UNCLASSIFIED

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

PERU

PROJECT PAPER

CHILD SURVIVAL ACTION

AID/LAC/P-395

Project Number: 527-0285

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Amendment Number: N/A — DOCUMENT CODE: 3

2. COUNTRY/ENTITY: PERU

3. PROJECT NUMBER: 527-0285

4. BUREAU/OFFICE: Latin America and Caribbean — 05

5. PROJECT TITLE (maximum 40 characters): Child Survival Action

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 12 DD 31 YY 92

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)
A. Initial FY 87 B. Quarter 4 C. Final FY 91

8. COSTS ($000 OR EQUIVALENT $1 = I/.20.00)

A. FUNDING SOURCE	FIRST FY 87 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total	2,075	525	2,600	13,972	5,028	19,000
(Grant)	(2,075)	(525)	(2,600)	(13,972)	(5,028)	(19,000)
(Loan)	(--)	(--)	(--)	(--)	(--)	(--)
Other U.S. 1.						
Other U.S. 2.						
Host Country	--	--	--	--	25,015	25,015
Other Donor(s)	--	--	--	--	--	--
TOTALS	2,075	525	2,600	13,972	30,043	44,015

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) CSF	534	510	--	--	--	2,500	--	18,900	--
(2) HE				--	--	100	--	100	--
(3)									
(4)									
TOTALS				--	--	2,600	--	19,000	--

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

11. SECONDARY PURPOSE CODE

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

A. Code	BWW	R/H	NUTR	PART	TNG		
B. Amount							

13. PROJECT PURPOSE (maximum 480 characters)

To strengthen the capability of the public health sector to deliver improved child survival health services through an integrated, expanded and sustainable health care system.

14. SCHEDULED EVALUATIONS
Interim MM 05 YY 90 | MM YY | Final MM 11 YY 92

15. SOURCE/ORIGIN OF GOODS AND SERVICES
[X] 000 [ ] 941 [X] Local [ ] Other (Specify)

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

Mission Controller has reviewed and concurs with the methods of implementation and financing included herein.

Robert Bonnaffon, Controller

17. APPROVED BY
Signature: Donor M. Lion
Title: Mission Director
Date Signed: MM 09 DD 28 YY 87

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
MM 03 DD 08 YY 88

AID 1330-4 (8-79)

PROJECT AUTHORIZATION

Name of Country : Peru

Name of Project : Child Survival Action

Number of Project : 527-0285

1. Pursuant to Section 104 of the Foreign Assistance Act of 1981, as amended, I hereby authorize the Child Survival Action Project ("Project") for Peru involving planned obligations of not to exceed Nineteen Million United States Dollars ($19,000,000) in Grant funds ("Grant") over a five (5) year period from date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the Project. The planned life of the Project is sixty-three (63) months from the date of initial obligation.

2. The Project consists of activities to strengthen the capability of the Ministry of Health (MOH) and the Peruvian Institute of Social Security (IPSS) to deliver improved child survival health services in family planning, immunizations, nutrition, diarrhea disease control, and acute respiratory infection control, through an integrated, expanded and sustainable health care system.

3. The Project Agreement, which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. Regulations and Delegations of Authority, shall be subject to the following essential terms, covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate:

a. Source and Origin of Commodities and Nationality of Services

Commodities financed by A.I.D. under the Grant shall have their source and origin in Peru or in the United States, except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services financed under the Grant shall have Peru or the United States as their place of nationality, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Grant shall be financed only on flag vessels of the United States, except as A.I.D. may otherwise agree in writing.

b. Conditions Precedent to Initial Disbursement for the Ministry of Health (MOH)

Except as A.I.D. may otherwise agree in writing, prior to the first disbursement of funds by A.I.D. under this Project, or to the issuance by

A.I.D. of documentation pursuant to which such disbursement will be made for activities involving the MOH, except for the procurement of technical consultants, regional coordinators, the A.I.D. Management Team, and vehicles to support these individuals, and the convening of regional planning workshops, Peru, through its MOH, shall furnish to A.I.D., in form and substance satisfactory to A.I.D.:

i. the name and title of the individual within the MOH who shall serve as the National Project Director; and,

ii. the names and titles of the individuals within the MOH who shall serve as members of the Project Coordination Committee.

c. Condition Precedent to Disbursement for the Health Departments in Calendar Year 1988

Except as A.I.D. may otherwise agree in writing, prior to the disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made for activities in a specific Health Department in calendar year 1988, except for the procurement of technical consultants, regional coordinators, the A.I.D. Management Team, and vehicles to support these individuals, and the convening of regional planning workshops, Peru, through its MOH, shall furnish to A.I.D., in form and substance satisfactory to A.I.D., an operational plan and budget for calendar year 1988 for that Health Department, the format and content of which shall be described in a Project Implementation Letter.

d. Condition Precedent to Subsequent Disbursements for the Health Departments After Calendar Year 1988

Except as A.I.D. may otherwise agree in writing, prior to the disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made in any year after calendar year 1988 for activities in a specific Health Department, Peru, through its MOH, shall furnish to A.I.D., in form and substance satisfactory to A.I.D., an annual operational plan and budget for that Health Department for that calendar year, the format and content of which shall be described in a Project Implementation Letter.

e. Conditions Precedent to Initial Disbursement for the Peruvian Institute of Social Security (IPSS)

Except as A.I.D. may otherwise agree in writing, prior to the first disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made for activities involving the IPSS, except for the procurement of technical consultants, regional coordinators, the A.I.D. Management Team, and vehicles

to support these individuals, and the convening of regional planning workshops, Peru, through its IPSS, shall furnish to A.I.D., in form and substance satisfactory to A.I.D.:

i. the name and title of the individual within the IPSS who shall serve as the National Project Director;

ii. the names and titles of the individuals within the IPSS who shall serve as members of the Project Coordination Committee; and,

iii. evidence that the IPSS has established a National Directorate for Project Administration and granted it independence and autonomy for the administrative and financial management of the Project.

f. Condition Precedent to Disbursement for Family Planning Activities in the Peruvian Institute of Social Security (IPSS)

Except as A.I.D. may otherwise agree in writing, prior to the disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made for family planning activities in the IPSS, Peru, through its IPSS, shall furnish to A.I.D., in form and substance satisfactory to A.I.D., evidence that a full-time technically qualified individual employed by Peru has been appointed to the post of Director of its National Family Planning Program.

g. Conditions Precedent to Initial Disbursement for Vehicles

Except as A.I.D. may otherwise agree in writing, prior to the first disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made for the procurement of vehicles, except those for technical consultants and regional coordinators, Peru, through its MOH, shall furnish to A.I.D., in form and substance satisfactory to A.I.D.:

i. evidence that the vehicles purchased with A.I.D. funds for the MOH under A.I.D. Projects 527-0219 and 527-0230 have been assigned to and are being used by appropriate personnel at the departmental level in support of child survival activities;

ii. evidence that a detailed analysis has been undertaken to support and justify the MOH's request for vehicles to be procured with A.I.D. funds, including a list of the locations and the titles of the personnel to which the vehicles will be assigned; and,

iii. a plan to ensure the proper use and maintenance of the vehicles to be procured with A.I.D. funds.

h. Condition Precedent to Subsequent Disbursements for Vehicles

Except as A.I.D. may otherwise agree in writing, prior to any subsequent disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made for vehicles, except those for technical consultants and regional coordinators, Peru, through its MOH, shall furnish to A.I.D., in form and substance satisfactory to A.I.D., evidence that the vehicles previously procured with A.I.D. funds are assigned to and are being used by the personnel for whom they were originally procured, or such other personnel as agreed to in writing by A.I.D., that they are being appropriately used to support Project activities, that sufficient Peru funds are available to operate them, and that they are being adequately maintained.

i. Condition Precedent to Initial Disbursement for Computers

Except as A.I.D. may otherwise agree in writing, prior to the first disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made for the procurement of computers and related software and auxiliary hardware, Peru, through its MOH, shall furnish to A.I.D., in form and substance satisfactory to A.I.D., detailed scopes of work and qualifications for the Peruvian computer systems engineers to be hired for the Health Departments and for the Peruvian health information system advisor to be hired for the central level.

j. Condition Precedent to Subsequent Disbursements for Computers

Except as A.I.D. may otherwise agree in writing, prior to any subsequent disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made for the procurement of computers and related software and auxiliary hardware, Peru, through its MOH, shall furnish to A.I.D., in form and substance satisfactory to A.I.D., evidence that permanent positions have been established and Peru funds budgeted for computer systems engineers, and that progress is being made to hire individuals to fill these positions in each of the Health Departments where A.I.D.-financed computers have been installed.

k. Conditions Precedent to Disbursement for the Field Epidemiology Training Program

Except as A.I.D. may otherwise agree in writing, prior to the disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made for the Field Epidemiology Training Program, Peru, through its MOH, shall furnish to A.I.D., in form and substance satisfactory to A.I.D.:

i. evidence that the MOH has negotiated and signed a written Letter of Understanding with the Centers for Disease Control (CDC) of

the United States which specifies, among other things, the obligations of the MOH and CDC to provide staff, space, services, funds, and equipment and to institute those modifications necessary to implement the Field Epidemiology Training Program, according to a mutually agreed upon schedule; and,

ii. evidence that sufficient space and adequate numbers of qualified personnel employed by Peru have been assigned to work on the Field Epidemiology Training Program under the Project.

l. Condition Precedent to Disbursement for Nutrition

Except as A.I.D. may otherwise agree in writing, prior to the disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made for nutrition activities in the MOH, Peru, through its MOH, shall furnish to A.I.D., in form and substance satisfactory to A.I.D., a detailed program description, implementation plan, and budget for nutrition activities to be undertaken by the MOH during the life of the Project.

m. Condition Precedent to Disbursement for Health Communications

Except as A.I.D. may otherwise agree in writing, prior to the disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made for health communications activities in the MOH, Peru, through its MOH, shall furnish to A.I.D., in form and substance satisfactory to A.I.D., a detailed program description, implementation plan, and budget for health communications activities to be undertaken by the MOH during the life of the Project.

n. Covenant as to External Evaluation

Peru agrees to participate in periodic external Project evaluations by assigning senior representatives of participating entities as resource personnel for the Evaluation Teams.

o. Covenants as to Monitoring and Evaluation

To ensure adequate monitoring and evaluation and adequate coordination of Project activities between the MOH and the IPSS, Peru shall:

i. carry out a scheduled monitoring program which shall include periodic site visits at all levels of the health delivery system by appropriate personnel to ensure the proper implementation of Project activities; and,

ii. arrange for key central and departmental level officials of the MOH and the IPSS, the A.I.D. Project Manager, members of the A.I.D. Management Team, and others as appropriate, to hold periodic review meetings for the purpose of evaluating Project progress and requirements.

p. Covenant as to Funding

Peru agrees to provide sufficient annual budget allocations following completion of A.I.D. financing to ensure continuity and sustained child survival services through the MOH and IPSS, including sufficient resources to maintain the health information, epidemiological surveillance, financial and personnel management and logistics systems, and adequate supervision, training, and health communications activities.

q. Covenant as to Automated Data Processing Equipment

Peru agrees to ensure that all automated data processing equipment, including computers and related software and auxiliary hardware, financed under the Project are assigned to and used by appropriate personnel in support of those activities for which they were procured; that adequate Peru funds are budgeted to operate and maintain the equipment; and that appropriate personnel are trained in the use and maintenance of the equipment.

r. Covenant as to Other Equipment and Commodities

Peru agrees to adequately maintain all other equipment and non-expendable commodities financed under the Project and to provide periodic training programs for equipment operators and maintenance personnel.

s. Covenant as to Pharmaceuticals, Contraceptives and Medical Supplies

Peru agrees to provide all health services delivery facilities of the MOH and the IPSS with adequate pharmaceuticals, contraceptives and medical supplies to effectively carry out Project activities.

t. Covenant as to Warehouse Facilities

Peru agrees to provide adequate Peru budgetary resources to construct or rehabilitate and maintain as necessary all warehouse storage facilities of the MOH and the IPSS in which commodities procured with both A.I.D. and Peru funds in support of Project activities are stored.

u. Covenant as to Personnel

Peru agrees to assign adequate numbers of qualified personnel at the central, departmental and peripheral levels in the MOH and the IPSS to effectively carry out Project activities.

v. Covenant as to Training

Peru agrees to make every reasonable effort to require that each person trained overseas, regardless of the duration of training, and each person trained in long-term in-country training programs of one year or more in duration under the Project, works in activities related to his/her field of training in Peru for not less than two times the length of time of his/her training program, provided, however, that in no event shall the individual be allowed to work in activities related to his/her field of training for less than one year from the date of the individual's completion of training, unless the Parties otherwise agree in writing.

w. Covenants as to Family Planning Activities

Peru agrees that none of the funds made available under this Grant for family planning activities may be used to finance any costs relating to:

i. the performance of abortion or involuntary sterilization as a method of family planning;

ii. the motivation or coercion of any person to undergo abortion or involuntary sterilization;

iii. biomedical research which relates, in whole or in part, to methods of, or the performance of, abortion or involuntary sterilization as a method of family planning;

iv. the active promotion of abortion or involuntary sterilization as a method of family planning; nor

v. the procurement of any equipment or materials for the purpose of abortion or involuntary sterilization.

Donor M. Lion
Mission Director
USAID/Peru

28 Sept. 1987
Date

Drafted by:PRO:BDoe/HR:LLion:mev

CLEARANCES:
HN:JLaRosa (In draft)
CONT:RBonnaffon (In draft)
GC/LAC:TGeiger (In draft)
PROG:WRhoads (In draft)

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LIST OF ABBREVIATIONS AND ACRONYMS

ADP	Automated Data Processing
ADRA/OFASA	Adventist Development and Relief Agency (Obra Filantrópica y Asistencia Social Adventista)
AIDS	Acquired Immune Deficiency Syndrome
AID/IG	AID's Office of the Inspector General
AID/W	AID/Washington
ANSSA	1986 Health Sector Analysis (1986 Análisis del Sector Salud)
APRA	American Revolutionary Popular Alliance (Alianza Popular Revolucionaria Americana)
ARI	Acute Respiratory Infection
CARE	Cooperative for American Relief Everywhere (Cooperative Americana de Remesas al Exterior)
CRS/CARITAS del Perú	Catholic Relief Services/CARITAS del Perú
CDC	Centers for Disease Control
CDSS	Country Development Strategy Statement
CONAMAD	National Commission of Medicines, Foods and Drugs (Comité Nacional de Medicamentos, Alimentos y Drogas)
CORDES	Departmental Development Corporations (Corporaciones Departamentales de Desarrollo)
CS	Child Survival
CSA	Child Survival Action
CSM	Contraceptive Social Marketing
CY	Calendar Year
DDC	Diarrheal Disease Control
DMU	Departmental Managerial Unit
DTA	Technical Directorate of Administration (Dirección Técnica de Administración)
DTCCE	Technical Directorate of Coordination of External Cooperation (Dirección Técnica de la Coordinación de Cooperación Externa)
DTID	Technical Directorate of Informatics and Documentation (Dirección Técnica de Informática y Documentación)
DTPE	Technical Directorate of Special Programs (Dirección Técnica de Programas Especiales)
DTPNS	Technical Directorate of Programs, Norms and Services (Dirección Técnica de Programas, Normas y Servicios)
DTDRH	Technical Directorate of Human Resources Development (Dirección Técnica de Desarrollo de Recursos Humanos)
EEP	Budgetary Executing Entity (Entidad Ejecutiva Presupuestal)
ENDES	1986 National Demographic and Family Health Survey (Encuesta Nacional Demográfica y de Salud Familiar)
ENNSA	1984 National Nutritional and Health Survey (Encuesta Nacional de Nutrición y Salud)

EPI	Expanded Program of Immunizations (El Programa Amplio de Inmunización)
ESAN	School of Business Administration (Escuela Superior de Administración de Negocios)
FFW	Food for Work
FETP	Field Epidemiological Training Program
FMS	Foreign Military Sales
FP	Family Planning
FX	Foreign Exchange
FY	Fiscal Year
GDP	Gross Domestic Product
GNP	Gross National Product
GOP	Government of Peru
GTZ	German Technical Assistance Agency
HIS	Health Information System
IBRD or World Bank	International Bank for Reconstruction and Development
IDB	InterAmerican Development Bank
IE&C	Information, Education, and Communications
IIN	Nutrition Research Institute (Instituto de Investigación Nutricional)
IMR	Infant Mortality Rate
INE	National Institute of Statistics (Instituto Nacional de Estadísticas)
INN	National Institute of Nutrition (Instituto Nacional de Nutrición)
INP	National Planning Institute (Instituto Nacional de Planificación)
IPSS	Peruvian Institute of Social Security (Instituto Peruano de Seguridad Social)
IQC	Indefinite Quantity Contract
IUD	Intra-Uterine Device
JHU	Johns Hopkins University
KAP	Knowledge, Attitude and Practices
LAC/DR	Bureau for Latin America and the Caribbean/Office of Development Resources
LC	Local Currency
L/COM	Letter of Commitment
LUSA	United Laboratories, South America (Laboratorios Unidos, America del Sur)
MCH	Maternal and Child Health
MEF	Ministry of Economy and Finance (Ministerio de Economía y Finanzas)
MOE	Ministry of Education (Ministerio de Educación)
MOH	Ministry of Health (Ministerio de Salud)
O/HR	Office of Human Resources
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
ORU	Oral Rehydration Units
PAC	Complementary Feeding Program (Programa de Alimentación Complementaria)

PACD	Project Assistance Completion Date
PAHO (OPS)	Pan American Health Organization (Organización Panamericana de Salud)
PAIT	Temporary Work Program (Programa de Apoyo al Ingreso Temporal)
PASA	Participating Agency Services Agreement
PHC	Primary Health Care
PID	Project Identification Document
PIL	Project Implementation Letter (Carta de Implementación)
PIO	Project Implementation Order
PIO/C	Project Implementation Order for Commodities
PP	Project Paper
PRISMA	Projects in Informatics, Health, Medicine and Agriculture (Proyectos de Informática, Salud, Medicina y Agricultura)
PSA	Procurement Services Agent
PSC	Personal Services Contract or Contractor
PVO	Private Voluntary Organization
PY	Project Year
RC	Regional Coordinator
RFP	Request for Proposals
SENAPA	National Service for Potable Water and Sewage Systems (Servicio Nacional de Agua Potable)
SEPAS	Peruvian Evangelical Service for Social Action (Servicio Evangélico Peruano de Acción Social)
SIID	Seton Institute for International Development
S&T	Science and Technology
TB	Tuberculosis
TBA	Traditional Birth Attendant
UDES	Health Department (Unidad Departamental de Salud)
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Emergency Fund
UNIPAC	UNICEF Packing and Assembly Center
UPCH	Cayetano Heredia University of Peru (Universidad Peruana Cayetano Heredia)
UP	Budgetary Unit (Unidad Presupuestal)
VEA	Active Epidemiological Surveillance (Vigilancia Epidemiológica Activa)
VFT	Vaginal Foaming Tablets
VSC	Voluntary Surgical Contraception
WB	Well Baby
WFA	Women of Fertile Age
WHO	World Health Organization

GLOSSARY

Budgetary Executing Entity (EEP): An MOH facility (hospital or health center) which implements programs and disburses funds. An EEP receives funds directly from a Budgetary Unit.

Budgetary Unit: An MOH facility (hospital or health center) or Health Department responsible for budget development and disbursement of funds to the Budgetary Executing Entity (EEP). Budgetary Units receive funds directly from the MOH central level.

Departmental Development Corporations (CORDES): Decentralized development agencies of the GOP, one in each of the 25 geopolitical Departments. The CORDES are responsible to the GOP for infrastructure development and coordination of activities in health, education, agriculture and all other ministerial functions within the specific Department.

IPSS Departmental Managerial Unit (DMU): Decentralized organizational offices of IPSS, with eight in Lima and one in each of the remaining 24 geopolitical Departments for a total of 32. The DMUs are responsible for preparing budgets and disbursing funds and for supervising, monitoring and providing logistic support to IPSS facilities in their respective Department or area of influence. The DMUs receive resources directly from the IPSS central level.

