

PROJECT PAPER

Project Title: Mobile Health Program - Chiquitos Vicariate
Project Location: Chiquitos Vicariate, Department of Santa Cruz
PVO Name and Location: Catholic Relief Services (CRS) La Paz
Central Headquarters: New York
Contact Persons: Robert F. Parker, Director, CRS
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Date of Submission to USAID: May 30, 1975
Total OPG Request: \$105,000

I. Project Purpose and Description

This project seeks to:

- A. Establish a link between the health services of the Santa Isabel Hospital in Chiquitos and 100,000 people living in 85 rural communities in remote areas of the Chiquitos Vicariate.
- B. Establish community participation in improvement of their own health situation.
- C. Obtain increasing GOB support for the institutionalization of a system of rural health services in the Chiquitos Vicariate.

The fulcrum of this project is the Santa Isabel Hospital which is located in San Ignacio de Velasco, Department of Santa Cruz. This hospital is the only institution of its kind in the vast Vicariate area which covers approximately 195,000 square kilometers. This project will extend the hospital's reach through the provision of two mobile health-educational teams, which, together with ten rural health officers strategically located at distinct points throughout the project area and rural collaborators in each community, will form a network that will provide regular medical attention and education in health to the population throughout the project target area.

The project calls for formal and on-the-job training of the health officers and the rural health collaborators. It will provide basic medical and educational equipment to these personnel and complete equipment to the two mobile units including specifically selected audio-visual teaching aids as well as sufficient medical items to make them independent during their extended trips to the field.

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The health network thus formed, trained and equipped will provide health services in areas where heretofore they were practically non-existent, will educate and encourage the populace to participate actively in improving their own health; and, will compile health data for the area that will help the GOB orient its health activities in the target area over the long term.

The multi-faceted aspect of this attack on the health problems in the Chiquitos Vicariate helps to insure realization of the short and long-term objectives of this project. The conditions expected at the end of three years of project life, when most outside financing terminates, are described in the logical framework.

II. Project Background

The operational area of this project includes the provinces of Velasco and Sandoval in their entirety and part of the province of Chiquitos. These three provinces lie in the eastern-most part of the Department of Santa Cruz, and all three border on Brazil. They are part of the lowland plains region of Bolivia and have a tropical climate. They experience heavy rains from November to April, but are relatively dry during the rest of the year. The area is very isolated having only third class roads which required the kind of four-wheel drive vehicles to be utilized in this project.

For many years Chiquitos Vicariate personnel under the direction of their bishop have been working with the local populace in activities of a social and/or economic nature which have benefitted or will benefit the poorer residents of the area. A brief account of some of these activities will serve to illustrate. The Vicariate has a well-based and developing agricultural improvement program which includes a training farm coordinated with the Ministry of Agriculture and production and marketing cooperatives for small farmers. There is home economics training for young campesino women and the initial activity for the establishment of a housing cooperative is underway. A system of radio-phonetic education was started some time ago and the Vicariate publishes a monthly newspaper which has a circulation of about 5,000 copies. The Vicariate operates an Adult Training Institute in San Ignacio for the formation and instruction of poor campesinos from all over the area and has set up a variety of cultural and recreational facilities.

The health of the populace has been one of the Vicariate's primary concerns. In 1959 ground was broken to initiate the construction of the general hospital, "Santa Isabel", which was finished in March, 1966. This hospital, which was financed almost completely by donations from outside the country, actually began operations in 1963. Since the annual national budget for health services in Bolivia does not permit any but the most meager support for even the major hospitals in large population centers and very little for rural areas such as Chiquitos, the Santa Isabel Hospital has filled a great void and is a vital link in the health services of the country.

The hospital is beset with a tremendous task due to the variety and frequency of illnesses and health problems in the area. The principal communicable diseases are: cholera, diphtheria and whooping cough. Other frequent ailments are: upper respiratory infections and pneumonia, gastro-intestinal disorders, intestinal parasites, tetanus, and bacterial and parasitic infections. The most frequent cause of death is advanced infection, which could be prevented if the inhabitants had better access to medical treatment. In many of the smaller communities traditional medicinal practices including the use of leaves, flowers and roots are still employed.

The hospital staff has not been discouraged by the enormity of the challenge they confront, but rather have endeavored to make the hospital fulfill its big role and have sought to extend its attention through incipient mobile health services. During 1973 the hospital experienced the following activity:

Patients attended	3,859
Patients that underwent surgery	893
Number of available beds	60
Percentage of bds normally occupied	92%
Average hospitalization of in-patients (high due to inclusion of TB patients)	40 days

The GOB has been increasing gradually its support to the Santa Isabel hospital. A yearly hospital maintenance allowance of US\$300 per month was initiated on January 1, 1973 and increased to US\$600 per month on January 1, 1974. The remaining financial support required for the hospital is obtained from patients' fees and foreign donations. However, the hospital cannot reach its full potential and cover the basic health needs of the Chiquitos Vicariate until it has its proper complement of related extension

services such as mobile units, country health posts, medical and public health auxiliaries, community-level collaborators, etc. This project's plan, then, is to institute these services principally through the provision of mobile health educational teams with their supporting elements.

The GOB continues to respond to the Vicariate's initiatives and recently has provided several financial inputs (see financial section) to make this plan possible. Furthermore, the Government has agreed that if the Vicariate can make this health program a reality during a three year period, it will assume all personnel, vehicle and equipment expenses to assure continuation of these highly desirable and necessary activities.

III. Project Analysis

A. This project involves a low-cost health delivery system which will bring health services to rural people and incorporates a health education program to enable the populace in the target area to understand and participate in plans and procedures that will help improve their health levels. Therein lie its economic benefits. Getting health assistance out to the remote rural areas will mean that many illnesses and other health problems would be discovered and treated in their early stages when their treatment and cure involve minimum costs. Under present circumstances many such health cases can advance to the point where hospitalization and long periods of recuperation are necessary. This means greater costs for the individual, for the Santa Isabel Hospital, and for the GOB. It also means more loss of productive work time.

Given the limited capacity of the Santa Isabel hospital, this also implies that cases that could have been treated on an out-patient basis are occupying hospital beds that may urgently be needed by cases that can be treated only in the hospital.

The health education systems incorporated in this project, including the use of audio-visual instruction materials in each community by the mobile health teams, the health officers, and the rural collaborators plus the use of the Vicariate's newspaper and radio-phonics school for health education, would represent a low-cost means of reaching and having a strong impact on the area's population.

Based on an estimated 100,000 direct project beneficiaries, this project would cost only about US\$4 per person for the initial three year period of operation. A more exact calculation would be the cost per community to be served by this health network (approx. 85 communities) which is about US\$4,650 for the three year period or about US\$1,550 per community per year.

B. The technology to be used in this program for the delivery of rural health services and health education is well adapted to the requirements and limitations of the current situation in the Chiquitos Vicariate.

The mobile health network incorporates an advantageous combination of medical and pramedical personnel. Many of these personnel are local community members and therefore have a grass-roots understanding of the health problems in their area and a special advantage in their role as change agents. The reinforcement of one element in the health network by another and the reinforcement of the whole network by other Chiquitos Vicariate personnel and the GOB provides the means to facilitate project implementation.

