding and Maternal and Neonatal Health)** helped launch a reproductive health education campaign and continued research and service projects in Inquisivi, Cochabamba, and remote rural areas.

**PRITECH II (Technologies for Primary Health Care)** supported studies on chronic diarrhea and dysentery, and assisted the MOH's cholera control program.

**REACH II (Resources for Child Health)** assessed PVO and MOH needs for assistance in controlling acute respiratory infections.

**TAACS (Technical Advisor in AIDS and Child Survival)** assisted in AIDS prevention and control and Chagas' disease.

**Wellstart (Women and Infant Nutrition)** assists in the development and funding of a national lactation management education program.

■ **Short-term technical assistance and support**

**Data for Decision Making (CDC)** assisted the MOH with expanded epidemiological training.

**Diarrheal and Respiratory Research and Coordination (WHO)** supported an ethnographic study in the city of El Alto on acute respiratory infections.

**Health Financing and Sustainability** investigated alternatives for financing government health services.

**HealthTech (Technologies in Child Health)** collaborated with the Pan-American Health Organization to research vaccination methods.

**Nutrition Education and Social Marketing** cooperated with PROCOSI and Esperança in Villamontes to field test a training manual.

**Vector Biology and Control** evaluated the progress of Chagas' disease control.

**VITAL (Vitamin A for Health)** helped the MOH complete a report on a national vitamin A deficiency survey.

**WASH (Water and Sanitation for Health)** contributed to a national cholera preparedness assessment.



## VI: DATA NOTES

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### *Notes On Mortality Estimation*

Throughout this profile, references are made to infant and under 5 mortality rates for individual countries or groups of countries. In past years, the primary source of data on infant mortality was the World Population Prospects, a set of estimates updated every two years by the Estimates and Projections Section of the Population Division of the Department of International Economic and Social Affairs, United Nations. The primary source of data on under 5 mortality was a special report published in 1988 by the same group. Where another source, such as a recent Demographic and Health Survey or a national census, was available for a given country, the reported values from that source were cited in place of the United Nations estimates if the technical staff of USAID in the Country Mission and/or the appropriate regional bureaus confirmed the validity of the alternative source.

Known as indirect estimates, those of the United Nations are generated from accepted demographic models which combine the results of all available surveys and censuses in a given country to produce a single time series of estimates and projections. When new empirical data becomes available for a given country, the entire time series of estimates and projections is updated. Thus, using conventional demographic approaches, a survey done in 1990 may generate a new estimate of a mortality rate for 1970 or 1980.

During 1993, a new set of estimates for mortality was generated for 82 countries for publication in the World

Development Report 1993 and a forthcoming UNICEF publication entitled The Progress of Nations. Based on a curve-fitting model, the methodology applied to generate these new estimates purports to depict more accurately the trend derived from all available data sources for a country. Like the estimates generated using conventional demographic models, the entire time series might change upon the addition of a new empirical source. These estimates were made available to USAID through the courtesy of the World Development Report of the World Bank and UNICEF.

The selection of the mortality rates was done through a consultative process involving representatives of the Office of Health in USAID's Research and Development Bureau, USAID's Regional Bureaus and, in many cases, the USAID Country Missions. The source determined to best reflect the reality in a country for the current values of infant and under 5 mortality was identified and one of a number of a computation procedures, depending on the source selected for the current value, was applied to estimate the longitudinal rates. The consideration of the additional source of data developed for the World Development Report and UNICEF during the consultative process has prompted some changes in the reporting of mortality rates from those reported in recent years.

### *Definitions*

#### *Demographic Indicators*

**Total Population:** The mid-year estimate of the total number of individuals in a country.

**Average Annual Rate of Growth:** An estimate of the rate at which a population is increasing (or decreasing) in a given year.

**Infant Mortality Rate:** The estimated number of deaths in infants (children under age one) in a given year per 1,000 live births in that same year. This rate may be calculated by direct methods (counting births and deaths) or by indirect methods (applying well-established demographic models).

**Under 5 Mortality Rate:** The estimated number of children born in a given year who will die before reaching age five per thousand live births in that same year. This rate may also be calculated by direct or indirect methods.

**Maternal Mortality Ratio:** The estimated number of maternal deaths per 100,000 live births where a maternal death is one which occurs when a woman is pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management. Although sometimes referred to as a rate, this measure is actually a ratio because the unit of measurement of the numerator (maternal deaths) is different than that of the denominator (live births). The measure would be a rate if the units were the same. Extremely difficult to measure, maternal mortality can be derived from vital registration systems (usually underestimated), community studies and surveys (requires very large sample sizes) or hospital registration (usually overestimated).