MOH Health Department (UDES): Decentralized organizational offices of the MOH, with four in Lima and one in each of the remaining 24 geopolitical Departments for a total of 28. The UDES are responsible for preparing budgets and disbursing funds and for supervising, monitoring and providing logistic support to the health facilities in their respective Department or area of influence.

Oral Rehydration Salts (ORS): Packets of salts composed of sodium chloride, potassium chloride, sodium bicarbonate or citrate and glucose used to maintain electrolyte balance during episodes of diarrhea.

Oral Rehydration Therapy (ORT): Therapy using ORS or other home-prepared fluids (soups, teas, etc.) and proper feeding, including breast-feeding, to prevent dehydration during episodes of diarrhea.

Peripheral Health Facilities: In the MOH, any health facility below the UDES level, including health centers and health posts. In the IPSS, any health facility below the DMU level, including polyclinics, medical posts and factory posts.

Polyclinic: An IPSS facility which offers multiple specialized medical services in both preventive and curative care and is staffed by, among others, specialist physicians.

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I. SUMMARY AND RECOMMENDATIONS

A. Recommendations

1. Funding

It is recommended that a grant of US$19,000,000 be authorized for the Child Survival Action (CSA) Project, which has a Project Assistance Completion Date (PACD) of December 31, 1992. The Government of Peru's (GOP's) contribution to the Project will be the equivalent of $25,015,115 over a five year period.

2. Geographic Code

The Project Authorization should specify that, except as A.I.D. may otherwise agree in writing:

a. goods and services financed by A.I.D. under this Project shall have their source and origin in A.I.D. Geographic Code 000 (U.S.) or Peru; and,

b. ocean shipping financed by A.I.D. under this Project shall be only on flag vessels of the United States.

3. Waivers

The following waivers of A.I.D. procurement procedures are likely to be sought:

a. a source/origin waiver for the procurement of vehicles; and,

b. source/origin and non-competitive procurement waivers for the procurement of cold chain equipment, needles, syringes and related equipment.

B. Summary Project Description and Financial Plan

The Ministry of Health (MOH) is about to initiate a major child survival (CS) program over the next five years. Comprehensive national plans for CS interventions with specific goals, objectives, and targets have been developed by the MOH to guide the implementation of its program. Through this Project, A.I.D. will assist the MOH to implement its program nationwide by providing financing to support specific activities contained in the national plans. In addition, the MOH will receive complementary financing from other donors for specific components of its program. This Project also will contribute resources to the Peruvian Institute of Social Security (IPSS) to support its efforts to expand the provision of CS services through IPSS facilities nationwide. Finally, this Project will provide assistance, primarily to the MOH, to strengthen several support systems which are integral elements of a sustainable CS health delivery system.

The Project goal is to improve the health of infants and children in Peru. The Project purpose is to strengthen the capability of the public health sector to deliver improved child survival health services through an integrated, expanded and sustainable health care system. The Project consists of two major components: 1) expansion of CS services; and 2) strengthening of decentralized support systems for sustainable CS services delivery. This Project will support the expansion of CS services in both the MOH and the IPSS. Project assistance to strengthen decentralized support systems will be provided primarily to the MOH.

1. Expansion of CS Services

Activities under this component include five major CS interventions: diarrheal disease control (DDC), nutrition, immunizations, family planning (FP) and control of acute respiratory infections (ARI).

a. Ministry of Health (MOH)

The Project will support the implementation of the MOH's National Plan for the Prevention and Control of Diarrheal Diseases prepared in late 1986. The Plan emphasizes adequate training, supervision, logistics, operations research and evaluation to promote the use of oral rehydration therapy (ORT) to prevent deaths due to dehydration caused by diarrheal illness in children less than five years of age. Specifically, the Project will support the establishment of five hospital-based rehydration units in five different Health Departments, which will serve as Regional Training Centers for DDC. These Centers will complement the four already established under a previous A.I.D. Project. In addition to training professional and auxiliary personnel in the clinical management of diarrhea, the Centers will report on diarrheal statistics and will undertake activities in prevention, detection, treatment and research. Project activities also include the promotion of appropriate home responses to diarrhea through community education and health communications. Messages will promote the appropriate use of ORT, dietary management of diarrhea, continued breast-feeding and prevention of diarrhea by means of improved water and sanitation facilities and improved hygienic behaviors.

The Project also will support a wide variety of nutrition activities to be undertaken by the MOH, including growth monitoring, the promotion of appropriate breast-feeding practices, research and the promotion of nutritious weaning foods in different geographic areas, proper dietary management of diarrhea, and improved targetting of the beneficiaries of supplementary feeding programs for pregnant and lactating women and preschool children in the rural areas of the sierra and jungle. Training and supervision of MOH personnel in these activities will be complemented by community education and promotion of nutrition education messages to communities and especially to mothers of infants and young children.

Implementation of the MOH's Five-Year Expanded Program of Immunizations (EPI) National Plan of Action, which was finalized in early 1987, will also be supported by the Project. Activities under this Plan will be financed by the Pan American Health Organization (PAHO), the United Nations Children's Emergency Fund (UNICEF), Rotary International, the MOH and A.I.D. The Peruvian Plan is included as a part of the PAHO Immunization of the Americas Five-Year Plan, which is funded by PAHO, AID/Washington (AID/W), UNICEF, Rotary International, the Inter-American Development Bank (IDB), and USAIDs throughout the hemisphere. USAID/Peru's financing of the Plan's activities constitutes this Project component. The Plan is designed to continue high levels of vaccination coverage (at least 80%) for children less than five years of age against measles, polio, diphtheria, whooping cough, tetanus and tuberculosis. In addition, women in high risk areas will be immunized against tetanus and, by the year 1990, the wild polio virus will be eradicated.

The Project will support the implementation of the MOH's National Family Planning Five-Year Plan prepared in early 1987. The objective of the Plan is to contribute to Peru's national goal to reduce maternal and infant mortality and morbidity rates by spacing births and reducing fertility from 4.2 children per woman in 1986 to 3.7 by 1991 for the entire country. The MOH will contribute toward achieving this goal by increasing the coverage of FP services to women of fertile age (WFA) in its target population from 28% in 1986 to 32% by 1991. In order to increase coverage rates, the MOH, with support under this Project, will increase FP services offered at health centers and posts by providing services during late afternoon hours in marginal-urban areas, by training personnel and assigning or relocating staff to priority health centers and posts in rural areas, by equipping laboratories to provide cervical cancer detection services, and by maintaining adequate quantities of contraceptives and FP supplies in all health establishments at all levels of service.

Finally, under this Project component, the Project will support the implementation of the MOH's National Plan to Control Acute Respiratory Infections (ARI), which was designed in early 1987. The Plan emphasizes training and supervision activities for all levels of MOH personnel in the early detection and treatment of moderate and severe cases of ARI that can benefit from antibiotics. Also included in the Plan are community education activities aimed at increasing community participation in the control of ARI and in preventive activites such as immunization, improvements in sanitation and hygiene, and prolonged breast-feeding.

Under the MOH Expansion of CS Services Component, A.I.D. will finance related technical assistance under the integrated health communications, epidemiological surveillance and statistical reporting programs to support all five CS programs -- DDC, nutrition, immunizations, FP and ARI control. In addition, A.I.D. will finance the purchase of equipment and supplies, operations research on weaning foods, short-term training outside of Peru and in-country long-term and short-term training. AID/W centrally-funded projects will provide additional complementary support under

the DDC component related to the increased local production of oral rehydration salts (ORS) and operations research. The MOH will finance, for all CS delivery programs: i) in-country training and supervision at all levels of service; ii) all recurrent costs for all CS programs; and, iii) local costs related to community education and mass media promotion. In addition, for the immunizations program, the MOH will finance the purchase of vaccines and vaccination cards as well as medicines and supplies for the DDC and ARI control programs.

b. Peruvian Institute of Social Security (IPSS)

The Project will support the IPSS's plans to expand FP coverage from the current 8% of WFA in its target population to 22.7% of WFA by 1991. This will be accomplished by: training personnel to deliver FP services; assigning personnel to provide FP services at its 26 hospitals, 48 polyclinics, 212 medical posts and 100 factory posts; providing medical equipment and FP supplies to all health establishments; providing adequate warehousing and distribution of contraceptives; and developing and disseminating appropriate information, education and communications (IE&C) materials.

The Project also will support the IPSS's efforts to reduce morbidity and mortality in children under five years of age in its target population by increasing the numbers of health facilities and trained health personnel providing CS services. To achieve this objective, IPSS personnel from each of its 32 Departmental Managerial Units (DMU) will receive training in DDC, nutrition, growth monitoring, immunizations and control of ARI under the Project. IPSS currently provides prenatal and postnatal care through child health units in its 26 hospitals. In addition to strengthening the capability of these units, the Project will facilitate the expansion of CS services to IPSS's 48 polyclinics, 212 medical posts, and 100 factory posts throughout the country where well baby (WB) clinics will be established and supported with equipment, supplies and training. Two hospital-based Regional Training Centers for DDC also will be established under the Project.

Under the IPSS Expansion of CS Services component, A.I.D. will finance, for the FP sub-component, equipment, contraceptive supplies, technical assistance, and selected in-country and short-term training outside of Peru. For the Other CS Services sub-component, A.I.D. will finance equipment, supplies, and selected in-country and short-term training outside of Peru. Under both sub-components, the IPSS will finance all remaining local costs such as personnel, in-service training and supervision, including in-country travel and per diem, logistics, supplies, monitoring, and vehicle operating expenses. In addition, the IPSS will finance medicines and supplies for the DDC and ARI control programs.

2. Strengthening Decentralized Support Systems for Sustainable Child Survival Services

Project assistance to strengthen decentralized support systems will ensure that CS services are institutionalized during the life of the

Project, and that they continue to be delivered by health care providers after the Project's completion. The support systems that will be strengthened under this Project, primarily in the MOH, include: training and supervision; health communications; financial and personnel management and logistics; active epidemiological surveillance (VEA); and the health information system (HIS).

In-service training and supervision are activities which the MOH and the IPSS program on a regular basis for staff at all levels of service. This Project will support the implementation of the MOH's comprehensive and detailed Integrated Training Plan and Integrated Supervision Plan for the five-year life of the Project. Activities in these Plans will provide technical and administrative support to the field staff who deliver CS services. In the same manner, the Project will support the IPSS's Extended Training Plan and supervision activities which will support the staff who work at the IPSS FP and WB clinics and hospital-based health units.

The Project also will support the implementation of the MOH's Integrated Health Communications Plan, including such activities as workshops on popular education methods to promote community participation to increase coverage of CS health services; the production of community level printed materials with health education messages promoting CS activities; social marketing research to serve as a basis for developing printed and radio promotional materials; and the purchase of equipment needed to produce printed and radio promotional materials.

The Project will support the expansion of computerized systems for financial and personnel management and logistics to the 28 Health Departments (UDES) of the MOH and the training of UDES personnel in the use of the automated data processing equipment and software programs. Currently, only the MOH central level and three UDES are utilizing these automated systems. To further improve the logistics system, the Project will support an assessment of the current status of MOH and IPSS warehouses to identify the rehabilitation and construction requirements related to the storage and distribution of Project-financed commodities for CS services delivery and food provided by A.I.D. under other Projects for the MOH feeding program. Based on the results of the assessment, the MOH and IPSS will make improvements in warehouse facilities that require rehabilitation, construct facilities where needed at hospitals, health centers and health posts, and train warehouse personnel in inventory control and commodity distribution procedures.

The development and implementation of a comprehensive national VEA Program within the MOH will also be supported by the Project. Three major activities will be carried out: a) an intensive two-year in-country Field Epidemiological Training Program (FETP) for up to 35 participants; b) the installation of a national computerized VEA system, including the training of personnel in all 28 UDES; and, c) the strengthening of the national laboratory system to support VEA and CS activities.

The HIS of the MOH supports automated data processing of information related to MOH administration, including budgeting, financial management, personnel management and logistics, as well as health statistics and epidemiological information. The Project will support the expansion of the HIS to all 28 UDES by providing computer equipment and supplies, software packages, technical assistance and training.

For all support systems strengthening activities, A.I.D. will finance: all foreign exchange costs related to the purchase of equipment and supplies; technical assistance; all overseas training and selected in-country training; and, local currency costs that facilitate the development of the newly designed support systems of VEA and HIS. The MOH and the IPSS will finance local recurrent costs for such routine and regularly scheduled activities as in-service training and supervision visits.

A summary of total Project costs by Project components, funding source, and foreign exchange (FX) and local currency (LC) costs is shown in Table 1.

C. Summary Findings of Project Analyses

The USAID/Peru Project Development Committee has reviewed the analyses and other documentation for this Project and has concluded that the Project is environmentally, socially, financially, and economically sound and technically and administratively feasible and is ready for implementation.

D. Project Checklists

The Project meets all applicable statutory criteria. Appropriate checklists are included in Annex I, Exhibit B.

E. AID/Washington (AID/W) Concerns and Project Design Issues

Several issues were raised during the AID/W review of this Project on June 13, 1986 as described in the Project Identification Document (PID) approval cable (Annex I, Exhibit A). USAID/Peru's response to these issues is summarized in this section and further discussed throughout the Project Paper (PP). During Project development, additional Project design issues were identified and resolved. These issues also are addressed in this section and throughout the PP.

1. A.I.D. Funding Level

Whether or not the proposed funding level represents a high risk strategy depends on several factors, among them being the opportunities for future obligations related to Brooke-Alexander and 620 Q. Notwithstanding the GOP's restrictive debt management policy and expected continued balance of payments, foreign exchange and domestic financial problems, the issue appears to be not whether there will be obligating opportunities but when. The GOP's policy with respect to A.I.D. and Foreign Military Sales (FMS) arrearages is

TABLE 1. TOTAL PROJECT COSTS BY PROJECT COMPONENTS, FUNDING SOURCE AND BY FOREIGN EXCHANGE (FX) AND LOCAL CURRENCY (LC) COSTS
(US$000)

PROJECT COMPONENT	AID FX	AID LC	AID TOTAL	GOP TOTAL	GRAND TOTAL
A. Expansion of CS Services by MOH					
1. Diarrheal Disease Control	117	56	173	819	992
2. Nutrition	216	114	330	40	370
3. Immunizations	2,590	114	2,704	0	2,704
4. Family Planning	3,012	321	3,333	0	3,333
5. Acute Respiratory Infect.	211	0	211	1,943	2,154
Sub-Total	6,146	605	6,751	2,802	9,553
B. Expansion of CS Services by IPSS a/					
1. Family Planning	1,106	52	1,158	154	1,312
2. Other Child Survival	583	0	583	355	938
Sub-Total	1,689	52	1,741	509	2,250
C. Systems Strengthening					
1. Field Epid. Trg. Prog.	1,431	441	1,872	44	1,916
2. VEA Laboratories	752	4	756	0	756
3. Epidemiolog. Surveillance	0	346	346	0	346
4. Health Info. System	831	501	1,332	0	1,332
5. Integrated Trg. Prog.	132	523	655	2,861	3,516
6. Integ. Supervision Prog.	0	0	0	1,549	1,549
7. Transportation	939	0	939	374	1,313
8. Health Communications	0	323	323	974	1,297
Sub-Total	4,085	2,138	6,223	5,802	12,025
D. General Project Support					
1. USAID Management Staff	826	274	1,100	0	1,100
2. Audits & Evaluations b/	230	305	535	0	535
3. Operating Expenses c/	0	0	0	13,652	13,652
4. Monitoring & Support d/	0	1,326	1,326	1,717	3,043
5. Other (FP Survey) e/	0	0	0	104	104
Sub-Total	1,056	1,905	2,961	15,473	18,434
E. Contingency	996	328	1,324	429	1,753
Grand Total	13,972	5,028	19,000	25,015	44,015

a/ In addition, A.I.D.-financed local commodity and training costs for IPSS totalling about $100,000 are included under other line items in the budget.
b/ Additional funds for evaluations are included in the Immunizations ($62,000) and Health Information System ($34,000) budget components.
c/ US$374,000 of GOP operating expenses is contained in the Transportation budget component.
d/ An additional US$1,549,000 of GOP funds for Monitoring and Support is included in the budget for the Integrated Supervision Program. This line item includes GOP costs such as radio time for health communications as well as other program support costs for other components.
e/ A.I.D. costs for this survey are included in item A.4. above.

to eliminate them. For the past two years, although these arrearages have not been eliminated, payments to the U.S. Government have been sufficient to provide obligating opportunities. USAID sees no reason to believe that the GOP's approach to managing its A.I.D. and FMS debt will change. This approach has been strongly reaffirmed by President Garcia and the new Minister of Economy and Finance. USAID expects that arranging for appropriate repayments will continue to require persistent attention, but also that the effort will be successful. There is increasing evidence, moreover, that the GOP is considering steps to re-establish productive relationships with the international financial community because of its appreciation that the current approach has insured a net capital outflow, thereby jeopardizing the GOP's economic and social goals. This appreciation reinforces the prospect that USAID will have obligating "windows" for the forseeable future. The USAID strategy to deal with obligating opportunities is two-fold: a) be ready to move when these opportunities emerge; and b) press hard to have sanctions lifted earlier in the year than has been the custom and seek to have the GOP repay on a regular basis in order to remain out of sanctions.

2. Recurrent Costs and Counterpart Funding

The Project development process reaffirmed the AID/W endorsed USAID strategy in the PID to require that the GOP carry the burden of recurrent and local costs. The Project design and budget reflect this strategy, thoroughly discussed with GOP counterparts. Domestic economic and financial problems could make it difficult for the GOP to fulfill its intentions, but the effort must be made. The issue itself is a key element of USAID's policy dialogue and should continually be pressed. Moreover, as indicated during the PID review, the GOP's commitment is real, as evidenced, for example, by increased allocations to the health sector, continued emphasis on CS programs, and, more recently, the appointment of a new Minister of Health who considers the MOH's CS Program and this Project to be of the highest priority, partly because of her own thinking as well as her perception that it reflects President Garcia's policy.

Counterpart funding will come from two sources: the GOP's generated revenues and PL 480 generated funds. Consistent with AID/W guidance, financial planning in this Project involves a declining portion of the GOP's contribution coming from PL 480 counterpart. Because of USAID's active role in PL 480 counterpart programming, it is in a good position to influence and monitor PL 480 allocations.

The AID/W PID approval cable expressed concern about the possible recurrent cost implications of the International Bank for Reconstruction and Development (IBRD or World Bank) project. World Bank projects are currently in suspense. The situation remains uncertain, but the GOP has indicated its interest in re-establishing World Bank-GOP cooperation. A rapprochement with the Bank would probably involve redesign and restructuring of the Bank's portfolio as well as provisions for substantial resource flows from the Bank to the GOP. Until this situation is clarified, USAID cannot apprise AID/W of the recurrent cost implications of the World Bank project.

3. Project Complexity, Management and Flexibility

During Project development and since the AID/W PID review, Project design has been further simplified. The Project now places emphasis on expanding on-going public sector (MOH and IPSS) programs. USAID intends to explore with the GOP a possible FY 1988 CS services delivery initiative involving the private sector. Negotiations with the MOH, the prudence of Project simplicity, and resource considerations led to the decision to eliminate private sector participation in this Project. The proposed pharmaceutical fund has also been dropped.

Organizational and administrative aspects are straightforward. The MOH is the major implementing agency, and close coordination with IPSS has been provided for at all levels of the service delivery system and for planning, implementation and evaluation purposes. The Project reinforces and supports the GOP's policy of enhanced decentralization to the departmental units (the MOH's UDES's and IPSS's DMUs). Implementation plans call for strengthening supervision at all levels of the health delivery system. USAID's management burden has been minimized by its approach to local costs and by arranging for consultants, financed from Project funds under Personal Services Contracts (PSCs), to assist in Project management. MOH Project management and implementation at the departmental level will be facilitated by a cadre of eight Project-financed Peruvian Regional Coordinators, each of whom will work intensively with three to four UDES at the field level and will play a major role in ensuring adequate coordination and communication among the MOH and IPSS at the central and departmental levels and among these entities and USAID. Also, financial management procedures have been simplified. The pari-passu disbursement mechanism has been eliminated as the MOH will administer only about US$1.8 million of the total US$19.0 million of A.I.D. resources over the five-year life of the Project.