The equipment required by the project was selected specifically to meet the needs of this geographical area and will enable effective operations even within the severe limitations imposed by the underdeveloped communication systems in the area. The educational materials and methods to be employed appropriately meet the non-formal health education needs of the populace. The audio-visual materials (See Annex III) will help all the project personnel from the medical doctor down to the rural health collaborator provide effective health education adapted to the needs and education levels of the population in the target areas. The training provided in the project for the rural health personnel will improve their ability to implement their assigned tasks and fulfill their project roles. In addition, a registered nurse who is the Ministry of Public Health's designated health director for the zone will participate with the project's professional medical and other project personnel in project implementation and overall coordination.

C. The beneficiaries of this project are the marginal population living in the 195,000 square kilometers in the project area. These are estimated at 100,000 people. Fortunately, due to other socio-economic activities promoted by Vicariate personnel many of them have begun the process of lifting themselves out of this marginality. This project will further support the importance of the people's participation in the process of development. The communities will become involved in sanitation and hygiene campaigns and traditional tabus and superstitions about health and nutrition will be refuted. The role of women in the family and in village society will be particularly enhanced by this project through the

maternal-child health and nutrition programs. These programs will be largely aimed at mothers who will play a predominant part in their realization. Their major involvement in these programs plus their inclusion in the other village-wide health activities will be an important step forward for greater women's participation in rural Chiquitos society.

No one's interests will be harmed by the project therefore there should be no critical opposition.

D. Target Population Profile

This project meets the conditions specified in the 1973 Foreign Assistance Act. The beneficiaries are definitely among the poorest majority and have very little access to public services. This health program ties in excellently with other development programs in the Vicariate as described in section II. It will reach large numbers of people in a large remote geographical area and will help them to experience better diets, health, and child care. It has an important focus on women and encourage creation of local motivations and meaningful local participation. The project promotes a low-cost health delivery system which has good potential for wide scale application and it incorporates promising ideas and methods that can be adopted by the GOB for use in other areas.

More specifically, the vast majority of the population in the target area are subsistence farmers who are poor, not only economically but in their condition of health. As a general rule, the population in the project area has only limited access to health facilities and relies on traditional community health practitioners or home remedies for many of the services they receive. The typical rural family consists of five to nine members often including grandparents and other relatives. The housewife, if in the childbearing years, is either pregnant, has just given birth, or has recently suffered an abortion. Probably as many children have died as are still living with the family. Children usually go barefooted and members of the family seldom bathe.

The family generally lives in a one or two room adobe house with unplastered walls, thatched roof, and dirt floor and screens are a rarity. The house offers little privacy and often is shared with the domestic animals. The family food intake is normally unvarying and un nourishing, consisting mostly of staples, and the majority of the family is infected with respiratory and parasitic diseases.

For statistical indicators specific to the project area, see Annex VI.

E. Even at its outset, the project will have a strong foundation in the Santa Isabel Hospital and its staff, in the Chiquitos Vicariate development personnel (salaried and voluntary), and in the Ministry of Public Health's technicians who will assist this project. Institutionalization of the proposed activity is further enhanced by the training of more local staff during the project. There are substantial other-than-AID financial inputs from the very initiation of the program and the GOB has agreed to make the financial inputs which will be needed when foreign financial assistance has terminated. This is not considered an improbable occurrence since the GOB is already providing some inputs. Thus their assumption of other costs would be simply an escalation of their present participation based on the successful progress of activities during the first three years of the project. In this sense the project is a stimulus to the GOB to adopt promising systems to meet the health needs of the area. Also, due to other development activities that are being carried out or will be carried out in the near future by the Vicariate, it is expected that the economic condition of the poor farmers will be improved during the next several years and they will be able to contribute more for the health services they receive..

IV. Project Design and Implementation

A. The Mobile Teams

The two mobile teams will have a medical doctor, a nurse and a driver. Mobile team N°1 will also have a medical assistant who has the equivalent of one year of nurse's training plus practical experience. This individual will be rotated to the other mobile team and/or to temporary duty in the ten rural health posts depending on observed needs during the realization of this health program.

Each team will have a specially equipped medical truck as its principal means of movement. These trucks will be of the heavy-duty type to endure the extremely rough roads in the Chiquitos area. Among their special equipment will be small refrigerators to store perishable drugs. The team's emergency means of transportation will be light-weight motorcycles. These cycles will be useful in areas that are inaccessible to the trucks either due to lack of roads or due to the impassable condition of some roads after the heavy rains which occur in

this tropical region. Since these motorcycles will be lightweight, they will be able to move with the trucks on specially designed racks which will be fitted onto the rear of each truck.

The mobile health units will divide up the project area, each one assuming responsibility for approximately half the geographical area. Their routes will be so designed as to minimize travel time between any two work stops. Each team will stay in its originally established half of the project area so that it may become more knowledgeable of the area, its particular health problems, and its people. To some extent, each team must come to know its patients and contacts and these must come to know and trust the team.

The teams will spend about two and half weeks out of four in the field. The remaining time they will spend in San Ignacio and its immediate environs reviewing their activities, compiling health statistics and information gathered during their field work, discussing the development of the program with the project coordinators and medical directors at the hospital, and working in peripheral communities that can be reached in two hours or less.

The time at project base, that is San Ignacio, will also allow the teams some rest and recuperation from their difficult travels and will enable them to stock up on needed supplies and perform maintenance on their vehicles and equipment. Very importantly they will be able to check on patients that they sent to the hospital based on field consultations. During this time they will also meet with the doctors, nurse, social workers and nutritionist from the Ministry of Public Health when the latter make their periodic visits to San Ignacio from their headquarters in the departmental capital, Santa Cruz; on some occasions these people will travel into the rural areas with the mobile teams.

The mobile team working the northern half of the project area will take advantage of fluvial routes to reach some of its beneficiaries. Using the motor launch to be purchased for this project the team will move along sections of the Paraguay River and the Itenez River that are inaccessible to land vehicles. They will cruise a 135 mile stretch attending about six villages and 40 little settlements with a total population of approximately 3,000 people.

The Chiquitos Vicariate presently is operating a government-approved radio station named John XXIII in San Ignacio. This mass communication media will be used as an integral part of the project to provide radio-phonetic health education to the people who will be served by the mobile health teams network. Since most families have radios, it will also be an excellent means of informing the populace as to the day-to-day location of the mobile health units. Thereby persons requiring treatment will know when medical attention will be available in their community or where they might go in case of emergency.

The radio (transmissions will be based in San Ignacio) will devote one hour a day Monday through Friday to health education, animation and orientation and will make spot announcements concerning the health program whenever necessary. The Vicariate's monthly newspaper, "Soypiaka", will cooperate with the health program in conjunction with the radio station by including information on health, hygiene and sanitation on a regular basis. The "Soypiaka" currently has a monthly circulation of 5,000 copies which are distributed throughout Chiquitos by the Vicariate's radio-phonetic school personnel.

B. The Mobile Teams and the Ten Rural Health Officers

Incorporated in the project field work planning is an intrinsic and very close coordination between the mobile team and the Rural Health Posts each of which is staffed by a salaried GOB Rural Health Officer. The team must develop an excellent working relationship with the health officers each of whom has had at least one month of training at the Santa Isabel hospital and some have attended courses given by the Ministry of Public Health. Besides the additional training courses they will attend during the first and second year of this project, they will have continual on-the-job training through their work with the mobile teams.