**Crude Birth Rate:** An estimate of the number of live births per 1,000 population in a given year.

**Crude Death Rate:** An estimate of the number of deaths per 1,000

## VI: Data Notes

population in a given year.

**Life Expectancy At Birth:** An estimate of the average number of years a newborn can expect to live. Life expectancy is computed from age-specific death rates for a given year. It should be noted that low life expectancies in developing countries are, in large part, due to high infant mortality.

**Children Under Age 1:** Mid-year estimate of the total number of children under age one.

**Annual Infant Deaths:** An estimate of the number of deaths occurring to children under age one in a given year.

**Total Fertility Rate:** An estimate of the average number of children a woman would bear during her lifetime given current age-specific fertility rates.

### *Child Survival Indicators*

**Vaccination Coverage In Children:** An estimate of the proportion of living children between the ages of 12 and 23 months who have been vaccinated before their first birthday--three times in the cases of polio and DPT and once for both measles and BCG. Vaccination coverage rates are calculated in two ways. Administrative estimates are based on reports of the number of inoculations of an antigen given during a year to children who have not yet reached their first birthday divided by an estimate of the pool of children under one year of age eligible for vaccination. Survey estimates are based on samples of children between the ages of 12 and 23 months.

**Vaccination Coverage In Mothers:** An estimate of the proportion of women in a given time period who have received two doses of tetanus toxoid during their pregnancies. This indicator is being changed in many countries to account for the cumulative effect of tetanus toxoid boosters. A

woman and her baby are protected against tetanus when a mother has had only one or, perhaps, no boosters during a given pregnancy so long as the woman had received the appropriate number of boosters in the years preceding the pregnancy in question. (The appropriate number of boosters required during any given pregnancy varies with number received previously and the time elapsed.) The revised indicator is referred to as TT2+. Rates are computed using administrative methods or surveys.

**DPT Drop-out Rate:** An estimate of the proportion of living children between the ages of 12 and 23 months who received at least one DPT vaccination but who did not receive the entire series of three vaccinations before their first birthdays.

**Oral Rehydration Salts (ORS) Access Rate:** An estimate of the proportion of the population under age five with reasonable access to a trained provider of oral rehydration salts who receives adequate supplies. This is a particularly difficult indicator to measure and, therefore, it may fluctuate dramatically from year to year as improved methods of estimation are devised.

**ORS and/or Recommended Home Fluid (RHF) Use Rate:** An estimate of the proportion of all cases of diarrhea in children under age five treated with ORS and/or a recommended home fluid. ORT use may be determined using administrative means or surveys. In general, administrative estimates are based on estimates of the number of episodes of diarrhea in the target population for a given year and the quantity of ORS available. Thus, changes in the estimates of the frequency of diarrhea episodes can alter the ORT use rate as well as "real" changes in the pattern of use. Surveys are more precise in that they focus on the actual behavior of mothers in

treating diarrhea in the two-week period prior to the survey.

**Contraceptive Prevalence Rate:** An estimate of the proportion of women, aged 15 through 44 (or, in some countries, 15 through 49), in union or married, currently using a modern method of contraception. Where sources fail to distinguish modern and traditional methods, the combined rate is shown.

**Adequate Nutritional Status:** An individual child of a certain age is said to be adequately nourished if his/her weight is greater than the weight corresponding to "two Z-scores" (two standard deviations) below the median weight achieved by children of that age. The median weight and the distribution of weights around that median in a healthy population are taken from a standard established by the National Center for Health Statistics, endorsed by the World Health Organization (WHO). The indicator for the population as a whole is the proportion of children 12 through 23 months of age who are adequately nourished.

**Appropriate Infant Feeding:** A composite estimate of the proportion of infants (children under age one) being breastfed and receiving other foods at an appropriate age according to the following criteria: breastfed through infancy with no bottle-feeding, exclusively breastfed through four months (120 days) of age, and receiving other foods if over six months of age (181 days). Water is not acceptable in the first four months (120 days). ORS is considered acceptable at any age. Surveys are the only source of data to form this indicator. Surveys yield an estimate of how many infants are being fed correctly at the moment of the survey. They do not give an indication of the proportion of individual children fed appropriately throughout their first year of life. A number of sub-indicators may be calculated from the data used to form the composite, of



which two are presented in this report.

**Exclusive Breastfeeding:** An estimate of the proportion of infants less than four months (120 days) of age who receive no foods or liquids other than breast milk.

**Complementary Feeding:** An estimate of the proportion of infants six to nine months of age (181 days to 299 days) still breastfeeding but also receiving complementary weaning foods.

**Continued Breastfeeding:** An estimate of the proportion of children breastfed for at least one year. In this report, all values presented for this indicator are the proportion of children 12 to 15 months of age at the time of the survey still receiving breast milk.