Project design provides considerable flexibility by establishing a phasing-in process for involving the UDES's and DMUs. Depending upon Project progress and GOP and A.I.D. funding levels, this process can be modified, and Project inputs adjusted accordingly.

4. Project Output Targets and Evaluation

As stated previously, in preparation for implementing its major CS action program over the next five years, the MOH has prepared comprehensive national plans for CS interventions with specific goals, objectives, and targets to guide the implementation of its program. Through this Project, A.I.D. will assist the MOH to implement its program nationwide by providing support to specific activities contained in the national plans. In addition, the MOH will receive complementary financing from other donors for specific components of its program. The Project will also provide resources to IPSS to support its efforts to expand the provision of CS services through IPSS facilities nationwide. Finally, the Project will provide assistance, primarily to the MOH, to strengthen several support systems which are integral elements of a sustainable CS health delivery system.

USAID is the only donor providing assistance to the MOH to strengthen its support systems. Since these are long-term institutional development efforts over the life of the Project, the output targets for these sub-components are expressed in global rather than incremental terms and can be directly attributed to the USAID Project. Similarly, USAID is by far the largest donor in the FP area, with the United Nations Fund for Population Activities (UNFPA) providing complementary contraceptives, training, and support for service delivery. Thus, the output targets in FP can be directly attributed to this Project. The same applies to nutrition, where USAID, through this Project, AID/W centrally-funded Projects, and PL 480 Title II and Section 416 Programs, represents the major external source of assistance to Peru in nutrition. USAID also is the largest donor contributing to the immunizations program. However, given the multiplicity of donors involved in the immunizations program and the co-mingling of their inputs operationally with those of the MOH, it is impossible to precisely identify the direct impact of this Project on the output targets for that sub-component. While the GOP's coverage target in its national immunization plan is 100% of all children less than five years old fully vaccinated by 1992, the Project's target is set at 80% coverage each year for the five years of the Project. USAID direct support for control of ARI and DDC is relatively small when compared to its support to the other Project components and also to the MOH's contributions in these areas (which is about five times more in the case of DDC and ten times more for control of ARI). Nevertheless, these two programs will also benefit significantly from resources made available under the Project for the integrated training, supervision and health communications programs. Here again, the Project's output target for DDC is 80% of diarrheal episodes treated with ORT and appropriate dietary management each year for the five years of the Project while the MOH target is 100%. The same targets have been established for both the IPSS and MOH CS Programs over the five-year life of the Project.

As discussed in the Monitoring and Evaluation Plan, Project incremental and global service delivery output targets in specific CS programs will be further described and defined once the planned baseline survey is undertaken in January 1988. Baseline data will be collected for both the MOH and IPSS Programs. Also, during the first six months of the Project, with the assistance of a consultant, USAID will establish specific indicators of program effectiveness and impact for all Project interventions in both the MOH and IPSS, and develop a plan for data collection via annual random household surveys and detailed analyses of MOH and IPSS service statistics. In addition, Project support to the development of nationwide computerized HIS and VEA systems should facilitate the timely and systematic collection of accurate data for monitoring project performance targets and evaluating Project impact.

5. Operations Research

In contrast to what was proposed in the PID, relatively modest amounts of funding have been budgeted under the Project for research in

support of the nutrition and integrated health communications sub-components. Operations research activities in other areas, especially health care financing, may be supported with funds under the contingency line item of the budget. However, it is expected that assistance for priority operations research in support of this Project will come primarily from three sources: a) AID/W centrally-funded projects such as HEALTHCOM, PRICOR, REACH and Applied Diarrheal Disease Research (ADDR) and other regionally-funded projects; b) the proposed FY 88 USAID-financed private sector health project; and c) on-going USAID Grant projects with such organizations as Projects in Informatics, Health, Medicine and Agriculture (PRISMA) (a local PVO), Cayetano Heredia University of Peru (UPCH), and the Nutrition Research Institute (IIN).

F. Contributors to the Project Paper

See Annex II, Exhibit D.

II. BACKGROUND

A. Country Setting

1. Social and Economic Conditions

Peru is a poor country, with diverse physical, demographic, social and economic characteristics. Of the total Peruvian population of 20.727 million (1987), almost 6 million live in conditions of absolute poverty, and another 3.5 million are deemed relatively poor according to the International Bank for Reconstruction and Development (IBRD or World Bank) data. Peru's average gross national product (GNP) per capita in 1985 was $960. That average belies the intensity of impoverishment of major segments of the population. For example, the 1984 National Nutritional and Health Survey (ENNSA) data indicate that nearly one million households (more than five million persons) had median household incomes of less than $30 per month (equivalent to an annual per capita income under $63). These primarily are rural families depending on agriculture for their livelihood, and the majority of them live in the Peruvian highlands. The ENNSA survey also showed that one-quarter of all households in Peru and more than half of highland households have at least one malnourished child. This compares with 19% of coastal households and 13% of Lima households.

Peru is the fourth largest country in Latin America, and with its current estimated population of 20.727 million, is the fifth most populous country in the region. The population size is large compared to its very small productive land base. Formidable physical barriers (e.g., deserts, mountains, and humid tropics with difficult access), a relatively large unassimilated native population, a risk averse private sector, and a public sector with limited technical staff and bureaucratic inertia constitute barriers to the effective implementation of social and economic development initiatives.

For two decades, Peru has experienced a high incidence of destabilizing political turbulence and socio-economic crises. More recently, it has begun to suffer the effects of an active and growing terrorist movement and drug trafficking. During the military dictatorship of the 1970's, widespread economic and socio-political changes were executed, including a massive land reform. These changes modified the structure and ownership of productive resources, and greatly increased the role of the State in the economy. In 1980, Peru elected a democratic government that set out to reverse the Statist oriented policies of the 1970's. The world recession of the early 1980's and the resulting sharp drop in prices of Peru's major traditional exports, combined with unprecedented and widespread climatic distortions and inappropriate monetary and fiscal policies, precipitated uncontrolled inflation and rapid deterioration of the economy. The "Shining Path" terrorist movement and drug trafficking activities have created social havoc, destroyed peaceful and normal living conditions in many parts of the country, and contributed to the deteriorated economic situation.

The American Revolutionary Popular Alliance (APRA) Government, elected in mid-1985, was the first democratically elected government to succeed another in forty years. It immediately instituted a short-term "shock

treatment" to control inflation and stimulate demand by freezing prices, declaring sharp wage increases, reducing interest rates, restricting imports, controlling exchange rates and limiting external debt payments. This economic growth plan stimulated domestic demand and achieved an impressive supply response, while sharply reducing the inflation rate. An almost uprecedented 8.5% real gross domestic product (GDP) growth rate was achieved in 1986, inflation was cut in half from 163% in 1985 to 78% in 1986, and real wages rose 18% in 1986. At the same time, this growth strategy has had serious negative impacts on prospects for longer run economic stability, and wage and unemployment levels still place Peru among the poorest countries of the hemisphere. Net international reserves have fallen significantly, exports and capital inflows have declined, and the central government deficit rose from 2.3% of GDP in 1985 to 5.3% in 1986. Peru continues to seek a policy mix capable of generating and sustaining growth and development.

Development in Peru has been very uneven, with most jobs created on the coast. Lima is the center of 80% of industrial activities while the 4,000 campesino communities have seen little social or economic development. Seventy-five percent of all Peruvians account for only 23% of national consumption. Uncontrolled urban migration has transformed Peru from a large agricultural society in 1940 when 65% of the population was rural, into a society that is 68% urban in 1987. Nearly one-third (28%) of the total population is now concentrated in the Lima and Callao metropolitan area. The demographic, social and cultural dislocation associated with this migration has created a tremendous strain on the urban labor market, shelter and public services. Extreme inter- and intra-regional inequalities exist, especially with regard to the distribution of schools, public services such as potable water, sewage systems, health facilities and health personnel. Health status indices, especially for children, reflect these maldistributions. Recognition of these inequalities led the MOH to establish in 1978 a Primary Health Care (PHC) Policy to improve delivery of health services at the community level, reorienting services from a hospital-based system to a system focussed on health centers and posts, emphasizing preventive strategies and PHC services for the neediest and most rural populations.

2. General Health Status

The total population of Peru in mid-1987 was estimated to be 20.727 million, with a predominance (40%) of children under age 15. Life expectancy at birth was 61.4 years in 1987, which is low compared to other countries. From 1981-1987, the crude birth rate declined from 37.6 to 34.9 births per 1,000 inhabitants. The crude death rate also declined, from 11.1 in 1981 to 9.4 per 1,000 inhabitants in 1987, although exhibiting wide regional differences, ranging from 5.9 per 1,000 in Lima to 18 per 1,000 in Huancavelica. However, the relative declines in these rates have not been sufficient to cause more than a 0.1% reduction in the population growth rate, which in 1986 was 2.56%, among the highest in Latin America.

Two important general health status indicators are maternal and infant mortality rates. In Peru, the national maternal mortality rate is 30.3 deaths per 100,000 live births. This is extremely high compared to rates of approximately 3 per 100,000 in developed societies. Along with maternal malnutrition and inadequate perinatal care, high levels of fertility and inadequate spacing between births contribute to poor maternal, fetal and

infant health. Infant mortality in Peru, at 88.2 per 1000 live births in 1987, is the third highest in Latin America. Mothers have an average of four live births in urban areas and eight births in rural areas (Health Sector Analysis (ANSSA) 1986). Use of modern contraceptive methods, which greatly contributes to improved maternal and infant health through child-spacing and reduced child-bearing, is low at 23% of women of fertile age (WFA). The majority of contraceptive users reside in urban areas.

The 1984 ENNSA Survey showed that across all age groups, the most serious health problems facing Peruvians today are respiratory and intestinal illnesses. Acute respiratory infections (ARI) account for almost half of all morbidity in Peruvians over the age of one year, and for nearly a third of all child and adolescent deaths. Digestive tract diseases caused by poor hygiene practices, lack of potable water and other environmental factors resulting in diarrhea, are among the most common health problems affecting Peruvians in all age groups over five years. Accidents are the most frequent cause of mortality in adults. Diseases such as malaria and tuberculosis have high prevalence rates, especially in rural and marginal urban areas.

3. Health Services Availability and Utilization

Health care is provided by a diversity of public and private institutions. The private sector, which includes fee-for-service physicians and private hospitals, covers an estimated 11% of the total population. The Peruvian Institute of Social Security (IPSS) is charged with providing hospital and ambulatory care for an estimated 28% of the total population (employed workers and their dependents), though actual coverage is less. Another 3% of the population is covered by the Armed Forces and Police and other public and para-statal facilities. All other Peruvians (58%) are considered to be under the care of the MOH. However, the MOH is currently providing services to only 26% of the population, leaving 32% of the total Peruvian population without access to modern medical services.

The number of MOH health centers and health posts has significantly expanded over the past ten years to support the delivery of PHC services. However, lack of adequate coverage of PHC services continues to be a major problem. In addition, adequate hospital level care is still lacking in many isolated areas where there is no place to refer patients who come from the primary level health establishments. In urban centers, hospitals tend to be overused for non-acute ambulatory care, while, at the same time, there is a shortage of health centers and posts to provide PHC. The IPSS system has focussed, until recently, almost exclusively on curative care. It only recently initiated PHC interventions for some parts of the population it serves through some hospitals, polyclinics and medical and factory posts. Facilities tend to be overconcentrated in Lima and other urban areas, and are used principally by the urban working middle class.

Human resources are the most costly factor in the delivery of health care, accounting for about two-thirds of the recurrent costs currently spent in the Peruvian health sector. The proportion of both MOH and IPSS personnel assigned to outlying health centers and health posts, relative to the population, however, is less than adequate. The geographic distribution of physicians, nurses, paramedics and pharmacists in both health care systems disproportionately favors urban areas, especially Lima.

Use of health services is closely related to their accessibility and to such user factors as socio-economic status, age, education, and severity of illness. All population groups use both formal and informal systems. Health problems of the poor do not receive sufficient attention from the formal sector, and the poor are more likely to seek health services through informal sector practitioners -- pharmacists, traditional healers, traditional birth attendants (TBAs), volunteer community promoters, and others. Urban populations receive more health care from the formal sector than rural populations, and the coast more than the sierra and jungle. Those with more education are more likely to use formal services than those with less education. The wealthy are more likely than the poor to use both private clinics and public hospitals. The rural poor are the main users of public health centers and posts, while the urban poor, when they use health services, are more likely to use public hospitals or private physicians or the informal private sector rather than public health centers or posts. Self-care at home also plays an important role in the treatment of illness in all socio-economic groups.

4. Public Sector Institutional Setting

a. Ministry of Health (MOH)

i. MOH Service Population

The percentage of the total population designated to receive health care through the MOH is 58% or about 12,021,660 individuals. However, only 26% of the total population actually receives such services, leaving 32% of the total population, or about 6,632,640 low-income individuals, without access to modern medical care. The MOH 1985 National Health Policy identifies high risk groups - low-income children under five and pregnant women in marginal urban and rural areas - which are the same as those specified by A.I.D. child survival (CS) guidelines.

ii. MOH Health Services Network

In 1985, a new law was passed which united, for the first time, the MOH, the IPSS, the Armed Forces Health Care System, medical and nursing schools, and private hospitals and clinics into a comprehensive "Health Sector" headed by the Minister of Health. The "Health Sector" was designed to improve coordination and avoid duplication of effort in health services delivery.

Although the MOH has provided PHC services for the last 15 years, and has constructed significantly more health posts (from 994 in 1975 to a current 2,738) and health centers (from 347 in 1975 to a current 689), than new hospitals (from 100 in 1975 to a current 125), the MOH system still favors (in terms of resource allocations) curative more than preventive care. In addition to the 2,738 health posts, 689 health centers, and 125 hospitals, the health services network of the MOH is comprised of ten National Institutes, one each for health, cancer, rehabilitation, emergencies, child health, mental health, maternal and child health (MCH), neurology and opthamology, occupational health, and nutrition. Table 2 shows the current number of each of these facilities in each of the 25 Departments (including Callao) in the country.

TABLE 2. Geographic Distribution of MOH National Institutes, Hospitals, Health Centers and Health Posts, 1987

DEPARTMENT	NATIONAL INSTITUTES	HOSPITALS	HEALTH CENTERS	HEALTH POSTS
Amazonas	--	1	11	99
Ancash	--	11	38	159
Apurimac	--	2	8	57
Arequipa	--	5	31	124
Ayacucho	--	7	18	152
Cajamarca	--	4	27	114
Cuzco	--	4	32	150
Huancavelica	--	1	19	123
Huánuco	--	4	17	117
Ica	--	6	28	54
Junín	--	8	48	237
Lambayeque	--	3	30	30
La Libertad	--	7	34	121
Lima	10	28	140	241
Callao	--	2	17	12
Loreto	--	3	15	162
Madre de Dios	--	2	4	25
Moquegua	--	2	16	26
Pasco	--	3	12	117
Piura	--	3	42	94
Puno	--	8	34	142
San Martín	--	7	38	225
Tacna	--	1	16	39
Tumbes	--	1	6	25
Ucayali	--	2	8	93
TOTAL	10	125	689	2,738

Source: MOH unpublished data.

At the lowest level of the MOH system, the health posts are responsible for health promotion and preventive community-based health care activities, stressing community participation. There are two levels of health posts. Level two is the most simple type of post, staffed by a nurse, midwife, or health auxiliary as the local situation may require. Periodic visits are made to health posts by physicians and dentists. Level one health posts are staffed by a physician, nurse, and/or technician or health auxiliary, and receive periodic visits by dentists. Health posts rely on a local Advisory Committee comprised of community members, which advises the health post on priority health issues. Health posts serve a population within a 10 km. radius, in general, approximately 3,000 in rural areas and 5,000 in urban areas. Health posts refer patients to health centers.

Health centers, which are located in the district or provincial capitals, encourage community participation and offer both preventive and curative health care in the areas of general medicine, minor surgery, pediatrics, ob-gyn, dental care and water sanitation. Health centers are also advised by a local Advisory Committee, consisting of community members with the same functions as the health post level Advisory Committee. In addition, health centers have a Technical Committee to coordinate development of health programs, resolve technical questions arising from patient consultations and make technical recommendations. Health centers also have a Work Team, consisting of professional staff members and administrators, which interprets the technical norms of the MOH and insures compliance, coordinates all community health activites, and promotes community participation. Health centers are usually staffed with nurses, health auxiliaries, technicians, and/or a physician where available. In larger urban areas, some are staffed by physicians, nurses, midwives, dentists, nutritionists or auxiliary nutritionists, social workers or assistant social workers, technicians or nurse auxiliaries, sanitation technicians, lab technicians, x-ray technicians, statistical technicians or auxiliaries, pharmaceutical auxiliaries, administrators, service personnel, a guard and chauffer. There are also two levels of health centers; level two does not have beds while level one health centers may have six to eight beds. Health centers generally serve the population within a 10 km. radius and the referrals from the health posts in its jurisdiction. The size of the population covered is approximately 35,000. Health centers refer patients to hospitals.

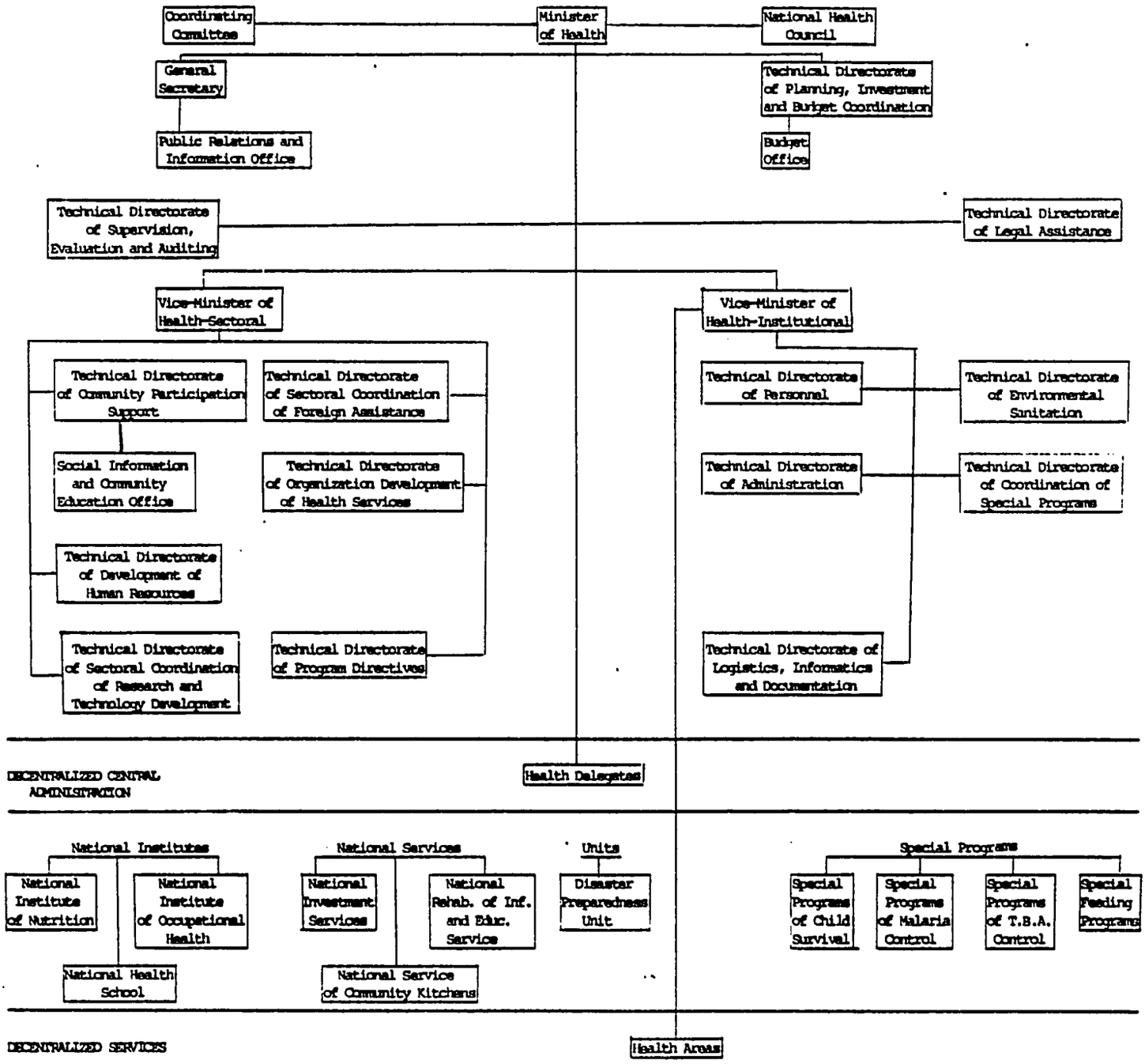
Hospitals exist at the provincial, departmental and national level and develop, with active community participation, preventive, curative and rehabilitative services, with emphasis on curative care. Hospitals have seven departments: medicine, surgery, ob-gyn, pediatrics, dentistry, emergency care and outpatient services, and also refer patients to the National Institutes.

iii. MOH Staffing and Organizational Structure

At the central level in Lima, two Vice-Ministers report directly to the Minister of Health, and various directorates/offices are the responsibility of one or the other. The Institutional Vice-Minister is responsible for: Personnel; Administration; Logistics; Information Systems; Environmental Sanitation; and, "Special Programs",[1/] which includes all CS activities. The directorates under the Sectoral Vice-Minister of

1/ As a result of a recent reorganization, the Directorate of Special Programs now falls under the Sectoral Vice-Minister.