At the end of the first year of project activity the most outstanding health officer in each mobile unit area will be selected as chief health officer in his half of the project area. In addition to work in his own particular zone, he will regularly visit the other health officers to encourage and assist them in project implementation. He will be provided a motorcycle to allow him the mobility necessary to make his rounds. The cycle will also enable him to contact the mobile team rapidly when this is necessary. Whenever possible, the health officer will move with the mobile team as it visits the villages in his particular zone.

Each mobile team has several health posts in its area. In the initial stage of this health program, work effort will be concentrated in the immediate area of the health posts which will be nuclei for the expansion of the health program to the other villages. This initial concentration of effort does not imply neglect of the immediate medical needs of sick or injured people in the other villages. Rather, those urgently requiring medical attention in any part of the project area will have access to the mobile teams and the health officers since these will move to all the communities in their area of jurisdiction from the inception of the project. However, the activities described below, which will give this program viability, long-term effectiveness and real significance, cannot be carried out in every community at once. Therefore, initially more time will be spent in the nuclei to develop these activities and train the rural health officer in systems for their execution.

The activities include a hygiene sanitation program, a maternal-child health program, a nutrition program, and a tuberculosis control program. All of these activities have at least two phases or aspects of major importance - education and implementation-. Local community participation in the realization of these programs will be promoted and local leaders will be enlisted to stimulate this participation.

C. The Hygiene-Sanitation Program

This program is perhaps the most basic of this general health project, for the rest of the programs cannot attain their potential effectiveness until the detrimental unhygienic and unsanitary conditions existent in the communities are confronted and improved. Even the basic activity of diagnosis and treatment of a patient's illness by the mobile unit doctor often will not be effective in the long run if the patient returns to an unsanitary environment.

The first step the team will take in each village to initiate this program involves education and animation. They will speak to the village authorities and general populace about the parasite problem explaining how parasites cause poor digestion, loss of food energy, anemia and other illnesses. They will expound on how they are transmitted and how their transmission can be prevented, giving emphasis to the importance of clean drinking water, proper food preparation, and the unexceptionable use of good latrines. The fact that improved health among the villagers depends on better sanitation throughout the village will be emphasized. The

The people will be taught how to construct a latrine and the local authorities will be convinced that it is up to them to manage a system that will insure that everyone uses the latrines. The block-making machines and the revolving latrine credit fund called for in this project will be instrumental in the realization of this activity.

Emphasis will be given to the need for potable drinking water. If there is any doubt about the purity of the water available, it must be boiled. A persuasive method of making the people really believe in the possible health hazards in their water supply will be employed. This method entails the use of a microscope that the mobile team will carry with them. A clean drop of water will be placed under the microscope along-side a drop of water requested from the villagers. Then the villagers will witness the movement of parasitic organisms in their water and the lack of this movement in the clean water. It is felt that actually seeing the "little animals" that they ingest in their drinking water will have a strong impact on the villagers and they will be induced to boil their water or assure its purity at source.

The second step toward hygiene and sanitation will take place about six weeks later when the team or a representative of the team such as the health officer returns to the subject village. The existence and use of latrines will be checked and all those families that are using latrines and have cleaned up their environment will be told that in a month the team will return with medicines so that they can get rid of their parasites. Those who have not responded to the instructions for latrine construction and general sanitation of their town will be told that they must take action before the next visit of the team if they want to receive medicines.

During the third stage anti-parasite medicines will be distributed to all those whose examinations for parasites are positive. This examination-medication process will continue two more times and at the end of this series any remaining parasite cases will be analyzed thoroughly to determine their persistent cause. During this stage certain important vaccinations will also be administered.

The fourth and final part of this program occurs whenever the team returns to this village, and consists of inspection of latrines, administration of anti-parasite medicine, and more mini-courses of hygiene.

Other aspects of this program will include insistence on use of foot-wear and the distribution of vitamins to the most anemic after parasite treatment.

D. The Maternal Child Health (MCH) and the Nutrition Programs

Because of the direct relationship between these two programs and because they will be developed jointly with basically the same inputs, they will be treated here as combined programs. Since the project personnel will be starting from scratch to implement MCH and nutrition activities, efforts in the first year will necessarily be limited to a small percentage of the project area and will not include all desirable program aspects which hopefully can be incorporated later.

When the mobile team comes into a town that previously has been selected for the initial MCH-Nutrition program they will separate consultations with pregnant women and women with children six years old and younger from the general consultations. This group of women will be introduced to the health program designed for them and will be encouraged to become active regular participants in it since its success will depend largely on them.

In group discussions the mothers will be taught nutrition, hygiene, and child care, and will be given pre-natal guidance. They will be introduced to a weight control system that will monitor their children's health and growth. During individual consultations each mother will be inscribed in the program and will be given a card which will have her personal and health data and will have space for comments on her progress if she is pregnant. For each child six years and under she will also receive a card on which will be recorded the child's bio-data and his weight on a monthly basis. A weight-curve or a weight-color system will be employed to teach the mothers what their children should weigh in their childhood years. The children will be given required vaccines and medications and this too will be recorded on their cards. Any critically sick children will be sent to the Santa Isabel Hospital.

PL 480, Title II inputs (about 300,000 lbs.) will be an integral part of the project's nutrition efforts under this activity. These inputs are expected to play an important role in upgrading the health status, especially of mothers and pre-school children in the target area who will be regular participants in the program.

E. The Tuberculosis Control Program

This program will try to control a serious disease which has a current mortality rate in Bolivia of 120 per 100,000 inhabitants. During the regular consultation visits in each village TB cases will be discovered and registered. Those that are serious enough to warrant it will be sent to the hospital for treatment, but most will be treated as outpatients since this can be just as effective as hospital treatment and is less costly. Of course, strict control of the progress of the patient is necessary and this will be pursued by the health officers and the rural collaborators (described below) as well as the mobile team. All family contacts of the TB patient will also be controlled and BCG vaccine will be administered to all those who should and can receive it.

F. The Rural Collaborators - The People's Own Animators

The two mobile teams plus ten health officers are not enough to enable this project to achieve all its desired effects. A representative who can devote part time to project activity is needed at the village level. This volunteer representative will be called the rural collaborator. The project will recruit at least 85 collaborators since there will be at least one in each of the 85 villages to be contacted in the program. The collaborator will be one of the village people and will become an animator and change agent among them. Each collaborator will be picked by the mobile team with the advice and consent of the Chiquitos Vicariate personnel who are familiar with the leaders in many of the towns through contact with them in other projects and activities. Besides possessing various leadership qualities they will have to have a sincere desire to help their village. They will generally be between 25 and 35 years of age, will be married, respected members of their community, and will be able to read and write.

The mobile team and the zonal health officer will spend some time talking and working with each potential collaborator to assure that he has the traits and abilities mentioned above. Once all the collaborators have been selected they will be given a one month training course in the Adult Training Institute located at the project base. This course will give them basic practical knowledge on their duties as health collaborators and how they will coordinate with their local health officer and the regional mobile team. It will teach them basic health, hygiene and sanitation concepts and will provide them with a foundation

on which they can continue their learning experience on the job and through regular instruction from their health officer and the mobile team personnel.