#### *Other Health Indicators*

**HIV-1 Seroprevalence, Urban:** An estimate of the proportion of all persons (pregnant women, blood donors, and other persons with no known risk factors) living in urban areas infected with HIV-1, the most virulent and globally prevalent strain of the human immunodeficiency virus.

**HIV-1 Seroprevalence, Rural:** An estimate of the proportion of all persons living in rural areas infected with HIV-1.

**Access to Improved Water, Urban:** An estimate of the proportion of all persons living in urban areas (defined roughly as population centers of 2,000 or more persons) who live within 200 meters of a stand pipe or fountain source of water.

**Access to Improved Water, Rural:** An estimate of the proportion of all persons not living in urban areas with a source of water close enough to home that family members do not spend a disproportionate amount of time fetching water.

**Access to Sanitation, Urban:** An estimate of the proportion of all

persons living in urban areas with sanitation service provided through sewer systems or individual in-house or in-compound excreta disposal facilities (latrines).

**Access to Sanitation, Rural:** An estimate of the proportion of all persons not living in urban areas with sanitation coverage provided through individual in-house or in-compound excreta disposal facilities (latrines).

**Deliveries By Trained Attendants:** An estimate of the proportion of deliveries attended by at least one physician, nurse, midwife, or trained traditional birth attendant.

#### *Notes on Project Information*

The primary source for information related to USAID projects is the USAID Health Projects Database (HPD) operated by the Center for International Health Information/ISTI.

The HPD tracks bilateral, regional and centrally-funded USAID projects and sub-projects with a health component, including child survival, HIV/AIDS, nutrition, water supply and sanitation, and other health related activities. Projects are identified for the HPD through the annual USAID Health and Child Survival Project Questionnaire, Annual Budget Submissions (ABS), Congressional Presentations (CP), and the Activity Code/Special Interest (AC/SI) System. Information on project activities, organizations implementing these activities, and project assistance completion dates is also taken from other official USAID documents such as project reports.

In the **Timeline: USAID Activities Related to Health and Population** table, Life-of-Project (LOP) funding indicates the total authorized funding planned for all project activities from the beginning until the conclusion of

the project. Projects may contain components which are not directly related to health, and therefore, LOP totals reported here may not be used to describe funding for health activities specifically. Please refer to the Fiscal Year Obligations for USAID-funded Projects Related to Health table to determine funding attributed to health activities. Where project assistance completion dates are not available, the timeline reports the planned final year of funding for the project and notes this with \*\*. Project activities may extend beyond this reported final year of funding.

The **Fiscal Year Obligations for USAID-funded Projects Related to Health** table does not include total project obligations; it includes only totals for health, child survival and HIV/AIDS activities. These funding totals are based on calculations of annual obligations reported in the USAID Congressional Presentation and on reported attributions for health activities. These attributions are reported through the annual USAID Health and Child Survival Project Questionnaires for Fiscal Year (FY) 1985-91, and the AC/SI System for FY 1992, with the exception of the Child Survival and Vitamin A grants as reported from FDC/PVC for all years. Reported obligations include all accounts except population account funds for FY 1985-91. Public Law 480 funding is not included in this report.

## VII: SOURCES

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- AID0000 Data for the timelines is a consolidation of data from: a) annual USAID Health and Child Survival Project Questionnaires, b) USAID Congressional Presentations (CPs), and c) the USAID Office of Private Voluntary Cooperation/Bureau for Food and Humanitarian Assistance.
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- AID9103 Government of Bolivia (as per Mothercare)
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- AID9202 MOH, Unidad de Investigacion y Analisis, Direccion General de Estadistica. Cited in USAID/Peru Mission Facsimile, 2/24/92.
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- AID9300 United States Agency for International Development. Child Survival: An Eighth Report to Congress on the USAID Program. December, 1993.
- AID9308 The USAID Activity Code/Special Interest (AC/SI) System, July 27, 1993.
- BOL9201 PLAN International. Mid-term evaluation of the Child Survival VI Project/Altiplano. October 1992.
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- BUC9105 Series of diskettes provided by Kevin Kinsella over a period of several months near the end of 1991 and the beginning of 1992. Data reported from the U.S. Bureau of the Census data base.
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- CAB9109 USAID/Washington #339873. October 1991.
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- LAC8900 Gwynne, Gretchen, and Dieter Zschock. Health Care Financing in Latin America and the Caribbean, 1985-89: Findings and Recommendations. HCFLAC Report No. 10, September, 1989.
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- UNP9200 Department of International Economic and Social Affairs, United Nations. World Population Prospects 1992. (ST/ESA/SER.A/120) New York: UN, 1992.
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