FIGURE 1. Current Organization of the Central MOH



Health include: Human Resources Development; Research and Technology Development; External (Foreign) Cooperation; Programs, Norms and Services; and Community Participation Support. Figure 1 shows the most recent official organization of the central MOH.

The newest reorganization of the MOH, in effect since mid-1986, was designed to implement the Government of Peru's (GOP) decentralization policy and gives more administrative autonomy to the 28 Health Departments (UDES's).1/ In this structure, the Minister assumes the role of "rector" in the health system, and each UDES Director becomes a mini-Minister within his/her area of influence.

In a Ministerial Resolution dated March 20, 1987, the UDES structure and functions were defined, with each UDES Director as the legal representative of the Minister of Health. The UDES's rely administratively on the Vice-Minister of Administration and technically on the Vice-Minister of Health. Each UDES, in general, parallels the MOH central organizational structure. Each UDES has a Director who is in charge of managing the UDES. He/she has two other Directors under his/her direct authority: a Director of Administrative Support and a Director of Technical Support. Each administrative and technical area or office in the UDES has a Chief or Director, but in some UDES, one Director may be responsible for more than one administrative and technical area or office. The UDES management team consists of: an Advisory Commission and Technical Committee, both permanent consulting groups to the UDES management; the Office of Supervision, Evaluation and Audit; the Office of Support for Community Participation; the Office for Technical Support; and the Office of Administrative Support.

The Advisory Commission is composed of: 1) the UDES Director; 2) two community representatives; 3) four representatives of the UDES workers; 4) one representative of the IPSS; 5) one representative of the Armed Forces and Police; and 6) one representative of the Welfare Society of the Departmental capital. It formulates Department health policies and strategies, taking into account: 1) the needs and health services demands of the community; 2) available resources; and 3) the National Health Policy and the Directives issued by the MOH central level. The Technical Committee is composed of: 1) the UDES Director; 2) the Directors of the Technical and Administrative Support Offices; 3) all Directors of the support hospitals of the Department; and 4) four representatives of UDES professionals. It is responsible for formulating and evaluating the action plans for the UDES.

The General Office for Technical Support is responsible for training, planning, investment and budgets, programs and norms, and health services. The Executive Office of Administrative Support is responsible for finance, personnel and logistics. The UDES is a budgetary unit (UP) and maintains the role of "rector" for all the support hospitals, health centers and health posts in the Department, which are considered an integral part of the UDES. Some support hospitals and health centers are also UPs, with all the rest considered as budgetary executing entities (EEP). Funds are disbursed directly from the Ministry of Economy and Finance (MEF) to the UPs, bypassing the central MOH. The UP then disburses funds to the EEPs. Generated income from health establishments, previously returned to a higher

1/ Four (4) in Lima and 1 in each of the 24 remaining Departments.

level for reprogramming, is now used in the administration of that particular EEP establishment.

The UDES's are mandated to: 1) adapt the National Health Policy to their circumstances and implement it; 2) promote community participation in the health care process; 3) develop annual operational plans and budgets; 4) manage health programs and coordinate with other departmental development activities as appropriate; 5) organize and implement the Health Services System efficiently and with efficacy in terms of services, administrative systems, and personnel; 6) develop appropriate health research plans and programs; 7) strengthen and utilize the Health Information System (HIS); 8) introduce and utilize supervision and evaluation processes; and 9) perform other functions as assigned by the Minister of Health and/or the two Vice-Ministers.

Table 3 shows the distribution of MOH personnel by type and Department. Of the total 65,000 MOH employees, 8% are physicians, 8% are nurses, 4% are other professionals, 1% are technicians, 6% are contracted staff, (breakdown not available) and the remaining 73% include administrative support and management personnel, financial and logistics personnel, auxiliary nurses, and sanitarians.

iv. MOH Financial Status

The MOH budget for 1986 was 6% of the total national budget, up from 4% in 1985. It continued to increase in 1987 to 7.2%. Of the total budget, approximately 80% is spent on salaries and pensions, and the remaining 20% is used for other recurrent costs and supplies. The MOH relies heavily on international donors for much of its supplies, equipment and some recurrent expenses (such as gas and other transportation costs for supervision.)

b. Peruvian Institute of Social Security (IPSS)

i. Introduction

The orientation to date of the IPSS has been largely recuperative and curative, not preventive nor promotional PHC. Only in the past few years, with support from USAID, has IPSS begun to include some PHC services, and it has done so in a small way by offering CS services (family planning (FP) and immunizations) in its hospitals and polyclinics. Other CS activities, namely diarrhea disease control (DDC), nutrition, and control of acute respiratory infections (ARI), were initiated about a year ago with the creation of the Preventive/Promotional Services Directorate, which is responsible for all CS interventions (except FP) and PHC services in IPSS. As with FP and immunizations, services and coverage of DDC, nutrition and control of ARI are very limited.

ii. IPSS Service Population

The IPSS is legally mandated to cover all public and private sector salaried workers as well as members of cooperatives and

TABLE 3. MOH Personnel by Health Department (UDES) and Position - June 1987

U.D.E.S.	PROFESSIONAL STAFF											TECHNICAL STAFF					ADMINISTRATIVE STAFF		CONTRACT STAFF	
	PHYSICIANS	DENTISTS	NURSES	MIDWIVES	SOCIAL WORKERS	PHARMACISTS	DIETITIANS	PSYCHOLOGISTS	THERAPISTS	SANITARY ENGINEERS	VETERINARIANS	PHARMACISTS ASSTS.	BIOLOGISTS	CHEMISTS	MEDICAL TECHNOLOGISTS	HEALTH SERVICES ASSTS.	ADM. SUPPORT STAFF a/	MANAGEMENT STAFF	CONTRACTED STAFF	TOTAL
ICA	149	36	147	46	3	21	5	-	-	-	3	-	-	-	1	-	1364	8	-	1783
JUNIN	136	31	346	77	24	13	9	3	-	-	-	-	3	-	5	-	2038	23	-	2708
LA LIBERTAD	250	27	244	21	5	11	35	1	-	-	2	-	5	-	34	-	1956	14	-	2605
LAMBAYEQUE	114	24	99	9	10	1	11	-	-	-	1	-	5	-	-	-	1096	16	-	1386
LORETO	63	17	43	8	4	2	4	2	-	-	-	-	1	-	2	-	995	12	-	1153
MADRE DE DIOS	11	3	22	2	2	1	1	-	-	-	-	-	1	-	2	-	181	10	-	236
MOQUEGUA	37	12	73	17	3	2	3	-	-	-	-	-	1	-	-	-	414	10	-	572
PASCO	17	4	25	8	2	1	-	-	-	-	-	-	-	-	-	-	298	10	-	365
PUNO	104	28	249	38	30	-	6	1	-	-	5	-	4	-	-	-	1460	17	-	1941
SAN MARTIN	76	18	84	11	2	5	6	1	-	-	2	-	1	-	12	-	1586	12	-	1816
LIMA c/	2527	309	2005	543	234	162	85	94	3	4	37	1	67	2	250	5	22356	317	-	29001
AMAZONAS	12	5	21	1	-	-	4	-	-	-	-	-	-	-	-	-	350	8	-	401
ANCASH	162	30	159	38	25	11	17	4	-	-	1	-	3	-	16	-	1825	21	-	2312
APURIMAC	21	5	60	18	2	2	-	-	-	-	1	-	-	-	-	-	395	11	-	515
AREQUIPA	245	31	375	74	23	4	2	-	-	1	1	-	1	1	1	-	1648	17	-	2424
AYACUCHO	37	9	75	50	11	4	5	1	-	-	-	-	5	-	1	-	783	12	-	993
CAJAMARCA	54	11	113	8	4	3	9	-	-	-	-	-	-	-	6	-	918	13	-	1139
CALLAO	304	31	221	49	24	8	10	13	-	-	1	-	2	-	41	-	1850	13	-	2567
CUZCO	130	18	206	50	8	3	5	-	-	-	-	-	4	-	-	-	1312	19	-	1755
HUANCAVELICA	15	8	35	13	4	2	1	-	-	-	-	-	-	-	-	-	437	8	-	523
HUANUCO	55	14	90	26	4	3	6	-	-	-	1	-	1	-	3	-	825	11	-	1039
TACNA	63	14	163	21	9	1	1	1	-	-	-	-	-	-	-	-	655	11	-	939
TUMBES	24	4	24	6	1	1	2	-	-	-	-	-	-	-	2	-	210	8	-	282
UCAYALI	34	4	42	13	-	3	2	-	-	-	-	-	1	-	-	-	548	11	-	658
PIURA	133	21	149	34	2	3	6	4	-	-	1	-	2	-	8	-	1450	13	-	1826
TOTAL NUMBER	4773	714	5070	1181	436	267	234	125	3	5	56	1	107	3	384	5	46950	625	4000	64939
%	8.0	1.0	8.0	2.0	1.0	b/	b/	b/	b/	b/	b/	b/	b/	b/	b/	b/	72.0	1.0	6	100
%	20 %											1.0 %					73 %		6 %	100

Source: Dirección Técnica de Informática y Documentación (DTID), MOH, 1987.

a/ Includes auxiliary nurses, sanitary technicians, and logistics, financial and other support personnel.

b/ Number is too small to be a significant percentage.

c/ Lima has 4 UDES.

para-statal enterprises. The self-employed may join voluntarily. In 1984, a law was passed to expand dependent coverage to include not only maternity care and children under one, but also some services for children age 1 to 14. More recently, IPSS has been mandated to extend coverage to farmers' groups, mothers clubs, rural co-operatives, housewives and children age 1 to 18. The IPSS target population for CS services now includes 720,000 WFA, 87,000 infants under age one, and 450,000 children under age five. Table 4 illustrates that the percentage of the total population covered by IPSS nearly doubled from 1975 to 1987, increasing from 14.7% to 28.3%. The actual number of persons covered increased by 263%, from 2,232,000 to nearly 6 million. Since 1985 alone, coverage supposedly increased by 62%, which is probably a somewhat high estimate. Due to inadequate and faulty records and statistics, and the lack of access to services due to non-possession of a valid ID card, actual coverage is probably lower. In fact, in 1985, IPSS estimated actual coverage at 15.3% of the total population, or about 83% of its target population of 3,661,000 individuals in 1985 or 3,013,000 individuals.

Such rapid expansion of the system carries with it a host of problems. A major problem in the IPSS system is unequal coverage. The IPSS covers primarily middle income urban workers in the relatively more developed Departments of Peru, while the rural population, self-employed, and children in the urban marginal areas are largely excluded. Actual coverage is still focussed on the productive age group and pensioners, with dependent children age 1 to 14 receiving less actual coverage.despite the 1984 law. Geographic differences in coverage by the IPSS are also significant. Table 5 illustrates the geographic differences by Department and by IPSS Region, differences which remained unchanged from 1961 to 1981. In 1987, Lima/Callao had the highest coverage rate (45%), followed by Ica (41%). In general, coverage is highest in the urbanized coastal area and lowest in the less accessible highlands (with only 5% to 6% coverage). Table 6 further illustrates the disproportionate IPSS health care coverage in Lima-Callao compared to the rest of the country. An inequity also exists between the "formal" sector of the economy (consisting mostly of government agencies and other state-owned enterprises) and the rural and informal sectors which comprise most of Peru's working population. The formal sector accounts for 40% of the labor force, but has 90% coverage by IPSS. Service to the rural and informal sectors is much less; the self-employed and unemployed are nearly completely excluded from coverage.

iii. IPSS Staffing and Organizational Structure

As shown in Table 7, the IPSS medical care program has approximately 20,000 employees, 13% of whom are physicians, 12% are nurses, 5.5% are other professionals, 6.5% are technicians, 35% are health auxiliaries, and 28% are administrative support personnel. The distribution of IPSS personnel is disproportionate to the national population, with 64% of the personnel stationed in Lima and 36% scattered around the rest of the country. However, it is consistent with the concentration of IPSS services in Lima as shown in Table 6.

TABLE 4. Estimated Population Coverage by the IPSS Medical Care Program, 1975, 1980-1985, and 1987

Year	IPSS Insured Population a/ (000s)	Total National Population (000s)	IPSS Insured As % of Total National Population
1975	2,232	15,161	14.7
1980	2,876	17,295	16.6
1981	2,995	17,755	16.9
1982	3,113	18,226	17.1
1983	3,380	18,707	18.1
1984	3,517	19,198	18.3
1985	3,661	19,698	18.6
1987	5,876	20,727	28.3

Source: "Coverage and Costs of Medical Care Under Social Security in Peru," ANSSA, July 1986, p. 28, and IPSS unpublished data.

a/ Includes both employees and dependents.

TABLE 5. Population Coverage by the IPSS Medical Care Program by IPSS Region and Department, 1987

Region a/	1987 Total Population	IPSS Insured Population	IPSS Insured As % of Total Population of Region
1. North Region	3,963,514	788,700	19.9
Tumbes	131,700	33,390	25.4
Piura	1,374,200	299,260	21.8
Lambayeque	854,600	267,090	31.3
Cajamarca	1,200,000	90,030	7.5
Amazonas	311,800	31,220	10.0
San Martin	91,214	67,710	20.2
2. North-Central Region	2,087,500	520,170	24.9
La Libertad	1,150,900	303,860	26.4
Ancash	936,600	216,310	23.1
3. Lima-Region	6,661,800	3,020,220	45.3
Lima	6,116,700	2,772,160	45.3
Callao	545,100	248,060	45.5
4. South-Central Region	508,200	206,930	40.7
Ica	508,200	206,930	40.7
5. South Region	1,195,900	416,740	34.8
Arequipa	884,200	312,740	35.4
Moquegua	123,400	37,940	30.4
Tacna	188,300	66,060	35.1
6. Central Region	2,798,300	472,860	16.9
Huánuco	571,600	68,920	12.1
Pasco	264,800	70,480	26.6
Junín	1,037,500	230,540	22.2
Huancavelica	371,400	39,320	10.6
Ayacucho	553,000	63,600	11.5
7. East Region	817,600	163,880	20.0
Loreto	605,900	114,030	18.8
Ucayali	211,700	49,850	23.5
8. South East Region	1,386,500	176,230	12.7
Apurimac	361,400	34,280	9.5
Cuzco	980,600	135,390	13.8
Madre de Dios	44,500	6,560	14.7
9. Highland Region	1,984,500	110,470	5.6
Puno	1,984,500	110,470	5.6
T O T A L	20,727,100	5,876,200	28.3

Source: IPSS unpublished data.

a/ The regional breakdown differs from that in Table 7 since different sources were used to obtain the data.

TABLE 6. IPSS Health Services in Lima/Callao, 1983

Lima	% of Total in Peru
Total Population (Lima-Callao)	31.0
IPSS Insured (Lima-Callao)	57.8
Health Expenditures (Region)	63.5
Hospital Beds	56.0
Clinics	55.0
Doctors	70.0
Nurses and Technicians	68-75
Out-Patient Visits	60.6
Surgical Interventions	57.0
Hospital Expenditures	56.0
Attended Births	62.2
Vaccinations	58.0
Laboratory Tests	67.0
Dental Care	52.0

Source: "Coverage and Costs of Medical Care Under Social Security in Peru," ANSSA, July 1986, p. 36.

The IPSS, as of two years ago, became a part of the now legally mandated "Health Sector" headed by the Minister of Health. There are three overall Directorates in the IPSS system: Directorate of Pensions; Directorate of Social Programs; and National Directorate of Health. Only the latter is involved with the social security health system, and it will be responsible for the implementation of IPSS activities under this Project. The heads of each of the three Directorates report to the President of IPSS, who in turn reports to the Minister of Health. The National FP Program is a separate office in IPSS, and the Director reports directly to the President of IPSS.

The National Directorate of Health consists of the following entities: 1) Planning and Programs Unit, which is responsible for developing nationwide operational plans on the basis of which the various health facilities receive their budget allocations; 2) Preventive/Promotional Services Directorate, which is responsible for all CS interventions (except FP) and PHC services; 3) Drug Control Unit; 4) General Health Services Unit; and 5) Social Security Contributions Unit.

Because of the fiscal autonomy that exists in the IPSS, the Planning and Programs Unit has direct access to the MEF. This Unit designs the overall annual plans and budgets and has autonomy within the IPSS for internal changes at any time, including budget line item transfers. The Planning and Programs Unit allocates funds to the Departmental Managerial Units (DMUs) in the IPSS system. The DMUs then allocate funds to the national, regional and zonal hospitals, polyclinics and medical and factory posts throughout Peru. Once the DMUs receive their budget allocations, they become autonomous units and can disburse funds without consulting with the central office in Lima. The IPSS is subdivided into 32 Managerial Units, 8 in

TABLE 7. IPSS Human Resources, 1987

POSITIONS	LIMA	REGIONS a/ NORTH & MID NORTH	SOUTH & MID SOUTH	CENTRAL	EAST	SOUTH EAST	TOTAL	%
A. PROFESSIONALS								
1.a. Physician Directors	42	20	11	11	4	--	88	.40
1.b. Physician Assistants	1619	455	293	116	19	29	2531	12.70
SUB-TOTAL (PHYSICIANS)	1661	475	304	127	23	29	2619	13.10
2. Dentists	117	43	33	18	7	4	222	1.12
3. Nurses	1638	427	244	101	1	11	2422	12.21
4. Nurse Mid-wives	255	38	22	6	-	-	321	1.62
5. Social Workers	78	23	11	7	3	-	122	.61
6. Pharmacists	74	19	8	9	1	-	111	.56
7. Dieticians	117	39	9	11	-	-	176	.88
8. Psychologists	12	02	1	-	-	-	15	.07
9. Accountants	33	18	8	9	1	1	70	.36
10. Engineers	4	2	-	-	-	-	6	.03
11. Others	29	5	6	3	-	-	43	.21
SUB-TOTAL (OTHER PROFESSIONALS)	2357	616	342	164	13	16	3508	17.67
TOTAL PROFESSIONALS	4018	1091	646	291	36	45	6127	30.77
B. TECHNICIANS								
1. Tech.Laboratory	186	41	11	9	2	3	252	1.27
2. Tech.X-Ray	112	17	7	5	-	3	144	.72
3. Tech.Rehabilitation	96	30	4	10	-	-	140	.70
4. Tech.Statistics	17	6	4	3	-	-	30	.15
5. Tech.Maintenance	160	75	70	38	4	11	358	1.75
6. Others	321	19	10	9	2	-	361	1.81
TOTAL TECHNICIANS	892	188	106	74	8	17	1285	6.45
C. HEALTH AUXILIARIES								
1. Nurses Aide	2469	775	398	141	16	57	3856	19.37
2. Laboratory Assistant	141	54	35	14	4	-	248	1.24
3. X-Ray Assistant	69	20	27	4	-	-	120	.60
4. Statistics Assistant	43	7	6	2	1	-	59	.30
5. Pharmacy Assistant	217	62	45	12	10	1	347	1.74
6. Rehabilitation Assistant	47	9	6	2	-	-	64	.33
7. Others	1468	410	191	117	39	3	2228	11.18
TOTAL AUXILIARIES	4454	1337	708	292	70	61	6922	34.76
D. ADMINISTRATIVE SUPPORT								
1. Accounting	383	93	57	51	3	-	587	2.95
2. Supplies	231	93	45	37	4	-	410	2.05
3. Personnel	175	38	20	31	1	-	265	1.33
4. Maintenance	1791	436	312	193	8	18	2758.	13.85
5. Others	1002	227	208	91	16	14	1558	7.83
TOTAL ADM. SUPPORT	3582	887	642	403	32	32	5578	28.01
TOTAL	12946	3503	2102	1060	146	155	19912	100.00

Source: IPSS unpublished data.

a/ The regional breakdown differs from that in Tables 5 and 9 since different sources were used to obtain the data.

the greater Lima Metropolitan area, known as Zonal Managerial Units, and one in each of the remaining 24 Departments, known as Departmental Managerial Units. Each one is in charge of all health facilities in its area.