The rural collaborator's principal work responsibilities can be divided into three main categories: contact, control, and statistics compilation. He is the projects' permanent direct contact at the grass-roots or village level because he is one of the villagers. His participation in the project assures greater participation by the rest of the community since he will prime the people for the scheduled arrivals of the mobile team thus assuring the team a good turn-out for its general consultations; maternal-child consultations, TB case treatment, and mini-courses on health, hygiene and sanitation. He will work with the team whenever it visits his community thereby instilling more confidence in these "outsiders" because they have the support of a known, respected local person. On the other hand, the collaborator's activities as a local change agent will be reinforced by the visits of these public health "personages" that comprise the mobile team. Their support will help to avoid frustration in the collaborator when he encounters passive or negative attitudes among his people as regards needed changes in the community.

The collaborator would act as a control element for the mobile team and health officer between their visits. He would know who the sick people, such as tuberculosis patients, are in his village and he checks to see that they take their prescribed medicines, follow a proper diet and make their appointments with the health officer and the mobile team. In case of deterioration of an ailing person's health the collaborator would contact the health officer as quickly as possible.

In addition to knowing the number of sick people and the kinds of illnesses present in his village, the collaborator would gather and record other statistics. He would take an informal census, record each birth and death, and note migrations to and from his area. These statistics would serve the health program in a variety of important ways such as in evaluation of the progress of the program.

Another important service that the collaborator would be able to render concerns observation of the progress of his people through the five typical stages of acceptance of new ideas and practices by simple farm-type people. These stages are:

- 1) the awareness stage - knowledge of idea
- 2) the interest stage - interest and inquiry about idea
- 3) the evaluation stage - consideration of possible use of idea
- 4) the trial stage - idea is tested or used a number of times
- 5) the adoption stage - idea is accepted for regular use

The collaborator would be able to assist the mobile team by determining what stage his people have reached in regard to various health practices and by detecting problems at each stage.

G. Fees to be Charged Beneficiaries of this Health Project

Most of the services and materials offered by this project would have no charge or very little charge to the beneficiaries at least for the first two years. The principal reason for this is the people's inability to pay more than a minimal fee if they can pay anything at all. However, lest the project be counter-productive or antipromotional from a developmental point of view, small fees would be collected for a number of the services such as treatment for parasites, maternal-child and general consultations, vaccines, etc. This would help to defray some of the project cost, but more importantly would be a step toward making the people participants in the project, not just beneficiaries. As mentioned above, it is expected that in the long run other projects being implemented in Chiquitos will increase the income of the poorer segments of the population and thereby permit their greater financial support of the project.

The present full-time salaried project coordinator for the Chiquitos Vicariate, and a registered nurse, the Ministry of Public Health's designated health director for the zone, will be the managers of this project. They will be responsible for the regular collection of information necessary for the measurement and evaluation of project accomplishments. The schedule of planned accomplishments is presented in the logical framework and is broken down into goal, purposes, and outputs and their indicators.

CRS/Caritas personnel will receive monthly reports from the project managers and will evaluate the project activities and progress in relation to the above mentioned logical framework elements. These personnel will also make at least two extended visits to the project area per year for supervisory, advisory, and evaluative purposes.

Most of the logical framework indicators specify achievement of certain targets within a certain time period. Where the time elements is not specifically described, it is understood that the condition is expected to be realized by the end of three years of project life or that regular progress will be registered from a baseline that will be established early during the course of project implementation.

H. Administrative and Technical Capability to Implement Project

The project incorporates an adequate number of technical and supervisory personnel to implement its various activities. The MOH registered nurse, a professional project coordinator, the local health collaborators and the Vicariate (Franciscan) personnel who have experience in implementing the type of activities proposed here, are believed to possess the technical and supervisory requirements to carry it out successfully. In addition, CRS local and U.S. personnel will make supervisory visits during the year, will coordinate it at the national level, and will participate in its evaluation.

V. Financial Plan

Detailed schedules of total cost inputs are attached. (See Annexes I, II and III) to the Logical Framework Matrix. In these sections a detailed breakdown of annual funding by AID, GOB and other entities is provided. A general breakdown of total costs shows that AID funding will be \$105,000 over the three year period, other funding will total about \$100,000. After the three-year period the GOB, through the Ministry of Health, will absorb all financial responsibilities to continue the project.

Catholic Relief Services maintains a purchasing and shipping service in New York and will provide this service to the project whenever it is required. CRS/Bolivia has an agreement with the GOB which will enable duty-free import of all foreign goods needed for this project.

Clearances:

PR:AM Diaz

HAD:ALandry

CAP:LArmstrong

CON:WMcMoil

AD:PMassey

ESTIMATED BUDGET (AID CONTRIBUTION)
(In US\$)

ANNEX I

	<u>Year</u> <u>1</u>	<u>Year</u> <u>2</u>	<u>Year</u> <u>3</u>	<u>Total</u>
<u>I. US Costs - Commodities</u>				
Two trailers	300	-	-	300
Two vehicular radio transceivers ^{1/}	400	-	-	400
Five bicycles & spare parts	-	750	-	750
Five small refrigerators	1,000	-	-	1,000
12 scales	75	-	-	75
Mimeograph machine	200	-	-	200
Mimeograph materials	60	60	60	180
Two portable typewriters	160	-	-	160
Field equipped medical truck	9,500	-	-	9,500
Launch, motor, spare parts	-	3,000	-	3,000
Portable generator	400	-	-	400
Camera to make visual aids	-	250	-	250
Electrical current transformer	50	-	-	50
Camping equipment	525	-	-	525
Movie projector (1)	410	-	-	410
Filmstrip projector (8)	400	-	-	400
6 battery filmstrip projectors	90	-	-	90
Megaphones (2)	40	-	-	40
Microscopes (2)	200	-	-	200
Films, filmstrips, books, *	517	-	-	517
Sub-total	14,327	4,060	60	18,447

II. Local Costs

A. Personnel Expenses

Doctor's salary	2,625	2,625	2,625	7,875
Per diem bonus for doctors (2)	1,632	1,632	1,632	4,896
Nurse's salary	1,500	1,500	1,500	4,500
Per diem bonus for nurses (2)	1,224	1,224	1,224	3,672
Per diem bonus for nurse's aide	408	408	408	1,224
Two driver-operator salaries	2,700	2,700	2,700	8,100
Per diem bonus for drivers	408	408	408	1,224
Public Health team-travel	210	210	210	630
Caritas evaluation, etc.	1,000	1,000	1,150	3,150

* See Appendix No.

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	Year <u>1</u>	Year <u>2</u>	Year <u>3</u>	<u>Total</u>
<u>B. Equipment and Maintenance</u>				
Repairs, maintenance of vehicles	900	1,300	1,300	3,500
Vehicle insurance	1,200	1,200	1,200	3,600
5 horses and accessories	-	1,500	-	1,500
Basic instruments - furnishing posts	3,500	-	-	3,500
Gas and oil	1,300	1,500	1,500	4,300
<u>C. Radio-Phonic Programs on Health</u>				
5 hours radio time p/week	720	720	720	2,160
Teaching materials-programs	300	100	100	500
Recording of programs	400	400	400	1,200
<u>D. Training Courses</u>				
Two courses each 1 month long	3,750	-	-	3,750
Two courses each 2 weeks long	-	1,875	-	1,875
Teaching and study materials	200	100	-	300
<u>E. All other Miscellaneous</u>				
<u>Other Costs</u>				
Credit fund-latrine const.	2,000	3,000	-	5,000
5 block machines for latrine const.	230	345	-	575
Office supplies	200	200	100	500
Freight expenses	1,500	100	100	1,700
Transport donated medicines	1,000	500	250	1,750
Medical record cards (50,000)	1,500	-	-	1,500
MCH cards (50,000)	1,500	1,500	-	3,000
Stock-locally produced medicines	800	1,200	500	2,500
Inflation allowance	445	1,255	1,200	2,900
Various	200	200	200	600
4 light weight motorcycles	2,200	2,200	-	4,400
2 motorcycle carrying racks	120	-	-	120
Sub-total - Local Costs	<u>35,672</u>	<u>30,902</u>	<u>19,427</u>	<u>86,001</u>
GRAND TOTAL	\$49,999	34,962	19,487	104,448
ROUNDED TO	<u>\$50,000</u>	<u>35,000</u>	<u>20,000</u>	<u>105,000</u>

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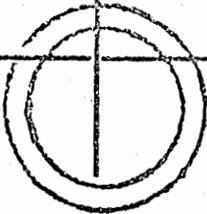
BUDGET BREAKDOWN: GOB FUNDING
 (follows items in input schedule) (US\$)

	Year:	1	2	3	Total
<u>A. Personnel Expenses</u>					
1. salary 1 mobile unit doctor		2,625	2,625	2,625	7,875
3. salary 1 nurse				1,500	1,500
5. salary 1 nurse's aide		1,250	1,250	1,250	3,750
9. salaries 10 health officers		6,000	6,000	6,000	18,000
10. Public Health Dept. team		<u>1,288</u>	<u>1,288</u>	<u>1,288</u>	<u>3,864</u>
SUBTOTAL		11,163	11,163	12,663	34,989
<u>E. Audio-Visual Materials</u>					
7. local production A.V. materials		<u>160</u>	<u>160</u>		<u>320</u>
SUBTOTAL		160	160		320
<u>F. Other Costs</u>					
7. nutrition-diet questionnaires		<u>135</u>			<u>135</u>
SUBTOTAL		135			135
TOTAL		11,458	11,323	12,663	35,444

VICARIATE-OBTAINED FUNDING - LOCAL AND FOREIGN

<u>A. Personnel Expenses</u>					
3. salary 1 nurse		1,500	1,500		3,000
12. projects coordinator		2,400	2,400	2,400	7,200
13. food & lodging for mobile teams		7,140	7,140	7,140	21,420
16. Sister Platz		<u>6,000</u>	<u>6,000</u>	<u>6,000</u>	<u>18,000</u>
SUBTOTAL		17,040	17,040	15,540	49,620
<u>B. Vehicles and Equipment</u>					
1. 1 field-equipped medical truck		5,200			5,200
15. transceiver base station		250			250
16. portable generator		<u>500</u>			<u>500</u>
SUBTOTAL		5,950			5,950
<u>F. Other Costs</u>					
3. medicines and medical equipment		500	500	500	1,500
9. newspaper articles		250	250	250	750
SUBTOTAL		<u>750</u>	<u>750</u>	<u>750</u>	<u>2,250</u>
TOTAL		23,740	17,790	16,290	57,820

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BUDGET BREAKDOWN: CRS FUNDING

	Year:	1	2	3	Total
A. Personnel Expenses					
15. CRS rep's work		<u>1,200</u>	<u>1,200</u>	<u>600</u>	<u>3,000</u>
SUBTOTAL		1,200	1,200	600	3,000
F. Other Costs					
1. office supplies		50	50	50	150
3. medicines & medical equipment		<u>1,000</u>	<u>1,000</u>	<u>1,000</u>	<u>3,000</u>
SUBTOTAL		1,050	1,050	1,050	3,150
TOTAL		2,250	2,250	1,650	6,150

Quality Film Laboratories

16 mm film "A Drop of Water"\$us 23.00

Carlos Campesino filmstrips: (4 copies of each)

"Learning Hygiene"	1.00
"Juanita and the Fly"	1.00
"Elimination of Intestinal Parasites"	1.00
"Prevention of Tuberculosis"	1.00
"Studying Nutrition"	1.00
"First Aid in the Home"	1.00
"Maria and Her Baby"	1.00
"Caring for your Child"	1.00
"Curing Your Child"	1.00
"Improving the Home"	1.00
	<u>10.00</u>
	x4
	\$ 40.00

Kimberly-Clark Corporation: (2 copies)

"The Story of Menstruation" (filmstrip)	\$ 3.00
	x2
	<u>6.00</u>

Instituto Latinoamericano de Cinematografia (filmstrips)

Educativa (Mexico): (2 copies each)

"Drink Pure Water"	1.20
"Pathways of Disease"	1.20
"Build your Latrine"	1.20
"Diarrhea"	1.20
"Simple Drainage"	1.20
"Septic Tanks"	1.20
"Man and Water"	1.20
"Latrine and Septic Tank"	1.20
"The Fly"	1.20
"The Well"	1.20
"Protect Your Well"	1.20
"Dispose of Wastes"	1.20
"Transmitters of Disease in the Home"	1.20
"Personal Cleanliness"	1.20
"Tuberculosis"	1.20
"We Should Drink Milk"	1.20
"Improve Your Diet"	1.20
"Foods I and II"	4.00
"Vitamins"	2.00
"Snakebite"	1.20
"When A Village Awakens"	1.50
"Audio-Visual Training"	1.50
"Community Health"	1.50
"Malnutrition in Infants"	1.50
"Improve your Diet"	1.50
"Rural Living"	1.50
	<u>36.60</u>
	x2
	73.20

"Making a Filmstrip" (1 copy)

2.00
<u>75.20</u>

21

FAO: (Filmstrips) (1 copy each)

"Good Food Wins the Game"	5.00
"A Little Bit More"	5.00
"Promoting the Consumption of Nutritious Foods"	5.00
(Booklets) (1 copy each)	
"Visual Aids In Nutrition Education"	3.00
"Planning and Evaluation of Applied Nutrition"	3.00
	<hr/>
	21.00

U.S.A. National Audio Visual Center:

16mm film "Infectious Diarrheas" (1 copy)	51.75
16mm film "Emergency Childbirth" (1 copy)	78.25
Filmstrip "Digging the Well" (1 copy)	5.00
	<hr/>
	135.00

Norwood Film Studios: (2 copies each)
(Filmstrips)

How To Sanitate the Village"	10.00
"Intestinal Worms In Man"	10.00
	<hr/>
	20.00
	x2
	<hr/>
	40.00

World Neighbors:

Booklet - "Visual Aids Training Manual" (1 copy)	2.40
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Pan American Health Organization:

Booklet - "General Procedures for Fortifying Foods in Latin America and the Caribbean" (1 copy)	1.00
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RTAC: (books)