The IPSS delivers it services via a six-tiered system as shown in Table 8. It has a total of 2 national, 9 regional and 15 zonal hospitals, 48 polyclinics, 212 medical posts, and 100 factory posts. The most specialized care is provided at the national hospital level, each of which has a minimum of 800 beds as well as the most advanced and specialized equipment in the IPSS system. Less specialized hospitals include the regional hospitals with at least 150 beds, and zonal hospitals with at least 80 beds. Table 9 illustrates the geographic location of the IPSS health facilities.

Outpatient care is provided in a number of different facilities, including polyclinics, medical posts, and factory posts. Polyclinics offer a complete range of specialty services on an outpatient basis in urban areas. Medical posts are much smaller facilities which offer general medical care. The factory post offers first aid as well as follow-up care at the factory site.

Health services are available to the IPSS population at any Social Security facility, or at any facility contracted by the IPSS (MOH, Air Force, mining companies and private clinics). If the IPSS beneficiary wishes to visit his own private physician or receive private health care services in a non-contracted facility, the IPSS will reimburse a portion of the cost.

iv. IPSS Financial Status

Only a small part (7%) of the IPSS budget comes from the GOP (as a direct outlay for budget support as opposed to contributions it makes as an employer), with the major part (93% from 1975-84) derived from contributions of the insured and the companies for which the insured work. Individual contributions, from wage-earning and salaried employees, are 3% with another 6% paid by the employer. Nine percent of earned income is paid into the system by the self-employed and other optionally insured. Pensioners pay 4% of their pensions, and the pension fund pays 5%. Table 10 illustrates the IPSS insured population by their contributor or dependent status.

Of the total IPSS budget, 60% of the funds are allocated to the National Directorate of Health. According to the ANSSA, 50.3% of the funds allocated to the Directorate was used to pay salaries in 1985. This percentage may be somewhat higher now, but it is still much lower than the approximately 80% paid by the MOH for salaries. Table 11 shows that the next largest expenditure was for medical supplies at 24.3% of the 1985 budget.

The overall financial status of the IPSS is negatively affected by the large debt owed to it by employers in both the GOP and the private sector. At the end of 1985, the two sectors owed the IPSS a total of $130 million, two-thirds ($83.8 million) of which was owed by the GOP. Until 1983, the GOP had consistently failed to pay its social security contributions as an employer and also neglected to transfer the IPSS contributions paid by its employees. In 1983, the GOP attempted to redress

TABLE 8. Organization of the IPSS Health Care Service System

Level and Description	No.
I. National Hospital	2
-800 + beds -Specialization of Services -Diagnosis and Treatment -Hospitalization and Outpatient Care -Ancillary Services -Preventive and Promotional -Family Planning	
II. Regional Hospital	9
-150 + beds -Less Specialized Services Than at National Hospital -Diagnosis and Treatment -Hospitalization and Outpatient Care -Ancillary Services -Preventive and Promotional	
III. Zonal Hospital	15
-80 + beds -Same Services as Regional Hospital	
IV. Polyclinic	48
-Outpatient Services -Basic Ancillary Services -10 or More Physicians -All Specialities Available	
V. Medical Post	212
-Outpatient Services -Minimal Ancillary Services -Nurses, Auxiliaries -General Practitioner Only (where available) -Referral	
VI. Factory Post	100
-First Aid -Follow-up and Referral -Nurse and Auxiliary -Physician on Call	

Source: IPSS unpublished reports.

TABLE 9. Geographical Location and Coverage of IPSS Health Facilities, 1987

Regions and Zones in IPSS	Hospitals	Polyclinics	Medical Posts	Factory Posts a/
Totals	26	48	212	100
1. North Region	5	16	47	
Tumbes	--	1	3	
Piura	3	2	8	
Lambayeque	2	3	12	
Cajamarca	--	4	12	
Amazonas	--	3	4	
San Martín	--	3	8	
2. North Central Region	3	6	18	
La Libertad	2	3	11	
Ancash	1	3	7	
3. Lima Region	4	8	24	
Lima Metropolitan South	--	3	--	
Lima Metropolitan North	--	2	--	
Lima Metropolitan Central	--	1	--	
Lima Metropolitan West	--	1	--	
Lime Metropolitan East	--	1	--	
Lima North	1	--	17	
Lima South	1	--	3	
Lima Central	1	--	3	
Callao	1	--	1	
4. South Central Region	3	1	24	
Ica	3	1	24	
5. South Region	1	5	31	
Arequipa	1	5	26	
Moquegua	--	--	4	
Tacna	--	--	1	
6. Central Region	5	6	37	
Huánuco	1	2	10	
Pasco	2	--	8	
Junín	2	3	13	
Huancavelica	--	--	3	
Ayacucho	--	1	3	
7. East Region	1	2	11	
Loreto	1	1	10	
Ucayali	--	1	1	
8. Southeast Region	2	4	11	
Apurimac	--	2	3	
Cuzco	2	1	4	
Madre de Dios	--	1	4	
9. Highland Region	2	--	9	
Puno	2	--	9	

Source: IPSS unpublished reports.

a/ Information about location of factory posts not available.

TABLE 10. National Population Covered by Law No. 22482, IPSS; 1987

Type of Beneficiary	No.	%
1. Contributors to IPSS	2,950,000	50.2
a. Actively Employed	2,579,170	43.9
b. Pensionists	240,000	4.1
c. Self-Employed	131,830	2.2
2. Dependents	2,926,200	49.8
a. Spouses	820,000	12.0
i. WFA	720,000	10.3
ii. Other	100,000	1.7
b. Dependents	2,106,200	35.8
i. Children Between 5-18	1,656,200	28.1
ii. Children Under 5	450,000	7.7
T O T A L	5,876,200	100.0

Source: "Coverage and Costs of Medical Care Under Social Security in Peru," ANSSA, July 1986.

TABLE 11. Percent Distribution of IPSS Medical Care Expenditures by Budgetary Item: 1981-1985

Budget Item	1981	1982	1983	1984	1985
			(Percent)		
Salaries and Fees	39.5	38.5	43.5	48.2	50.3
Medical Supplies	20.0	20.0	21.8	20.9	24.3
Contracted and Free-Choice Services	20.7	21.9	18.1	18.0	15.0
Monetary Benefits	17.1	18.0	16.0	12.8	10.4
Capital Goods	2.7	1.6	0.6	0.1	0.0
Total	100.0	100.0	100.0	100.0	100.0

Source: "Coverage and Costs of Medical Care Under Social Security in Peru," ANSSA, July 1986, p. 42.

the situation for the first time by paying 80% of its annual contribution as employer, including wage deductions for the insured, and has continued partial payments since. The $130 million debt is a low estimate; due to inflation, it would be much higher if calculated at constant prices. Additionally, the real cost of the GOP debt is even higher ($194 million) (see Table 12) if the impact of the Peruvian currency devaluation is considered. Despite the GOP's failure to pay its full share to the IPSS, the IPSS has continued to provide health services to the insured in the public sector, aggravating the deficit of its medical care program and in effect, subsidizing public sector cost coverage with private sector contributions.

Similarly, private employers have evaded social security contributions in the 1980s. It is estimated that in 1985, 65% of all employers completely or partially evaded paying the legal full amount, resulting in 35% to 40% of the mandated contributions uncollected. The estimated debt ($46.2 million) (see Table 12) is actually higher, as this figure reflects only known evaders. From 1975 to 1983, renegotiated payment arrangements were granted six times to those in default, but were ineffectual due to lack of control. In 1984, IPSS initiated stronger measures, including denial of services to workers of employers in default. However, the IPSS has considerably improved its ability to collect payments from employers through a new computerized system initiated approximately one year ago in Lima and Cuzco. Plans are to expand the system nationwide.

Another factor which has contributed to IPSS's financial difficulties is that its investments have resulted in a negative real rate of return until 1984, and only changed to a positive rate of return in mid-1985. Its actual reserve fund shrunk from $153 million in 1975 to $.05 million in 1984, with only a slight increase to $1.3 million in 1985. (One factor contributing to the reserve fund reduction occurred in 1982-83 when the GOP utilized the reserves from all public sector entities to help pay for the serious and costly damages caused by the major El Niño disaster.)

Despite these problems, and although not entirely reliable, IPSS records do show that it generated an annual surplus from 1975 to 1984. It was a surplus, however, produced by the pension fund. The medical care fund shows a deficit from 1977 to 1984. Deficits in the medical care fund have always been covered by borrowing from the pension and disability programs.

c. MOH and IPSS Integration

Functional integration of the health services of the MOH and the IPSS was mandated in the Integral Health Sector Law, Supreme Decree Number 22, of July 28, 1986, which specifies that the integration is to be carried out through joint utilization of health resources--infrastructure and personnel. The health facilities involved are to remain the property of the institutions which currently own them. However, management, operation and supervision of all hospitals will be carried out by the IPSS, and all health and factory posts, health and medical centers, and polyclinics will be the responsibility of the MOH. The integration process, much of which is left to the discretion of the UDES's, has already begun in some Departments, with transferral of selected MOH hospitals to IPSS management. During the transition phase (which could take several months or even years to complete), the IPSS will continue to operate its peripheral health facilities.

TABLE 12. Public and Private Sector Debt to IPSS and Its Devaluation: 1969 - 1985 a/

Sector	Period	Debt in 1985 Dollars (Millions)	Devaluation Loss in Current Dollars (Millions)
I. Public Sector			
A. Central Government	1969-79 b/	1.4	58.3
	1980-82	2.4	28.2
	1983	25.4	35.6
	1985	28.7	0
Sub-Total	1969-85	67.7	164.3
B. Public Enterprises	1969-84	10.4	14.6
C. Local Governments b/	1969-84	5.3	7.4
D. Parastatal Enterprises	1975-81	0.4	7.7
Sub-Total		83.8	194.0
II. Private Sector		46.2	unknown
TOTAL		130.0	194.0

Source: "Coverage and Costs of Medical Care Under Social Security in Peru," ANSSA, July 1986, p. 45.

a/ Including delinquency.

b/ Metropolitan Lima only.

d. Summary

Table 13 provides a summary of the total employees, target populations, and facilities of the MOH, the IPSS, Armed Forces, and the private sector as of 1987.

B. Status of Child Health in Peru

1. Child Mortality and Morbidity

Child health in Peru ranks among the worst in Latin America. Although actual vital events are underestimated, available data reveal that 44% of all deaths in Peru occur in children under five. Of all under-five deaths, 61% occur before the age of one. Peru's infant mortality rate (IMR) in 1987 was 88.2 per 1,000 live births, the third highest in Latin America. (The average IMR for all of Latin America is 63 per 1,000.) Extreme regional differences exist, with estimates of more than 200 per 1,000 in some rural micro-regions. In contrast, urban rates are significantly lower, e.g., 59.3 per 1,000 in Callao and 61.4 in Lima.

Of all infant deaths, 40% occur in the first month of life and 75% in the first six months. Prematurity and neonatal tetanus are major factors. ENNSA data indicate that in 1984, only 52% of births occurred in health facilities nationwide, and as few as 15% in rural areas. Only 39% of rural women, but 81% of urban women, received prenatal care. Low birth weight rates are estimated to be high in rural areas. Young infants are susceptible to respiratory and gastrointestinal infections resulting from poor living conditions and improper feeding practices, which initiate the vicious cycle of infection and malnutrition. Poor access to health services increases the risk of death for critically ill infants. The low level of family planning use also contributes to low infant and maternal health levels. The 1977-79 World Fertility Survey showed that infants born four years apart had twice the likelihood of survival as those infants born each year with no spacing. And, families with fewer children tend to have better health status.

Respiratory illness is the leading cause of morbidity in Peruvian children under one year. Dehydration due to diarrhea is the greatest cause of morbidity in children age two to five years. Estimates of episodes of diarrhea per year per child under one year of age range from 3 to 11 and average 8 to 11 episodes per year in some areas. The ENNSA Study revealed that 35-40% of children aged 6 to 18 months had reported symptoms of diarrhea in the two-week recall period, with a higher prevalence in rural and marginal urban areas. Half of those with reported diarrhea also had reported respiratory symptoms (Altobelli, 1987). In addition, Peru has high incidence rates of five major immuno-preventable illnesses: polio, tetanus, diphtheria, pertussis, and measles, as well as tuberculosis for which a less effective vaccine is available.

2. Nutritional Status of Children

The 1984 ENNSA Study reported that 37.8% of the 0 to 5 year old children surveyed (15,314) were chronically malnourished (below two standard deviations of the mean normal height for age). More than 60% of children under six and over 70% of four and five year olds living in the rural

TABLE 13. Summary of Employees, Target Populations and Facilities by Institution in Peru, 1987

	PUBLIC SECTOR			PRIVATE SECTOR	
	IPSS	MOH	Armed Forces		Total
1. No. of Employees	20,000	65,000	a/	a/	--
2. Target Population					
Number b/	5,876,200	12,021,660	621,810	2,279,970	20,727,000
%	28%	58%	3%	11%	100%
3. Facilities					
National Institutes	--	10	--	--	10
Hospitals	26	125	14	186	351
Polyclinics	48	--	--	--	48
Health Centers	--	689	84	55	828
Health Posts	212 c/	2,738	52	128	3,130
Factory Posts	100		--	--	100

Sources: "Health Care Facilities in Peru," ANSSA, July 1986, p. 28 and MOH unpublished data.

a/ Data not available.

b/ Numbers do not add exactly to the total due to different sources of information.

c/ Called "Medical Posts" in IPSS system.

sierra were chronically malnourished, while over 50% of children under six and nearly 70% of children 18 to 23 months from the jungle regions of Peru suffered chronic malnutrition. In Lima, 15.8% of children under six were chronically malnourished with the highest percentage among three and four year olds. One cause of malnutrition and growth retardation (stunting) is the overwhelming burden of infectious disease. Each episode of diarrhea can retard normal growth..

Acute malnutrition is not as severe a problem, with less than 1% of children under age six more than 2% below the mean weight for height. This percentage, however, approaches 5% in certain age groups in different geographical areas: urban coastal 12 to 17 months, 4.7%; urban jungle 6 to 11 months 4.4%; rural coast 12 to 17 months, 4.8%; rural sierra 12 to 17 months, 4.6%; and rural jungle 18 to 23 months, 5.7% (ENNSA, 1984).

C. Constraints to Improved Child Health in Peru

1. Social and Demographic Realities

In 1986, 80% of Lima's nearly 6 million inhabitants lived in working-class neighborhoods or squatter settlements and slums known as pueblos jovenes. Between 1940 and 1986, the population of Lima increased more than tenfold, and continues to grow. Conditions will worsen in Lima due to this precipitous growth. Lima's growth rate was 3.1% in 1987, compared to the national crude population growth rate of 2.56%, and reflects the migration of young families and adolescents to Lima. The resulting concentration in Lima of women of child-bearing age has created both an unmet demand for all health services, and, at the same time, an opportunity to reach a significant number of mothers and children with mass media health communications and health services.

In rural areas, Peru's large size and difficult geography, poor road system, lack of adequate communication facilities, and limited human and financial resources represent major obstacles to the delivery of education and health services. Logistical and communications problems are even more severe in the poor rural areas of the central and southern sierra, where, in addition, terrorist activities are a constant threat.

2. Curative Versus Preventive Care

In the past, both the MOH and IPSS systems devoted considerably more resources to curative, hospital-based care rather than preventive care. As a result, MOH and IPSS health facilities tend to be used inefficiently. Specifically, polyclinics, health posts, health centers, and medical and factory posts, which should be the major point of entry for PHC, are underutilized, at least partly because they are usually understaffed, undersupplied and underequipped. The national average user rate for IPSS clinics, for example, is only 49%. MOH and IPSS hospitals, because they are relatively better equipped, supplied and staffed, inappropriately become the primary service delivery point for PHC. The overemphasis on hospital-based curative care has also led to an overabundance of hospitals beds in both systems, draining limited resources which could more efficiently be spent on intermediate facilities, such as polyclinics or health centers.

3. Administrative and Institutional Constraints

The MOH and IPSS have been mandated to work together to provide national health coverage. There are a number of characteristics of the public health sector which pose problems for the development of an integrated sustainable health care system. These include: excessive hospital-based provision of services in large urban areas; lack of trained managers to plan, train and supervise personnel at all levels of the health service delivery system; difficulties in coordination between administrative and technical personnel; complicated bureaucratic procedures required to secure funds for the MOH from the MEF; lack of supplies and properly functioning equipment in service facilities; and, lack of an effective management information system.

4. Financial Resource Constraints

The MOH received 2% more of the GOP budget in 1986 than in 1985, and received an increase again in 1987 to 7.2% of the national GOP budget, one of the highest in Latin America. The average health budget in developing countries is approximately 4.5% of the national budget. Total health sector expenditures (public and private) is 4.5% of GDP, which compares favorably with other Latin American countries with a similar per capita income (ANSSA, 1986). However, about 47% of MOH health expenditures are urban hospital-based and, therefore, expensive. Although the current GOP policy gives priority to rural and marginal urban populations, there is still an urban concentration of curative facilities. Per capita health expenditures are four times greater in Lima and Callao--where income is higher and health status indicators are better--than in other areas. Approximately 25% of the MOH operational budget is allocated to PHC, while international donor organizations have financed almost 75% of the costs by supporting PHC projects.

The IPSS receives a direct allocation of only 7% of its total budget from the GOP; the remaining 93% comes from employee and employer contributions, with the GOP one of the largest employers. Of the total budget, 60% is spent on the health care program. A major problem is the failure of the GOP, as an employer, and other private employers to pay their full contributions, resulting in a debt to the IPSS that runs into millions of dollars. The ability of IPSS to collect this debt and employer contributions on a regular basis has improved somewhat with computerized billing in Lima and Cuzco but still remains problematic.

The underemphasis on less expensive, preventive PHC in favor of more expensive curative care contributes to the financial problems of both the MOH and IPSS. This is particularly significant given the fact that 56% of all deaths in Peru are registered in the 0 to 14 age group and that most causes of child mortality could be significantly reduced by preventive measures and health education.