<u>Municipal and Rural Sanitation</u> (161-69) 2 copies x 7.50	15.00
<u>Prenatal Care</u> (164-14-A) 6 copies x 0.98	5.88
<u>Infant Care</u> (164-14-B) 6 copies x 1.50	9.00
<u>Your Child From 1 to 6</u> (164-14-C) 6 x 1.50	9.00
<u>Growth And Development of Children</u> (163-244) (2 copies x 4.80)	9.60
<u>The Transmission and Pathogenesis of Tuberculosis</u> (173-94) 4 copies x 0.75	3.00
<u>Epidemiology - Its Practical Concepts</u> (163-101) 4 copies x 1.20	4.80
<u>Basic Nursing Procedures</u> (168-24-A) 2 copies x 3.90	7.80
<u>Manual for the Nurse's Aide</u> (168-28-A) 4 copies x 2.03	8.12
<u>Health Assistant</u> (169-79-A) 4 copies x 4.35	17.40
<u>Health Assistant-Instructor's Guide</u> " (169-79-B)	0.64
<u>Manual for Teaching Midwives</u> (163-C6) 2 copies x 1.05	2.10
<u>Medicine for the Paramedical</u> <u>Professions</u> (172-193) 2 copies x 5.34	10.68
<u>Midwifery Manual - A Guide For Auxiliary</u> <u>Midwives</u> (472-19) 4 copies x 2.46	9.84
<u>Nutrition and Diet Modifications for the Nurse</u> (168-30-A) 2 copies x 3.11	6.22

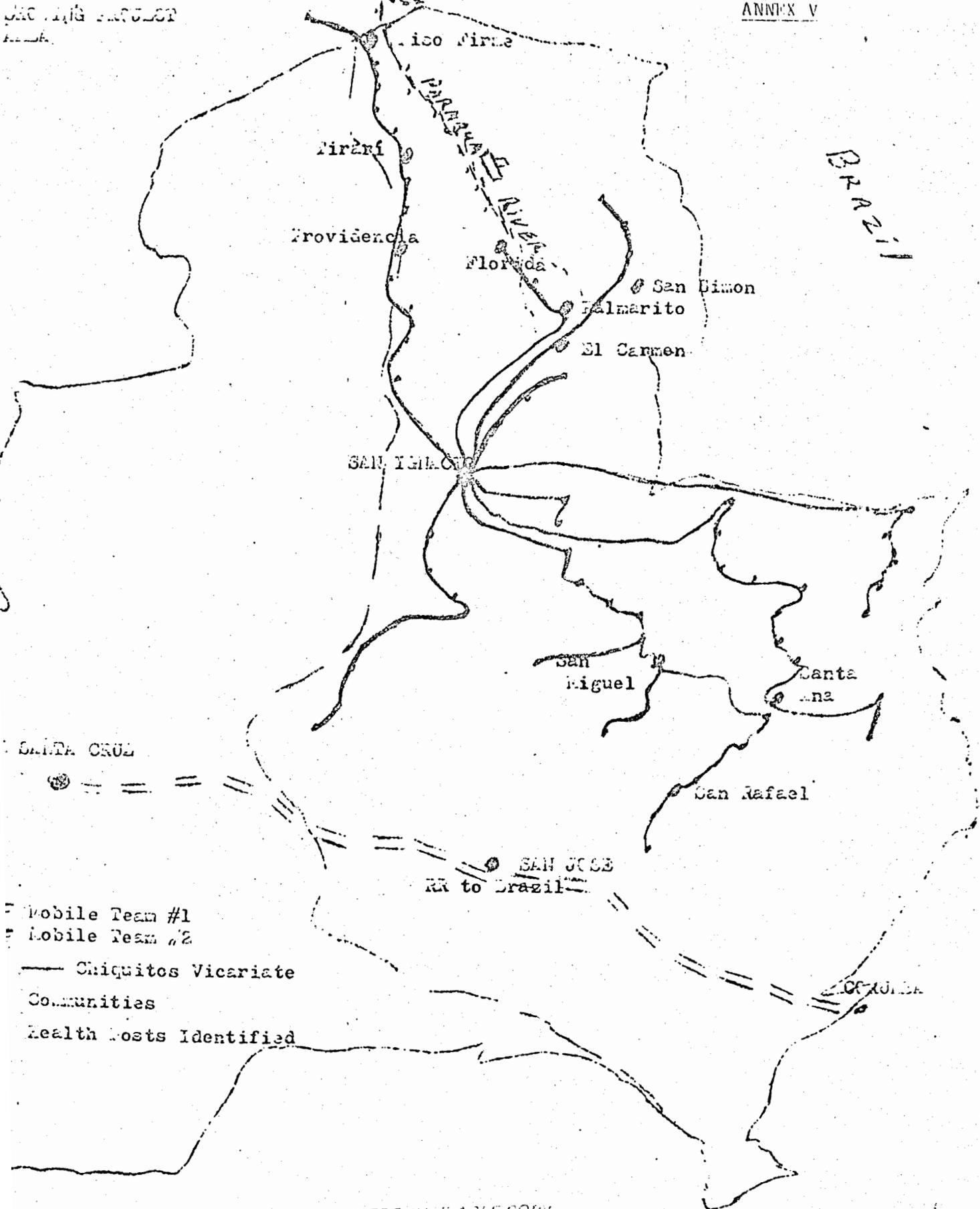
22

<u>Nurse-Instructor's Guide" (168-30-B)</u>	0.64
<u>Medical Care In Developing Countries</u>	
(171-118) 2 copies x 5.40	10.80
<u>Child Nutrition In Developing Countries</u>	
(69-222) 12 copies x 2.40	28.80
<u>Standard First Aid Training Course U.S. Navy</u>	
(167-85) 11 copies x 1.20	13.20
Total Cost:	<u>516.12</u>

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C. A. W.

Caritas Boliviana

Santa Isabel Hospital

Vicariate Radio Station

Mobile Health Team #1

Mobile Health Team #2

HEALTH POSTS (Small)

HEALTH POSTS (Large)*

Palmarito

Florida

San Simon

Provi-
dencia

Tirari

Piso
Firme

San Miguel

Santa Ana

San Rafael

Communities
Rural Health
Collaborators

*Greater Number of
Communities Per Post;
Denser Population

Caritas Bolivian

Santa Isabel Hospital

Vicariate Radio Station

Mobile Health Team #1

Mobile Health Team #2

HEALTH POSTS (Small)