5. Human Resource Constraints

In spite of a large investment in personnel, (over 70% of the MOH budget and over 50% of the IPSS budget is for salaries and pensions), the MOH and IPSS are inappropriately staffed. Maldistribution and inefficient

utilization of existing personnel are the two main problems. This is especially true in rural areas where many posts are not filled due to a lack of an incentive system to retain qualified personnel and to motivate staff to work in rural areas.

A complicating factor is the inadequate professional administrative direction and guidance available at both the MOH and IPSS, which are administered by physicians largely untrained in management. Also contributing to the less than adequate management was the change of government in mid-1985, and the subsequent frequent changes in MOH leadership and system-wide reorganizations. In essence, the MOH was paralyzed for nearly a year after the 1985 national elections. Though many MOH staff received training in administration, financial management and PHC delivery under a recent A.I.D. project, many were reassigned under the various reorganizations to positions which could not utilize or take advantage of the training.

Other major human resource constraints in both the IPSS and MOH include: over-specialization of physicians and lack of training in public health; professional rivalries among physicians, nurses, midwives, and auxiliary workers which makes team work difficult and impedes the delegation of tasks to lower levels of care; and poor personnel planning.

6. Uneven Distribution of Health Services Delivery

Health services are unevenly distributed within Peru, with hospitals overly concentrated in Lima and Callao and insufficient health centers and health posts in low income urban and rural areas. The Lima-Callao area, with 28% of the total population, has 47% of all MOH hospital beds and 13 of the country's 20 large hospitals (defined as 300 beds or more). Distribution of MOH health centers and health posts is less disproportionate with respect to population than that of MOH hospitals, but still shows substantial variation among Departments. IPSS service coverage is also disproportionate to population. Again, with less than a third of the country's population in Lima and Callao, IPSS has 45% of its insured population, 70% of its physicians and 68-75% of its nurses and technicians in those two Departments.

D. GOP Health Policies and Programs

1. Historical Perspective

The MOH first established a national policy for PHC in 1978, following the publication of the World Health Organization (WHO) Declaration of Alma Ata on PHC in 1978. During the period 1980-1984, this policy was continually modified and strengthened, with considerable emphasis placed on family planning (FP), oral rehydration therapy (ORT) and immunizations. During this period, international donor agencies, including the World Bank (IBRD), Interamerican Development Bank (IDB), United Nations Emergency Children's Fund (UNICEF), Pan American Health Organization (PAHO) and USAID, played a large role in supporting PHC activities at the peripheral health service and community levels, while the GOP fiscal contribution was minimal.

From 1980-1984, the MOH made substantial progress in the development of official norms and standards for the control of diarrheal diseases, the promotion of growth and development of children under five, proper feeding and nutrition, maternal health care, training of health promoters and TBAs, delivery of FP services, including prevention of pregnancy for women at high risk, and other areas related to CS activities. The IPSS has been using the same norms to implement its CS activities. Problems in management and administration, logistics, human and financial resources, and community participation, among others, have thus far prohibited full implementation of MOH policies.

2. Current GOP Health Policies and Programs

Published in September 1985, the most recent National Health Policy is an integral part of the Policy for National Development, and applies equally to the MOH and IPSS. Basic goals include achievement of a more equitable distribution of health resources, multi-sectoral collaboration, and the facilitation of community participation in all health-related activities. The new policy calls for decentralization, i.e., significantly less central level MOH staffing and a delegation of program authority to the UDES's, allowing health service planning and resource allocation to more closely match the needs of communities rather than central level priorities. Decentralization to the DMUs is also being implemented by IPSS. Both institutions are coordinating service delivery at the departmental level.

This policy was formalized in the GOP's new 1986 Integral Health Sector Law, which places priority on the delivery of MOH and IPSS services to certain priority populations by: social groups (rural and urban marginal populations); groups at risk (children under five years of age and women of child-bearing age); and geographic areas (Departments of the southern sierra that comprise the trapecio andino (Cuzco, Puno, Apurimac, Huancavelica, Ayacucho and parts of Arequipa) and priority micro-regions across the country). Other priorities identified include control of diseases that can be reduced through better nutrition, basic sanitation, immunization and FP and the reorientation of peripheral health services toward health promotion and prevention of illness.

Special Programs of the MOH have been recently identified and defined as those that, because of their magnitude, nature and prevalence, require vertical planning, organization and supervision at the central level but horizontal implementation at the UDES level. In other words, the central MOH has designed immunization, FP and DDC interventions as vertical programs, charging the UDES level staff with the responsiblity of integrating them into horizontal programs which target the same mothers and infants with these CS interventions, and which will be implemented by the same staff. Other Special Programs are: control of ARI, malaria and other vector borne diseases, tuberculosis, oral health and feeding and nutrition. Priority activities within these programs include: the basic and essential medicines program; development of appropriate health technologies through research in collaboration with academic and other scientific Peruvian institutions; and, development of human resources at all levels in coordination with universities, the education sector, and related institutions.

E. Other Donor Activities

On-going and recently approved donor assistance to the health sector in Peru, in addition to the $28.45 million currently being provided by USAID[1/], totals approximately $148 million. Most of the assistance has been used to support PHC. PAHO has provided technical assistance in such areas as oral rehydration and immunizations. PHC activities have been stressed in training supported by German Technical Assistance Agency (GTZ) and World Bank projects at the peripheral level. Both the World Bank and Inter-American Development Bank have supported construction of health centers and health posts in designated areas of the country. On-going assistance by these and other donor agencies is discussed below. Without exception, all, in some manner, are continuing to support PHC, with particular emphasis on CS activities.

1. International Bank for Reconstruction and Development (IBRD or World Bank)

A World Bank $33.5 million loan, authorized in May 1983, was designed to increase the availability and access of PHC services for 3.5 million inhabitants of specified geographical areas in four Health Departments--two on the coast and two in the jungle. World Bank funds were to be used to finance equipment, supplies, and medicines for newly constructed peripheral health establishments and training for a new cadre of health post visiting nurses. GOP counterpart funds were to provide all local currency costs for health establishment construction and salaries for additional health workers. Due to slow implementation, the project had utilized only approximately $3 million when the APRA government came to power in July, 1985. The Project was redesigned during late 1985 and early 1986 to change the geographical focus to cover Health Departments in the northern and southern sierra. By redesigning health post construction to use more appropriate and less expensive materials, the projected population coverage was significantly increased. Although World Bank loan funds have not been disbursed since 1985, and all World Bank disbursements to Peru have been indefinitely suspended since May 1987, $20 million in GOP counterpart funds have financed the construction of 62 new health centers and posts over the past 18 months.

2. German Technical Assistance Agency (GTZ)

After USAID, the next largest bilateral donor is the Federal Republic of Germany which provides support through its development agency, GTZ, for PHC and nutrition. GTZ also provided support until July 1987, along with USAID and PAHO, to the MOH's management information system. GTZ currently supports PHC activities in the Departments of Cuzco, Madre de Dios, and Apurimac ($3.5 million), and in La Libertad ($3 million).

3. Inter-American Development Bank (IDB)

The IDB is completing disbursement of a $11.2 million loan for training of health workers and construction of health facilities in three

1/ This figure does not include an additional $8.25 million in health, $142.95 million in food assistance, nor $20.4 million in population assistance provided by A.I.D. since 1979, nor this $19 million Project.

jungle sites which are related to IDB's integrated regional development programs in Peru. Another $31.3 million loan-funded project involving the construction of urban water and sanitation systems through SENAPA (National Service for Potable Water and Sewerage Systems) is scheduled to be completed in 1988. A new $41.8 million loan (plus $9 million in GOP counterpart) project with the MOH to support the rehabilitation of 31 hospitals in 19 Health Departments is currently under consideration. In the planning stages is a possible project with the Housing Bank for potable water and electrification systems in pueblos jovenes, with 30% in Lima and 70% in other urban areas.

4. United Nations Fund for Population Activities (UNFPA)

The UNFPA is implementing a $2.4 million grant project in MCH and FP during the 1986-89 period. This project will provide services to three million women and children under five. The program includes training, FP supplies, education and communication. Other smaller projects include: improvement of vital registration by the National Institute of Statistics (INE); community-based distribution of oral rehydration salts (ORS) and FP supplies in peri-urban slums of Iquitos; and a natural FP method project in five townships of Lima.

5. United Nations Emergency Children's Fund (UNICEF)

A recently approved $5.375 million budget for 1987-92 will support self-help projects by women's community groups among the poorest populations. The five-year program emphasizes CS interventions that will be managed through a variety of public and private sector organizations, including the National Planning Institute (INP), MOH, Ministry of Education (MOE), and Departmental Development Corporations (CORDES). Under the program, priority rural areas will receive: technical assistance to train communities, especially women's groups, in participatory programming; financing to support the production of training materials on low-cost techniques for CS and the role of women; and equipment and supplies for women's groups. In urban areas, UNICEF will work through PAIT (Programa de Apoyo al Ingreso Temporal--the GOP public works organization), multi-family and child feeding centers, the Lima municipal Vaso de Leche program, Clubes de Madres, other women's groups, and agencies providing loans to the informal sector. The UNICEF budget also includes $.6 million to support the MOH's EPI National Plan of Action in collaboration with USAID, PAHO and Rotary International.

6. Government of Italy

The Government of Italy is funding a $5 million multisectoral community-based nutrition project (PROCAN) in the Departments of Puno, Moquegua and Tacna, which is being jointly implemented by UNICEF and PAHO through the MOH.

7. Pan American Health Organization (PAHO)

Special Programs of the MOH related to CS supported by technical assistance from PAHO are immunizations, DDC, FP, and feeding and nutrition. Other related MOH programs receiving technical assistance from PAHO include development of human resources, information systems, statistics

and telecommunications, active epidemiological surveillance, and environmental health. PAHO provides approximately US$1 million annually to Peru in the form of technical advisory staff and limited program support to the MOH. In addition, it has committed US$580,000 over the next five years for the MOH's EPI National Plan of Action in collaboration with USAID, UNICEF and Rotary International.

8. Swedish Aid and Technical Cooperation Agency

The Swedish Aid and Technical Cooperation Agency will support the MOH immunization plan with refrigerators valued at $400,000.

9. Rotary International

Rotary International will provide $800,000 to support the MOH's EPI National Plan of Action in collaboration with USAID, PAHO and UNICEF.

10. Summary

Table 14 summarizes on-going and recently approved donor assistance to Peru in the health sector. This Project has been designed to complement and reinforce the efforts of other donors. For example, UNFPA and A.I.D. will provide complementary FP commodities for the MOH's FP Program. Also, four of the donors, including A.I.D., have formalized in a Memorandum of Understanding their complementary inputs to the MOH's Immunization Program. Similarly, the selection by the UDES of those peripheral health facilities which will be supported by this Project will take into account the inputs of the various donors who are focusing their PHC and CS efforts in specific Departments or regions of the country.

F. USAID's Child Survival Strategy

USAID's overall CS Strategy is to assist the GOP (MOH and IPSS) and the private sector to provide sustainable services throughout the country, with first priority to the most needy areas, especially to families whose children are at highest risk. The strategy consists of a series of complementary and coordinated sub-strategies in a number of key service delivery and support system areas.

1. Diarrheal Disease Control (DDC) and Nutrition Strategy

Diarrheal diseases account for 22% of all infant deaths in Peru. The problem of diarrheal illness is compounded by the high prevalence of malnutrition in children, which influences the duration and severity of the diarrhea, leading to increased risk of death. The anorexia, transitory malabsorption and increased metabolic needs caused by diarrhea contribute to a vicious cycle of infection and worsening nutritional status. This, in turn, leads to retardation of physical growth and mental development and reduced resistance to other infections. Promotion of sound nutritional practices, including appropriate breast-feeding practices, proper weaning, and dietary management of diarrhea are important elements of the strategy for diarrheal disease control and nutrition.

TABLE 14. Summary of On-going and Recently Approved Donor Assistance to Peru in the Health Sector

	DONOR	AMOUNT IN US$
1.	IDB	$ 84,300,000 a/
2.	A.I.D.	28,450,000 b/
3.	World Bank	33,500,000 c/ (loan)
4.	UNICEF	5,375,000
5.	GTZ	6,500,000
6.	Government of Italy	5,000,000
7.	UNFPA	2,400,000
8.	PAHO	9,580,000
9.	Rotary International	800,000
10.	Swedish Aid and Technical Cooperation Agency	400,000
	TOTAL	$176,305,000

a/ Includes a proposed new $41.8 million project to begin in 1987 or 1988.

b/ Does not include this $19 million Project.

c/ Approximately $3 million utilized; further disbursements indefinitely suspended.

In conjunction with the GOP and other international donors, USAID's goal is to promote the use of oral rehydration therapy (ORT) for diarrhea in all children under five, using a combination of promotion of breast-feeding, home solutions (such as soups and teas), proper dietary management, and use of ORS to treat dehydration. To achieve this goal, USAID's strategy is to strengthen local ORS production capabilities and strengthen MOH and IPSS capabilities to deliver services to the appropriate target groups. The latter will be accomplished by: a) promoting the use of simplified diarrhea treatment technologies in health centers, health posts and communities and among all levels of health care workers through the establishment of Regional Training Centers at major hospitals, oral rehydration units at hospitals, and through university-based professional training programs; b) improving monitoring and evaluation capabilities; and c) increasing demand by families and communities through promotion and education regarding proper treatment and feeding of children during diarrheal episodes.

In recognition of the important link between diarrheal episodes and declining nutritional status, the USAID strategy also includes: a) promotion of appropriate dietary management of diarrhea; b) encouragement of appropriate breast-feeding practices and appropriate timing of the introduction of nutritious weaning foods; c) growth monitoring; d) maternal nutrition enhancement to reduce low birth weight and improve breast-feeding capability; and e) improved targeting and integration of PL 480 MCH feeding program foodstuffs to accomplish (a) through (d). USAID's strategy also includes support for operations research related to diarrheal disease prevention and control and improved nutritional practices in the home and through the health delivery system.

2. Immunizations Strategy

Under a mandate of the U.S. Congress, A.I.D. is working closely with the World Health Organizations's (WHO/PAHO) Expanded Program of Immunizations (EPI) to reach and maintain the target of 80% national coverage by 1991 of children under age five for six vaccines: polio, measles, diphtheria, pertussis, tetanus and tuberculosis. In the Americas, A.I.D. also has joined with PAHO, IDB, UNICEF and Rotary International to interrupt the transmission of the wild polio virus, with the objective of eradicating polio from the Americas by 1990. The MOH, in collaboration with USAID, PAHO and other donors, has developed an immunization strategy for Peru in which the IPSS will also participate. The strategy calls for universal immunization coverage for children less than one year of age by 1991 through a combination of public campaigns, improvements in the cold chain and increased capacity for delivery of services. To assist the MOH and IPSS in this effort, USAID's strategy is to support improvements in service delivery to achieve these targets. USAID support includes: the purchase, installation and maintenance of cold chain equipment, support for health communications, including promotion of public awareness of and demand for services, the establishment of an active epidemiological surveillance system, decision-linked operations research financed under AID/W centrally or regionally-funded projects, and evaluation activities.

3. Family Planning (FP) Strategy

USAID's goal in the FP sector is to help lower the current high population growth rate of 2.56%, a goal consistent with USAID/Peru's Country Development Strategy Statement (CDSS) which cites rapid population growth as "a serious impediment to development" in Peru. One major element of USAID's overall development strategy is to expand the efficiency and coverage of social services, including FP, to low income rural and urban populations as an effective means to increase the real income and living standards of the poor, and to reduce the negative impact of continued high population growth on economic and social development. This goal is consistent with both the A.I.D. Latin American and Caribbean (LAC) Bureau strategy and the target set by the GOP's National Population Commission to lower the fertility rate from 4.2 to 3.7 by 1991.

The strategy to achieve this goal is to improve the capability of the MOH and the IPSS systems at all levels to deliver FP services nationwide. USAID will implement this strategy through: a) increasing and improving personnel training; b) providing needed supplies and equipment; c) developing and implementing public education and information campaigns; d) improving the logistics system; e) promoting decision-linked operations research financed under AID/W centrally or regionally-funded projects; and f) continuing the development of a management information system. USAID is also working with the private sector to provide FP services, conduct operations research and training, and develop IE&C activities.

4. Institutional Development Strategy

The USAID CS strategy supports improvements in the MOH systems that provide the financial, logistics, personnel and informational support required to deliver CS services. An adequate epidemiological surveillance

system is also needed to measure the impact of the health services delivered and to indicate the priority areas where health resources should be directed. In order to improve service delivery and monitor management effectiveness, the institutional development strategy includes support for training, supervision, transportation and, computer-based management information systems, including the development and institutionalization of computer-based Active Epidemiological Surveillance (VEA) and health information systems (HIS). In addition, USAID encourages support from AID/W centrally-funded projects that can help strengthen MOH and IPSS delivery of CS services. The MOH will finance the recurrent costs associated with in-service technical and administrative training for health professionals and para-professionals, and for supervision of health workers at all levels of the service delivery system. MOH financing of training and supervision activities over the past several years has been limited. By establishing a system of programming for and financing these recurrent costs during the life of the Project, the process should be institutionalized and the support continued even after the Project is completed.

5. Other Focuses

In addition to the major strategies outlined above, the global CS strategy in Peru includes support for other activities which are priority areas and Special Programs of the MOH. Control of acute respiratory infections, rural water and sanitation, tuberculosis, health communications and food assistance are included because they significantly influence rates of infant and child mortality in Peru.

a. Control of Acute Respiratory Infections (ARI)

USAID's goal, in conjuction with the GOP and other international donors, is to reduce the death rate due to ARI in children under five and to reduce morbidity through the promotion of preventive and early treatment measures. To achieve this goal, USAID's strategy is to improve early detection and home treatment capabilities of families and communities, provide assistance for investigations of the causes and cost-effective prevention and treatment strategies for ARI, strengthen MOH capabilities to deliver services, and increase public knowledge and demand for services.

b. Rural Water and Sanitation

Lack of access to basic sanitation is a major contributing factor to the incidence of diarrheal and other infectious diseases. Only 50% of households in Peru have access to public water systems. More than 30% of households obtain their water from rivers, streams, or springs. As many as 56% of households have no adequate sewage system. Under an on-going Rural Water and Sanitation Project, USAID is supporting the construction of rural water systems and latrines in rural sierra and coastal communities. Health education messages are an important element in the rural water and sanitation strategy that links the provision of potable water systems with new behaviors related to proper water and latrine use that improve health status, particularly decreasing the rates of diarrheal diseases in children under five years.

Another important element of the rural water and sanitation strategy is community participation. One of the most effective ways to organize a community to improve its health status is through a community water system construction project. The interface between the organized community and the MOH, once established, can be expanded to include other preventive health activities that benefit the families of the community, especially children.

c. Tuberculosis and Other Infectious Diseases

Tuberculosis (TB), with an annual infection rate of 2%, is a significant health problem in crowded urban areas across the country. Children are infected by adult contacts, but since they cannot provide sputum specimens, TB is much more difficult to detect in children. Included in USAID's CS strategy is use of the epidemiological surveillance system to identify the most important diseases affecting the health of Peruvians, particularly children, and to study disease transmission patterns, behavioral factors and community responses. Through epidemiological and operations research studies on important diseases, financed under AID/W centrally-funded projects, cost-effective measures of prevention and control can be developed and incorporated into programs to improve CS.

d. Integrated Health Communications

The integrated health communications strategy seeks to catalyze community participation, especially with regard to CS interventions. Messages to increase knowledge and change attitudes and behaviors are included in each one of the CS programs. For effective and successful communications, however, these messages must be tailored to the target audience. The ecological and cultural diversity of Peru requires that the integrated health communications strategy focus on improving the capability to produce and distribute appropriate materials and messages through a decentralized system. The strategy emphasizes design and production of materials developed at community workshops using locally available materials in close collaboration with UNICEF. The strategy also emphasizes the use of radio through various local radio stations that reach different target populations. Use of television will be limited, given the expense involved and the relatively low population coverage achieved with this form of communication, especially outside of Lima.

e. Food Assistance

The malnutrition problem in Peru continues to be severe, as shown in the 1984 ENNSA study where chronic malnutrition within the 0-5 age group was determined to be about three times worse in the rural sierra (63%) than in urban coastal areas (27%) or the poorest areas of Greater Lima (19%). The USAID food asssistance strategy calls for improved targeting of Title II program resources, which are channeled through PVOs (namely, Catholic Relief Services/CARITAS (CRS/CARITAS), Cooperative for American Relief Everywhere (CARE), and Adventist Development and Relief Agency (ADRA/OFASA)), and complementary bilateral Section 416 resources, which are provided to the MOH, in order to improve the nutritional status of Peru's poorest mothers and children. The PVOs and the MOH bilateral supplementary feeding programs are changing their geographic targets to increase program coverage in rural

areas. Complementary CS funds have been channeled to PVOs to undertake activities within their Title II maternal and child health care (MCH) programs in growth monitoring, ORT, promotion of breast-feeding, immunization, better hygiene and appropriate nutritional practices. Since 1985, the Nutrition Research Institute (IIN) has provided to the PVOs: training in nutrition and CS interventions for the nutritionists who are in charge of the PVO feeding programs; teaching materials and portable weighing scales to support growth monitoring and nutrition education activities; and technical assistance to regional level personnel in organizing and carrying out feeding programs with CS interventions. The bilateral MOH Section 416 program, after years of concentration in school feeding, is now totally MCH oriented, and complements the other MOH CS activities that will be supported by this Project. PVO Food for Work (FFW) programs, by including activities such as small animal raising, family and community gardens, and seed banks, also contribute to improving the nutritional status of the most vulnerable population groups.

G. Relationship of This Project to Other USAID Projects in Peru

USAID launched its PHC strategy in 1979, with the authorization of a $1.4 million pilot project, Sur Medio (527-0224), and the $7.1 million Extension of Integrated Primary Health Project (527-0219). These activities were followed by the $11 million Rural Water and Sanitation Project (527-0221) in 1980, and the $10.8 million Integrated Health and Family Planning Project (527-0230) authorized in 1981, which will continue until the end of 1987. These four projects formed an integrated package for PHC which included support in such areas as immunizations, FP, water, and environmental sanitation. With the $1.1 million Nutrition Amendment to Project 527-0219 in 1985, nutrition also became a priority for USAID support. The above projects focused on improving the management of the PHC system, increasing service coverage in both the private and public sectors, and gathering and analyzing data for improved planning and decision-making.

The Rural Water and Sanitation Project has been extended to June 1989 in order to continue construction and health education activities. The extension will allow the MOH ultimately to construct 1,200 water systems. The project includes support for the MOH Office of Rural Sanitation, simplification of water system design, construction and utilization of latrines, the provision of related health education, and training of villagers in operations and maintenance.

Since 1983, USAID also has been supporting Peruvian researchers with the aim of developing program and technology improvements for CS interventions. During 1985/1986, grant agreements were signed with the Nutrition Research Institute (IIN), the Peruvian University Cayetano Heredia (UPCH), and PRISMA (a local PVO formed in 1986), to conduct CS research activities in the areas of diarrheal disease treatment and control, nutrition and dietary management of diarrhea, and family risk assessment. Private sector training and development of service delivery methodologies for CS interventions are also being carried out, with USAID grant support, in different parts of the country by CARE, Puentes de Salud (SIID--Seton Institute for International Development), ADRA/OFASA, CARITAS, IIN, PRISMA and UPCH.

In addition to the FP components of Project 527-0230 being implemented by the IPSS, MOH and various PVOs, in 1984, USAID signed an agreement for a $4.7 million Contraceptive Social Marketing (CSM) Project with a local PVO. Also initiated in 1986 was a new USAID-supported $13 million Private Sector FP Project. In addition, a one-year Limited Scope Grant Agreement for $165,000 was signed with the IPSS in 1986 to initiate a National FP Program. A Demographic and Family Health Survey (ENDES), financed by AID/W, was completed in 1986 that verifies the current growth rate and establishes current FP usage rates. The two private sector FP projects and this Project, which will provide FP services through the public sector, together are intended to facilitate an increase in contraceptive use to meet the high but unmet demand for services.

In 1985, USAID initiated a comprehensive $1.3 million Health Sector Analysis (ANSSA) which was carried out under a cooperative agreement with the State University of New York at Stony Brook in conjunction with PAHO, the MOH, and an array of Peruvian institutions including IPSS, the School of Business Administration (ESAN), UPCH, the Central Bank of Peru, and other U.S. firms under contract to Stony Brook. The ANSSA consisted of nine technical/analytical studies which yielded research findings and policy recommendations for: 1) operating costs and cost containment possibilities for MOH/IPSS hospitals; 2) improvements in utilization of existing health care facilities; 3) health system organization and management changes to improve human and pharmaceutical resource utilization and generate cost savings; 4) increased domestic health care financing with particular emphasis on social insurance and private sector alternatives; and 5) decentralization of planning, programming and budgeting to the departmental level. The ANSSA will serve both the analytical and programming needs of Peruvian health sector agencies and the donor agencies in making investment decisions in the health sector.

Utilizing data on malnutrition from the 1984 ENNSA Survey has allowed better targeting of food assistance to the most at risk groups through on-going and new Title II and Section 416 feeding programs with PVO's and the MOH, respectively. Since 1984, CS funds totalling $500,000 also have been provided by USAID to the PVOs, CARITAS, CARE, ADRA/OFASA and SEPAS, to enhance the nutritional impact of their feeding programs. Over 30,000 metric tons of dry milk, butteroil and blended foods have been programmed through the PVOs for their CS programs during 1984-88. While these activities are being carried out in both marginal urban areas and depressed sierra regions, all the PVOs have projected and are actively reprogramming resources to expand their programs in the rural sierra. Through separate USAID-financed agreements with the IIN, each PVO is coordinating the training of nutritionists and health promoters in growth monitoring and development and basic ORT treatment of diarrhea and proper infant feeding, and is receiving IIN technical assistance in the development of its own nutrition education program.

In addition, the USAID Food for Development Program is supporting CS activities through the MOH Complementary Feeding Program (PAC). A $7 million Section 416 program grant agreement was signed in August 1987 to continue and expand activities in 22 of the 25 Peruvian Departments, including Callao. The CS components of the PAC Program will be supported through the direct distribution of approximately 5,000 metric tons of dry powdered milk

and butteroil. Title I counterpart funds totalling $1.3 million will help cover PAC logistical costs of the food distribution and the implementation of new PAC CS pilot projects.

A.I.D./W centrally-funded projects also will play an important role in supporting the implementation of this Project. HEALTHCOM or the Population Communications Services Project might provide technical assistance for the health communications activities. Project SUPPORT will provide technical assistance and a loan to purchase equipment to LUSA Laboratories, the major local ORS manufacturer, to expand local ORS production. It is expected that assistance for priority operations research in support of this Project will come primarily from three sources: 1) AID/W centrally-funded projects such as HEALTHCOM, PRICOR, REACH and Applied Diarrheal Disease Research (ADDR) and other regionally-funded projects; 2) the proposed FY 88 USAID-financed private sector health project; and, 3) on-going USAID Grant projects with such organizations as Projects in Informatics, Health, Medicine and Agriculture (PRISMA) (a local PVO), Cayetano Heredia University of Peru (UPCH), and the Nutrition Research Institute (IIN). A variety of A.I.D./Washington centrally-funded projects are also available to provide support to strengthen FP services delivery.

H. Lessons Learned from On-Going and Recent USAID Projects

This Project will benefit from the experience gained by USAID from implementation of the three integrated PHC projects in Peru during the period 1979-87: the Sur Medio Project (527-0224), Extension of Integrated Primary Health Care (527-0219), and Integrated Health and Family Planning (527-0230).

Major constraints in project administration and management included: overcentralization and ineffective integration of regional and local personnel in the planning process for PHC; lack of coordination among the over 60 donor and public and private sector implementing agencies involved in PHC delivery; high turnover of regional management and professional personnel; and the absence of effective performance evaluations and realistic project and personnel performance targets. Recommendations which emerged from various project evaluations included: modification of USAID financial procedures conducive to decentralized operations by the MOH; more in-service training for MOH personnel to perform management and administrative responsibilities effectively; development of a feedback/redesign system; and development of a PHC monitoring committee at the central level.

Financial management in the MOH is characterized by an overly complex disbursement and reporting system. Other problems encountered were lack of budget planning on the basis of past experience and available resources, and lack of orientation and motivation of administrative personnel. Simplification and emphasis on output-oriented financial management, delegation of authority to departmental directors for budget management and execution, and the disbursement of funds directly to the regions are lessons learned from previous projects which have been incorporated into the design of this Project.

Analysis of procurement and logistics procedures under previous projects revealed a cumbersome purchasing system in the MOH. Shortages and maldistribution of many basic supplies, medicines and equipment were found in hospitals, health centers and health posts. Other issues identified were the

scarcity and poor maintenance of vehicles, lengthy and cumbersome customs procedures, and warehouse storage and transportation inadequacies. Better inventory control systems and training for selected logistics personnel were also areas requiring increased attention and support. A computerized system was seen as potentially of great benefit.

The health information system in Peru has seen remarkable progress as a result of technical assistance provided under previous USAID projects. Design of the new system using a consensus-building approach and the major ENNSA Study was accomplished. Further needs identified were the development of subcomponents of the information system, improved analytic capability at all levels, especially the central level, epidemiological capability at the departmental level, and an improved vital registration system.

Training and supervision were found to be critical areas for continued support at all levels of management and service delivery. In particular, the MOH needs to specify clearly the mix of tasks to be carried out by PHC workers, using operations research to guide this decision, and to develop a comprehensive training plan for all levels of personnel, including training of trainers as a priority training activity. The inability of the MOH to pay adequate per diems for supervisory visits was identified as an important implementation constraint. The MOH has recently raised the per diem rates. However, unless they are periodically adjusted, the inflation rate in Peru will soon render these new rates inadequate.

These lessons learned have been taken into account in the development of this Project. Many of the recommendations and findings of the evaluations noted above have been incorporated into the design of this Project.

I. Project Rationale and Strategy

1. Project Rationale

Peru is one of the poorest countries in Latin American, with 46% of is population living in conditions of absolute or relative poverty. Reflecting such poverty is the dramatically poor health status of its population, described earlier. Increasing emphasis by the MOH, A.I.D. and other international donors on PHC, principally since 1979, has begun to have some impact. However, the MOH is still in the critical process of developing, expanding and strengthening its service delivery system to an appropriate level capable of meeting on a sustained basis the needs of its target population. In addition, the target population of the IPSS most in need of CS health interventions (infants, children, and WFA), has grown significantly, and is expected to continue to do so. This rapid growth and the fact that IPSS only very recently has begun to offer CS services underscore the need to strengthen and extend its service capacity.

This Project is fully congruent with USAID's development objectives and strategy as outlined in this and other USAID programming documents. The Project is the next logical step in implementing USAID's PHC strategy, which began in 1979 with the Sur Medio Pilot Projet and the Extension of Integrated Primary Health Project. It complements the on-going activities of the Rural Water and Sanitation and the Integrated Health and Family Planning Projects. The Project's public sector FP component also complements the Contraceptive Social Marketing and Private Sector FP Projects

supported by USAID. This Project also is completely in accord with GOP policy, specifically the 1985 National Health Policy and the health service norms developed by the MOH. Finally, as the major bilateral donor in health, A.I.D's continued involvement in health in Peru is important for: immediate humanitarian reasons (saving children's lives and improving their health); mid-term development reasons (contribution to decreasing population growth); and, for longer term investment in improving human capital.

In summary, building on the experience of past and on-going health projects, this Project will assist both the MOH and the IPSS to improve and expand their delivery of CS services. The Project will significantly contribute to overall long-term development through improved health and through its FP activity. Finally, this Project is an indispensable part of USAID's health sector and overall development strategy, will complement the efforts of other donors in the health sector, and is consistent with GOP policies and goals.

2. Project Strategy

Since the MOH and IPSS together are responsible for providing health care to 86% of the Peruvian population, this Project seeks to reach the largest number of individuals by providing support to these two public sector institutions. Of the approximately 12 million individuals, or 58% of the total population which is supposed to receive health care services through the MOH, only 26% or 5.4 million actually receive such services, leaving about 6.6 million people without access to modern medical care. Similarly, an estimated 70%, or 4.1 million of IPSS's total target population of 5.9 million, which represents 28% of the total Peruvian population, actually receives services, leaving about 1.8 million without adequate health care coverage. Thus, this Project is designed to increase health service delivery coverage by the MOH and IPSS.

Child health in Peru ranks among the worst in Latin America, with Peru's infant mortality rate being the third highest in Latin America. The national maternal mortality rate is 30.3 deaths per 100,000 live births, which is extremely high when compared to rates of approximately 3 per 100,000 in developed societies. Women of child-bearing age and children under five years of age are, therefore, the priority target populations under this Project.

Dehydration due to diarrhea is the greatest cause of morbidity in children age two to five years. Almost 40% of the 0 to 5 year old children surveyed in 1984 were chronically malnourished. Peru also has high incidence rates of five major immuno-preventable illnesses. In addition to maternal malnutrition and inadequate perinatal care, high levels of fertility and inadequate spacing between births have resulted in poor maternal, fetal and infant health. Use of modern contraceptive methods, which greatly contributes to improved maternal, fetal and infant health through child-spacing and reduced child-bearing, is low at 23% of WFA. Finally, respiratory illness is the leading cause of morbidity in Peruvian children under one year. Thus, this Project will focus on the improved delivery of health care services in diarrheal disease control (DDC), nutrition, immunizations, family planning (FP), and control of acute respiratory diseases (ARI).

Between 1975 and 1987, the number of MOH hospitals increased by 25% from 100 to 125 while the number of MOH health centers just about doubled (from 347 to 689) and the number of MOH health posts almost tripled (from 994 to 2,738). Such a significant expansion in facilities along with a concomitant increase in staff in a relatively short period of time has exacerbated existing institutional weaknesses and highlighted the critical need for increased attention and resources in a number of key service delivery support areas. These include: training and supervision of both technical and administrative staff at all levels of service; improved management information systems for health statistics, epidemiological surveillance, personnel and financial management and logistics; transportation; and equipment and supplies. All of these areas will receive assistance under this Project in order to improve the quality of service delivery. The Project strategy also includes support to the MOH's "democratization of health" objective, which calls for active community participation, by financing the design and implementation of an integrated health communications program.

Decentralization of health services and GOP financing of recurrent costs are two additional elements of the Project strategy. The Project will support the decentralization policy of the GOP by placing implementation responsibility at the departmental and peripheral levels of the health system where the majority of Project inputs will be delivered. In addition, in order to sustain the delivery of CS services, this Project requires that the GOP finance almost all of the local recurrent costs of the program, with a declining portion of the GOP's contribution coming from PL 480 counterpart funds over the five-year life of the Project. This strategy means that A.I.D. will finance: a) all foreign exchange costs (technical assistance, commodities, overseas training); b) all local costs directly related to project management and evaluation (annual regional planning/evaluation workshops, specific management training activities, operations research and data collection and analysis); and c) all local costs directly related to the introduction of new technologies or delivery systems (active epidemiological surveillance and health information system).

Finally, the Project strategy recognizes the importance of facilitating the MOH-IPSS integration process by accelerating the adoption of a PHC and CS orientation within IPSS in preparation for the eventual transfer of IPSS polyclinics and health posts to the MOH, and MOH hospitals to IPSS. Prior to 1985, the only services available to dependents of IPSS-insured employees were FP services for spouses and postnatal care for children up to eight months of age. Since IPSS coverage has only recently been extended to the target population groups under this Project, coverage of these groups is low, CS services delivery is limited, IPSS staff require training in CS health delivery, and IPSS facilities require CS equipment and supplies to offer CS services. Thus, the Project will provide support for training, technical assistance and commodities for IPSS. In addition, to further promote the integration process, ensure complementarity and the sharing of knowledge and experience, and maximize the impact of CS services delivery at the departmental and peripheral levels, the Project provides for close collaboration and coordination between the MOH and IPSS at all levels of the health system in the design, implementation, monitoring and evaluation of all activities under this Project.

III. DETAILED PROJECT DESCRIPTION

A. Project Goal and Purpose

The Project goal is to improve the health of infants and children in Peru. The Project purpose is to strengthen the capability of the public health sector to deliver improved child survival health services through an integrated, expanded and sustainable health care system.

B. End of Project Status Indicators

The Ministry of Health (MOH) is about to initiate a major child survival (CS) program over the next five years. Comprehensive national plans for CS interventions with specific goals, objectives, and targets have been developed by the MOH to guide the implementation of its program. Through this Project, A.I.D. will assist the MOH to implement its program nationwide by providing financing to support specific activities contained in the national plans. In addition, the MOH will receive complementary financing from other donors for specific components of its program. This Project also will contribute resources to the Peruvian Institute of Social Security (IPSS) to support its efforts to expand the provision of CS services through IPSS facilities nationwide. Finally, this Project will provide assistance, primarily to the MOH, to strengthen several support systems which are integral elements of a sustainable CS health delivery system. Thus, this Project, in concert with the efforts of other donors and the broader program initiatives of the MOH and IPSS, will result in the following conditions by the end of the Project:

1. 80% of diarrheal episodes will be treated with ORT and appropriate dietary management.

2. A functioning MOH and IPSS service delivery system will be in place that achieves and maintains nationwide immunization coverage of 80% of all children less than five years old for a complete series of polio, measles, diphtheria, whooping cough, tetanus and tuberculosis.

3. Wild polio virus will have been eradicated.

4. The number of family planning users served by the MOH and IPSS will have increased by at least 50%.

5. At least one nutritious weaning food will be promoted in different geographic regions of the country.

6. A comprehensive Health Information System (HIS) will be installed and operational nationwide.

7. An Active Epidemiology Surveillance (VEA) system will be in place and up to 35 physicians trained in field epidemiology will have been assigned at the central and departmental levels.

8. Pharmaceuticals, contraceptives and medical supplies will be available at all health facilities through a functioning logistics system.

9. Peru financial resources for the delivery of CS services will have increased such that adequate Peru budgetary support for local operating expenditures (local recurrent costs) associated with these programs will have been provided for five years.

C. Project Components

The Project consists of two major components: 1) expansion of CS services; and 2) strengthening of decentralized support systems for sustainable CS service delivery. This Project will support the expansion of CS services in both the MOH and IPSS. Project assistance to strengthen decentralized support systems will be provided primarily to the MOH.

1. Expansion of Child Survival (CS) Services

Activities under this component include five major CS interventions: DDC, nutrition, immunizations, FP and ARI control.

a. Ministry of Health (MOH)

i. Diarrheal Disease Control (DDC)

The control of diarrheal disease is a major priority within the Peruvian health sector. It is one of the greatest causes of death in children under age five in Peru. Children under age three have an estimated five to ten episodes of diarrhea per year, and the disease is a major contributory factor in the etiology of malnutrition. Diarrhea preferentially affects children from the poorest and most depressed rural and marginal urban areas.

Oral rehydration therapy (ORT) can prevent most deaths from dehydration caused by diarrhea. Nevertheless, many health workers continue to resist promoting this simple therapy. An evaluation of the MOH Diarrheal Disease Control (DDC) Program in 1985 indicated that physicians, especially, were making unnecessary use of intravenous, antimicrobial and antidiarrheal therapies and were recommending other inappropriate responses to diarrhea. For this reason, the MOH program has focussed over the last two years on training physicians, particularly in those teaching hospitals where medical students are assigned for pediatric training. Rehydration units with adequate laboratory facilities are being established as Regional Training Centers for DDC in four Health Departments with medical schools (Ica, Trujillo, Arequipa and Lima) with funds from A.I.D. Project 527-0230. An additional five Health Department Regional Training Centers for DDC will be established under this Project.