HEALTH POSTS (Large)*

- El Ermen
- Palmarito
- Florida
- San Simon
- Providencia
- Tirari
- Piso Firme

- San Miguel
- Santa Ana
- San Pa

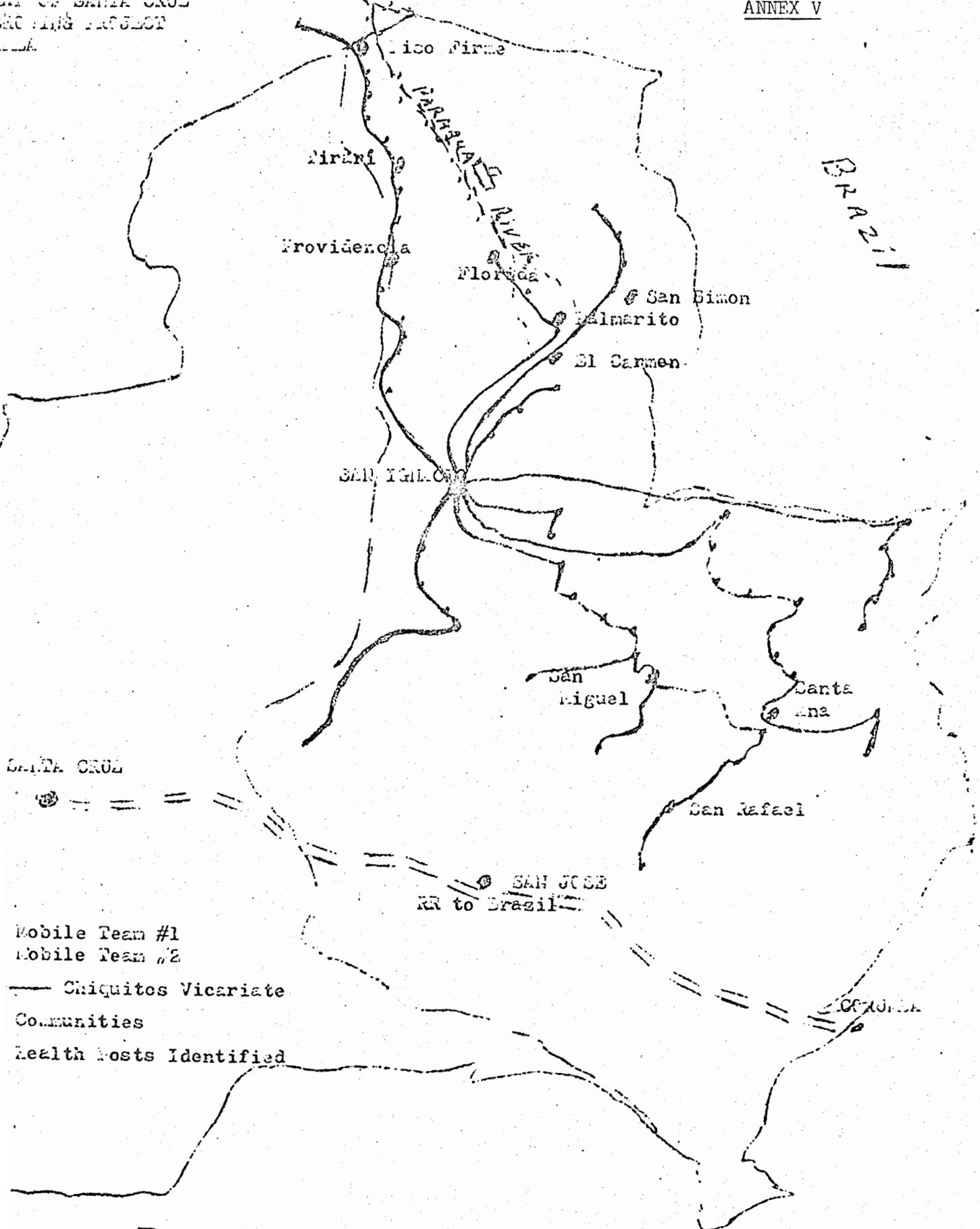
Communities Rural Health Collaborators

*Greater Number of Communities Per Denser Population

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DIAGRAM OF SANTA CRUZ
MAPPING PROJECT



Best Available Document

BASIC STATISTICS - CHIQUITOS VICARIATE

Note: There is a dearth of reliable statistics in Bolivia. However, the following data provides a fair approximation of the situation in the project area. Some of the statistical indicators will be refined and/or confirmed during project implementation.

Estimated income: \$300/family, of which approx. \$6 (2%) is spent on health services (traditional and modern); ave. of 5-7 persons/family.

Estimated prevalence of major diseases: Preschool (0-4) malnutrition = more than 60%
Parasitic infections = more than 90%
Tuberculosis = almost 5%
Measles, yellow fever, malaria also high.

Estimated mortality: Infant (0-1) mortality = 300/1000 live births
Preschool (0-4) mortality = 50%
Crude mortality = 27/1000 inhabitants.

Estimated birth and abortion rates: Crude birth rate = 65/1000 inhabitants
Fertility = 8-10 pregnancies/female, 15-49
Abortions = at least 25% of all pregnancies

Age structure (population distribution):
Male/female ratio = 1.04 under 20 years.
0.82 over 50 years.
Population under 20 years = 52%
20-49 years = 37%
50 and over years = 11%
Density = 7 inhabitants/km²
Communities over 2,000 inhabitants = less than 1/3 pop.
Clusters less than 200 and dispersed = more than 1/2 pop.

Status of women: 85% illiterate, more than twice that of men.

COPIA LEGALIZADA

R0379

RESOLUCION MINISTERIAL No.

La Paz, 1 de julio de 1974



V I S T O S:

Los antecedentes del caso y

CONSIDERANDO:

Que benefactores de Austria han donado al Hospital Santa Isabel, de San Ignacio de Velasco, Departamento de Santa Cruz, dos unidades móviles equipadas para prestar servicios de salud rural en la zona de influencia del nombrado nosocomio.

Que es preciso determinar el apoyo que a tal programa del Hospital Santa Isabel prestará el Estado.

SE RESUELVE:

1o.- Tomar nota, aprobar y agradecer el programa de Salud rural proyectado por el Hospital Santa Isabel, de San Ignacio de Velasco, determinado que el Ministerio de Previsión Social y Salud Pública le preste su apoyo en los términos de esta Resolución.

2o.- A partir de la gestión de 1977, el Ministerio se hará cargo del pago de haberes del personal del programa, compuesto de dos médico móviles, una enfermera y dos choferes, que deberán ser designados por este Despacho, así como de los gastos de carburantes y mantenimiento de los vehículos:

3o.- La Directora del Hospital Santa Isabel tendrá a su cargo la supervisión del programa, con especial énfasis en el buen uso de las unidades móviles donadas por benefactores de Austria.

La Dirección Nacional Administrativa, la División Nacional de Hospitales y el Departamento de Personal, tomarán nota y se encargarán del cumplimiento de esta Resolución.

Regístrese, hágase saber y archívese.

Fdo. Dr. Luis Leigue Suárez
MINISTRO DE PREVISION SOCIAL Y SALUD PUBLICA

FDO. Dr. Lucio Candia Ribera
SECRETARIO GENERAL DEL MINISTERIO DE
PREVISION SOCIAL Y SALUD PUBLICA

Fdo. Dr. Hugo Uzeda Gonzales
SUBSECRETARIO DE SALUD PUBLICA

Fdo. Dr. Juan Rivero Lazcano
DIRECTOR GENERAL DE PREVISION SOCIAL

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: _____
From FY 1976 to FY 1978 (f)
Total U.S. Funding \$105,000
Date Prepared: June 6, 1975

1020-28 (7-71)
PLEMENT I

Project Title & Number: Mobile Health Program for the Chiquitos Farmers

PA

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p>Institutionalize a system of basic health services for the rural population of the Chiquitos Vicariate, of approximately 100,000 people.</p>	<p>Measures of Goal Achievement:</p> <ol style="list-style-type: none"> 1. Reduce general mortality by _____% from the present estimated rate of _____ per 1,000 by 1979. 2. Reduce general morbidity by _____% from the present estimated rate of _____ per 1,000 by 1979. 3. Reduce infant mortality (1-3 years old) by _____% from the present estimated rate of _____ per 1,000 by 1979. 	<ol style="list-style-type: none"> 1. Government and church records and project personnel, especially the Rural Collaborators. 	<p>Assumptions for achieving goal targets:</p> <ol style="list-style-type: none"> 1. The PVO, GOB and local resources will be available to implement the project. 2. That participating communities will be responsible to proposed program.

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: _____
From FY 1976 to FY 1978 (fundi
Total U. S. Funding \$105,000
Date Prepared: June 6, 1975

1020-23 (7-71)
PLEMENT 1

ject Title & Number: Mobile Health Program for the Chiquitos Farmers

PAGE 2

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>ject Purpose:</p> <p>To establish a link between the health services of the Santa Isabel Hospital in order to provide basic health services to approximately 100 communities in remote rural areas of the Chiquitos Vicariate.</p> <p>To establish a local organizational capability to facilitate rural community participation in the improvement of the health situation in the target area.</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <ol style="list-style-type: none"> Two mobile health teams will be spending more than half of each month working in the rural areas and will be visiting each community at least twice a year. Ten appropriately equipped health stations at key points throughout the project area will be operating effectively under the direction of the salaried Health Officers who coordinate directly with the mobile teams. Mobile health teams, Health Officers, and Rural Collaborators combined will be realizing at least 100 mini-courses or lectures on health at community level per month by the end of the fifth semester of project life. Reduction in frequency of prevalent communicable diseases such as measles, whooping cough, TB, etc. by ___% by the third year of project life. Age-weight correlations among babies and children move towards normal. Incidence of parasite infection or other ailments due to water or food-borne microorganisms will be reduced by ___%. 	<ol style="list-style-type: none"> 1, 2, 3, 5, & 7. Project records. 4 & 6. Project and Ministry of Public Health Records. 8 & 9. Project and hospital Records. 1-5. Project personnel and their Records. Government and project Records. Record of number of patients sent to the Hospital by the health team network and the nature of their illness. 	<p>Assumptions for achieving purpose:</p> <ol style="list-style-type: none"> Vicariate can maintain funding for its personnel and facilities that play a part in project realization. Dedicated, energetic Rural Collaborators can be enlisted. Rural populace enthusiastically receives health teams. Latrine loans are paid off on a timely basis. Other Vicariate and government-sponsored projects in the area assist the populace in improving their economic situation. GOB meets its project obligations as scheduled.

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: _____
From FY 1976 to FY 1978 (funds)
Total U. S. Funding \$105,000
Date Prepared: June 6, 1975

Project Title & Number: Mobile Health Program for the Chiquitos Farmers

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Purpose:</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <p>7. Regular compilation of health information and statistics in each community by the Rural Collaborators.</p> <p>8. Reduced hospitalization of cases by ___% that should have been treated and cured on an out-patient basis.</p> <p>9. ___% of the communities will have established some kind of local health community organizations.</p> <p>10. Use of sanitary food storage, food preparation, and garbage disposal methods will be adopted by ___% of the population in the 85 target communities.</p> <p>11. ___% of the target communities will have installed and will be maintaining adequate potable water facilities or alternatively, they will be boiling their drinking water.</p> <p>12. Community installation and maintenance of clean water sources or where this is not possible boiling of water from doubtful sources.</p> <p>13. There will be a sufficient number of sanitary latrines in each village which will be regularly used by the target communities.</p>		<p>Assumptions for achieving purpose:</p>

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: _____
From FY 1976 to FY 1978 (func)
Total U. S. Funding \$105,000
Date Prepared: June 6, 1975

Project Title & Number: Mobile Health Program for the Chiquitos Farmers

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Purpose:</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <p>14. Increasing financial participation of the populace for health services offered.</p> <p>15. At least one health collaborator will be active in each participating community.</p> <p>16. Increased GOB awareness of the result of the project will provide the necessary motivation to officials at the central level to support continuation and expansion of the project after termination of outside assistance.</p>		<p>Assumptions for achieving purpose:</p>

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**PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK**

Life of Project: From FY 1976 to FY 1978 (2 years)
 Total U.S. Funding \$105,000
 Date Prepared: June 5, 1975

FD 1020-28 (7-71)
 SUPPLEMENT I

Project Title & Number: Mobile Health Program for the Chiquitos Farmers

PAGE

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Outputs:	Magnitude of Outputs:		Assumptions for achieving outputs:
. Trained salaried Rural Health Officers	Year: 1 2 3 10 same same	Project, Caritas, and CRS records	1. Ministry of Public Health meets its personnel and financial commitments
. Trained Rural Health Collaborators	one in each of 85 communities	" " " " "	
. Number of teaching-advisory visits in project area by Public Health Team	25 days/year same same	" " " " "	2. No unforeseeably long delays in arrival of imported items
. Number of supervisory visits by RS and Caritas	4 4 3		
. Number of loans made for latrine construction or improvement	50 100 100	" " " " "	
. Production of manuals or pamphlets or health education	20 pgs. 20 pgs. 20 pgs. x200 copies x200 cop. x200 cop.	" " " " "	
. Number and kind of consultations per year by the mobile teams		Baseline information will be developed during the first year of project.	
. Number and kind of consultations per year by the Rural Health Officers		" " " " "	
. Quantity and kind of medicines prescribed and distributed by the mobile teams and health officers per year		" " " " "	
. Radio programs and announcements dealing with health	260 hours/260 hrs./260 hrs. year year year	Project, Caritas, and CRS records	
. Number of Rural Collaborators and Health Officers trained in health at the Adult Training Institute (1 month course 1st. year; 2 weeks 2nd. year)	The same 100 individuals will participate in both courses		
. Enhanced teaching ability of health team network through use of audio-visual teaching materials	Daily use of these materials	" " " " "	
. A medical record system developed for health team network	This system will be developed by 1979	" " " " "	
. A health control data collection system developed for Maternal Child Health and Nutrition Programs	Data on all participants by 1978	" " " " "	

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: _____
From FY 1976 to FY 1978 (fundi
Total U.S. Funding \$105,000
Date Prepared: June 5, 1975

PAGE 4

AID 1029-28 (7-71)
SUPPLEMENT I

Project Title & Number: Mobile Health Program for the Chiquitos Farmers

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Outputs (Cont.)	Magnitude of Outputs (Cont.)		
15. Information on nutrition-dietary practices of the population	Baseline information will be developed during the first year and surveys will be taken each succeeding year	Project, Caritas, and CRS records	
16. Local newspaper articles on health topics	monthly monthly monthly	" " " " "	
Inputs from All Sources: * (for details see Annexes)	Implementation Target:		Assumptions for Providing Inputs:
Personnel Expenses	Year: <u>1</u> <u>2</u> <u>3</u> Total	Vicariate's agreements with Ministry of Public Health	That PVO, GOB and local resources will be available to carry out program as planned.
Vehicles Equipment	41,110 41,110 40,660 122,880	Vicariate-obtained foreign donations	
Educational Radio Programs on Health, Hygiene and Nutrition	30,070 15,105 4,060 49,235	Vicariate sponsored personnel and facilities	
Training Courses for Rural Health Collaborators and Officers	1,420 1,220 1,220 3,860	Local community support	
Audio-Visual Teaching Materials	3,950 1,975 - 5,925	AID Funding	
Other Costs	1,817 160 - 1,977	CRS Assistance	
TOTAL	9,080 6,755 4,150 19,985		
	88,447 66,325 50,090 203,862		
* CRS and Caritas will also distribute about 300,000 lbs. of Title II foods in the project area per year in nutrition-health oriented programs.	70,000 70,000 70,000 210,000		