In March 1986, four infants who were being treated in the Cayetano Heredia Hospital Rehydration Unit--the model unit and training

center for the country--were given improperly manufactured prepackaged oral rehydration salts (ORS). Their sudden deaths resulted in a great deal of negative publicity for the DDC Program and ORS in particular. All prepackaged ORS were recalled in April 1986. There were no prepackaged ORS available in Peru from June until November 1986. As a result of the 1986 ORS crisis, the MOH prepared a National Plan for the Prevention and Control of Diarrheal Diseases in late 1986. The goal of this Plan is to reduce morbidity and mortality due to dehydration caused by diarrheal illness in children less than five years of age through emphasizing adequate training, supervision, logistics, operations research and evaluation to promote increased effective use of ORT both in health facilities and the home.

This Project will support the implementation of the MOH's National Plan. Specifically, the Project will support the establishment of five hospital-based rehydration units in five different Health Departments, which will serve as Regional Training Centers for DDC. These Centers will complement the four already established under a previous A.I.D. Project. In addition to training professional and auxiliary personnel in the clinical management of diarrhea, the Centers will report on diarrheal statistics and will undertake activities in prevention, detection, treatment and research. Project activities also include the promotion of appropriate home responses to diarrhea through community education and health communications. Messages will promote the appropriate use of ORT, dietary management of diarrhea, continued breast-feeding and prevention of diarrhea by means of improved water and sanitation facilities and improved hygienic behaviors. To ensure that a reliable, accessible supply of prepackaged ORS will be provided for those cases which require it, the Project will support increased local production capacity, improved quality control measures and expanded and improved distribution systems in both the private and public sectors. Under the DDC component of the Project, physicians, nurses, other health care personnel, and mothers and other persons responsible for the care of infants and young children will be trained to correctly use ORT. This training is intended to ensure that ORT and beneficial feeding practices are accepted as a standard treatment by both health professionals and community members.

Demand for ORS will be increased through community oriented health messages. The development and dissemination of this information will take into account the variety of languages, health beliefs and practices in Peru. Appropriate dietary management of diarrhea, including continued breast-feeding and the use and proper preparation of nutritious weaning foods, will be promoted through in-service training programs for health workers.

ORT can prevent deaths in children with diarrhea, but will not reduce the rates of diarrhea. Therefore, the DDC Program includes preventive efforts, which will be coordinated with other public and private programs including education, communications and other activities which promote and support potable water supply and sanitation and which reduce the incidence of diarrhea. Operations research in DDC, supported by AID/Washington (AID/W) centrally-funded projects, will include studies on home rehydration solutions, chronic diarrhea, training and information

dissemination. The results of these studies will be used to improve the DDC Program coverage and effectiveness.

A.I.D. will finance: 1) the purchase of equipment and supplies for five hospital-based Regional Training Centers for DDC in different Health Departments and 110 hospital-based oral rehydration units; 2) short-term training outside of Peru; and, 3) related technical assistance under the integrated health communications, epidemiological surveillance and statistical reporting programs. The MOH will finance: 1) in-country training and supervision at all levels of service related to the DDC Program; 2) all recurrent costs related to the treatment of diarrheal cases including the purchase of ORS; and, 3) local costs related to community education and mass media promotion. In addition, under the AID/W centrally-funded Project SUPPORT, credit for the purchase of equipment to increase production capacity and technical assistance to improve quality control and packaging will be provided to Laboratorios Unidos S.A. (LUSA), the local manufacturer of ORS. This support is in addition to the resources provided by A.I.D. under this Project. Other AID/W centrally-funded projects in applied diarrheal disease research also will finance studies in Peru to improve the delivery of DDC services and related training programs.

ii. Nutrition

A comprehensive Nutrition Program was incorporated into A.I.D. Project 527-0219, by amending that Project, in December 1984. In addition to providing a long-term Nutrition Advisor, A.I.D. funds supported training and supervision activities, the purchase of portable weighing scales, the printing of growth charts and teaching materials, research studies on weaning foods and the prevalence of iodine deficiency, and the development and diffusion of radio and television spots related to the dietary management of diarrhea. At the same time, analyses of data from the 1984 ENNSA Study resulted in improved targeting of PL 480 supplementary foods to the most malnourished populations of the rural sierra, and provided detailed information on the priority target populations. The Nutritional Functional Classification Study of Peru: Who and Where Are the Poor?[1/] determined that the groups in need of priority assistance in the rural areas were the families of day laborers, subsistence farmers and commercial farmers of the sierra, jungle and northern coast. The Study also found that three out of every four children living in the sierra were chronically malnourished, and the relative risk of malnutrition was almost four times greater for a child living in the sierra relative to a child who lived in metropolitan Lima.

The exact nature of nutrition activities, aimed at these population groups, to be financed under the Project will be defined in a plan which will be prepared by the MOH and submitted to A.I.D. for approval prior to the disbursement of A.I.D. funds for this purpose. Nutrition activities are likely to include growth monitoring, the promotion of appropriate breast-feeding practices for infants, research and the promotion of nutritious weaning foods, proper dietary management of diarrhea and improved targeting of the beneficiaries of supplementary feeding programs for

1/ Sigma One Corporation, January 1987.

pregnant and lactating women and preschool children in the rural areas of the sierra and jungle. Training and supervision of MOH personnel in these activities will be complemented by community education and promotion of nutrition education messages to communities and especially to mothers of infants and young children.

A.I.D. is likely to finance: 1) the purchase of equipment; 2) operations research studies on weaning foods; 3) short-term training outside of Peru; and, 4) related technical assistance under the integrated health communications, epidemiological surveillance and statistical reporting programs. The MOH is likely to finance: 1) in-country training and supervision at all levels of service related to the Nutrition Program; 2) all recurrent costs related with growth monitoring activities; and, 3) the local costs related to community education and mass media promotion.

iii. Immunizations

Diseases which could be prevented by immunizations are the fourth cause of death in Peruvian children less than one year of age (6.5% of all infant deaths in 1984). National vaccination campaigns carried out in 1984, 1985 and 1986 resulted in significantly improved rates of coverage--from less than 30% of children under five completely immunized before the 1984 campaign, to almost 80% complete coverage at the end of 1986. National statistics, however, are somewhat misleading in that coverage rates in urban areas, where health care services are more accessible, were over 90%, while in isolated areas, the MOH estimates that complete coverage was 50% or even less. In January 1987, the MOH approved its Five-Year Expanded Program of Immunization (EPI) National Plan of Action, with a goal of universal immunization of all children less than five years of age against measles, polio, diphtheria, whooping cough, tetanus and tuberculosis by 1991.

This Project will support the implementation of the MOH's EPI National Plan of Action. Activities under this Plan will be financed by PAHO ($.58 million), UNICEF ($.6 million), Rotary International ($.8 million), the MOH ($9.3 million), and A.I.D. ($2.5 million). Because the Peruvian Plan is included as a part of the PAHO Immunization of the Americas Five-Year Plan (which is funded by PAHO, AID/W, UNICEF, Rotary International and the IDB), A.I.D. financing of the Plan, which constitutes this Project component, was documented in a Memorandum of Understanding which was signed by the MOH and the other donor agencies on August 7, 1987. Regular coordination meetings between the MOH and the financing agencies will be held to ensure that inputs are provided in a timely manner, and that the program progresses as scheduled.

The immunizations component of this Project is designed to continue high levels of vaccination coverage (at least 80%) for children less than five years of age against measles, polio, diphtheria, whooping cough, tetanus and tuberculosis. This will be accomplished through targeted mini-campaigns organized by each UDES, and by strengthening MOH EPI logistics services to ensure that a functioning cold chain and vaccines are available at all service delivery points on a continuous basis. Public demand for available services also will be increased through community participation and the use of health communications, employing social marketing techniques.

In addition to the objective of fully immunizing at least 80% of children under the age of five, the Plan calls for immunization against tetanus of women who live in high risk areas and the eradication of the wild polio virus from Peru by the year 1990.

Because of its ambitious objectives, implementation of the EPI National Plan requires the involvement of all branches of the health sector, including IPSS, the Armed Forces, and private institutions. Other GOP agencies, especially the MOE and local governments, public and private sector institutions such as professional associations, scientific institutions, mass media communications agencies, pharmaceutical companies, and churches also will participate in the EPI program.

Under this Project, A.I.D. will finance: 1) the purchase of needles and syringes and related equipment and cold chain equipment; 2) short-term training outside of Peru; and, 3) related technical assistance under the integrated health communications, epidemiological surveillance and statistical reporting programs. The MOH will finance: 1) vaccines; 2) vaccination cards; 3) in-country training and supervision at all levels of service related to the Immunization Program; 4) all recurrent operational costs; and, 5) the local costs associated with community education and mass media promotion. Other donors will finance: 1) commodities, including vaccines, needles, syringes, vaccination cards, cold chain equipment and maintenance tool kits; 2) technical assistance; and, 3) specialized training in cold chain equipment maintenance.

iv. Family Planning (FP)

The MOH began offering family planning (FP) services under its Maternal-Child Health Program in 1980. A.I.D. support for the national level program began under Project 527-0230 in August 1981. Project support included equipment for hospitals and health centers, contraceptives, training of physicians, nurses, midwives, auxiliaries and community level promoters and traditional birth attendants (TBAs), and supervision of FP providers at all levels of service. Under this Project, USAID will continue to support the national FP program, which, in December 1986, became a high national priority with the strong personal and public support of the President.

This Project will support the implementation of the MOH's new National Family Planning Five-Year Plan, which was developed and approved in early 1987. The objective of the Plan is to contribute to Peru's national goal to reduce maternal and infant mortality and morbidity rates by reducing fertility from 4.2 children per woman in 1986 to 3.7 by 1991 for the entire country. The MOH will contribute toward achieving this goal by increasing the coverage of FP services to WFA in its target group from 28% in 1986 to 32% by 1991. The special emphasis of the program is the provision of FP services to women of high reproductive risk, with the target of 75% coverage of this group by 1991. Approximately 26% of WFA in Peru are over 30 years old and have more than four children, which puts them at high risk for both maternal and infant mortality. This group is the priority target population to receive FP services under the Project.

Since 1984, the MOH has focussed its FP efforts on women in high reproductive risk categories in order to reduce maternal mortality, which results primarily from hemorrhages due to pregnancy, birthing and abortions. Maternal mortality is highest for women less than 20 and more than 35 years old, women with many children, as well as those with closely spaced children because close spacing results in a cumulative reduction of the mother's nutritional status (maternal depletion syndrome) which is manifested in anemia and calcium and vitamin deficiencies.

Providing FP services to increase the amount of time between births not only will improve the status of mothers' health, but will actually reduce infant mortality rates. Results of the 1977-79 World Fertility Survey revealed that, in Peru, the infant mortality rate was 137.1 for children who were born less than 24 months after the next youngest sibling, but this figure decreased to 54.9 when children were spaced 48 months or more apart.

The demand for FP services is high. The 1986 ENDES Study found that 77% of all WFA did not desire any more children. Only 23% of these women, however, were using modern FP methods. Although the number of FP acceptors has steadily increased since the MOH program began in 1980, significant coverage rates have not yet been achieved. Lack of a well planned information, education and communications (IE&C) component, logistics problems, lack of supplies, and lack of trained professionals and paraprofessionals are the major constraints that will be addressed by this Project.

In order to increase the FP coverage rate of its target population to 32% by 1991, the MOH, with support under this Project, will increase FP services offered at health centers and posts, especially in rural and marginal urban areas, through a variety of activities. FP services will be provided in the late afternoon hours in marginal-urban areas. Appropriately trained personnel will be assigned or relocated to priority health centers and posts in rural areas. Five decentralized laboratories will be equipped to provide cervical cancer detection services. Ten Regional Demonstration-Teaching Centers also will be established. And, FP supplies will be provided to all health establishments at all levels of service through an improved warehousing infrastructure and logistics system.

IE&C activities will include mass media promotion of appropriate messages to sensitize the population to the demographic problem, and provide information regarding FP services. In collaboration with community organizations, printed materials such as posters, flipcharts and pamphlets will be developed, produced and financed by the MOH. A.I.D. will provide technical assistance and equipment to assist in the development of these materials. Other activities to increase community participation will be promoted and carried out by MOH personnel. Operations research studies and surveys will also be financed under the Project and/or through AID/W centrally-funded projects to improve FP service delivery and to monitor and evaluate the FP activities.

Specifically, A.I.D. will finance: 1) contraceptive supplies; 2) FP audio-visual and laboratory equipment; 3) short-term training outside of Peru; 4) long-term, in-country training in reproductive health, FP, and public health; and, 5) related technical assistance under the integrated health communications, epidemiological surveillance, and statistical reporting programs. The MOH will finance: 1) in-country training and supervision at all levels of service related to the FP program; 2) all recurrent costs related to the delivery of FP services; and, 3) the local costs associated with community education and mass media promotion. UNFPA will finance other contraceptives.

v. Control of Acute Respiratory Infections (ARI)

Acute respiratory infections (ARI) are the leading cause of death in children under age five in Peru. In this age group, 30% of all deaths are due to ARI, 50% of which occur in children less than one year of age. ARI occupies first place among the causes of morbidity from birth through age four. In health service facilities, 80% of all visits are associated with ARI.

This Project will support the implementation of the MOH's National Plan to Control Acute Respiratory Infections (ARI) which was designed in early 1987. The Plan emphasizes training and supervision activities for all levels of MOH personnel in the early detection and treatment of moderate and severe cases of ARI that can benefit from antibiotics. Also included in the Plan are community education activities aimed at increasing community participation in the control of ARI and in preventive activities such as immunization, improvements in sanitation and hygiene, and prolonged breast-feeding, and in the recognition and home treatment of early-stage ARI.

Under this component, A.I.D. will finance: 1) the procurement of equipment, including needles, syringes and related equipment, stethoscopes, ophthalmoscopes, and laboratory supplies; 2) short-term training outside of Peru; and, 3) related technical assistance under the integrated health communications, epidemiological surveillance and statistical reporting programs. The MOH will finance: 1) medicines; 2) in-country training and supervision at all levels of service related to the ARI Program; 3) all recurrent costs related to ARI activities; and, 4) the local costs associated with community education and mass media promotion.

b. Peruvian Institute for Social Security (IPSS)

This Project will provide support to IPSS in all five CS program areas. Both FP services initiated by the IPSS with A.I.D. assistance under previous A.I.D. projects and the delivery of the other CS services will be expanded under this Project.

i. Family Planning (FP)

The IPSS FP program began in 1981 under A.I.D. Project 527-0230 when A.I.D. began to supply contraceptives, equipment and training. Additional resources were provided to IPSS under another A.I.D. Project

initiated in 1986. It was designed to complement the MOH program and provide services to that population insured under the Peruvian Social Security system, which, in mid-1987, was 28% of the general population.

To achieve this objective, the IPSS will: 1) train personnel to deliver FP services; 2) assign personnel to provide FP services at its 26 hospitals, 48 polyclinics, 212 medical posts and 100 factory posts in all of its 32 Departmental Managerial Units (DMUs); 3) provide medical equipment and FP supplies to all health establishments; 4) provide adequate warehousing and distribution of contraceptives; and, 5) develop and disseminate appropriate IE&C materials. The IPSS IE&C strategy calls for the initial targeting of managers of small businesses, social workers from those businesses, and labor union leaders regarding the promotion of FP, followed by IE&C activities aimed at workers and other community members. Implementation of the IPSS FP program will be phased in, beginning in Lima and Ica in the first Project year (PY 1), expanding to Piura, Cuzco and Iquitos in PY 2, and to the rest of the country by the end of the Project.

Under this component, A.I.D. will finance: 1) the purchase of audio-visual and FP equipment, such as IUD insertion kits, specula and minilap equipment; 2) contraceptive supplies; 3) the services of a long-term Peruvian advisor for a minimum of two years; and, 4) selected in-country and all short-term training outside of Peru. IPSS will finance all the remaining local costs of the Program, including personnel, in-service training, supervision, logistics, supplies and monitoring.

ii. Other Child Survival (CS) Services

In addition to the MOH program, an objective of this Project is to reduce morbidity and mortality in children under age five in the IPSS target population. In order to do this, the IPSS plans to increase the numbers of health facilities and trained health personnel providing CS services. To achieve this objective, IPSS personnel from each of its 32 DMUs will receive training in DDC, nutrition, growth monitoring, immunizations and control of ARI under the Project. To implement those activities, the IPSS plans to: 1) establish and train a technical committee in each of the 32 DMUs that will be responsible for implementing CS activities in the 48 polyclinics, 212 medical posts, and 100 factory posts throughout the country where well baby (WB) clinics will be established and supported with equipment, supplies and training; 2) assign one person in each of its service delivery facilities to be responsible for CS activities; 3) closely coordinate with MOH UDES personnel who are managing similar CS programs to share experiences; 4) coordinate with other sectors (education, agriculture, etc.) in such activities as IE&C and nutrition; 5) ensure the timely acquisition and distribution of equipment and supplies to all service facilities; 6) provide continuous supervision from the central level to the DMUs and from the DMUs to the peripheral health facilities; 7) provide continuing education and in-service training for operational personnel in all DMU committees; and 8) maintain adequate records for evaluative and administrative purposes. Under the Project, A.I.D. funds will support these activities by providing medical equipment and supplies for CS interventions in IPSS hospital-based child health units and WB clinics in its polyclinics, medical posts and factory posts, training equipment, and selected in-country and overseas training.

IPSS currently provides prenatal and postnatal care through child health units in its 26 hospitals. In addition to strengthening the capability of these units, the Project will facilitate the expansion of CS services to IPSS's 48 polyclinics, 212 medical posts and 100 factory posts throughout the country where WB clinics will be established and supported with equipment, supplies and training. These WB clinics will offer services to children under age five and incorporate activities of growth monitoring and development, DDC, immunizations, control of ARI, nutrition education and teaching. In addition to the WB clinics, other health units that provide prenatal and postnatal care will be supported, and community outreach programs will be developed. A.I.D. funds will support these activities by equipping the WB clinics and other health units with scales, stoves, cold chain equipment and other CS equipment. A.I.D. also will finance the procurement of audio-visual equipment to carry out community education and training of health care providers at health establishments. IPSS will finance all of the recurrent costs for these programs.

On the hospital level, IPSS plans to establish two Rehydration Units to serve as Regional Training Centers for DDC which A.I.D. will support with laboratory and other equipment, and training. DDC is a relatively new program in IPSS. Accordingly, prior to establishing these units, IPSS will conduct intensive training for appropriate personnel. In this regard, A.I.D. will provide funds to train teams of physicians and nurses who will manage these Regional Training Centers for DDC, possibly through the training program at the Rehydration Unit at Cayetano Heredia Hospital in Rimac. These two new units will then also be used to train health care providers in other IPSS establishments. In addition, through training for physicians and nurses, the norms in the IPSS hospitals regarding the promotion of rooming-in and breast-feeding will be implemented. All CS activities of IPSS will be carried out in accordance with national norms developed by the MOH.

In summary, A.I.D. will finance: 1) selected in-country and overseas training; and, 2) the purchase of equipment for the WB clinics, hospital-based child health units, and Regional Training Centers for DDC, including scales, stoves, cold chain equipment, and audio-visual equipment. The latter will be used to train IPSS personnel and support community education activities. IPSS will finance all remaining local costs including personnel, in-service training, supervision, logistics, supplies and monitoring.

2. Strengthening Decentralized Support Systems for Sustainable Child Survival (CS) Services

Project assistance to strengthen decentralized support systems will ensure that CS services are institutionalized during the life of the

Project, and that they continue to be delivered by health care providers after the Project's completion. The support systems that will be stengthened under this Project include: training and supervision; health communications; financial and personnel management and logistics; active epidemiological surveillance (VEA); and the health information system (HIS). In all these areas, A.I.D. will finance: 1) all foreign exchange costs related to the purchase of equipment and supplies; 2) technical assistance; 3) all overseas training and selected in-country training; and, 4) local currency costs that facilitate the development of the newly designed support systems of VEA and HIS. The MOH and the IPSS will finance local recurrent costs for such routine and regularly scheduled activities as in-service training and supervision visits.

a. Training and Supervision

As part of the Project, the MOH has prepared a comprehensive and detailed integrated training plan and an integrated supervision plan for the five-year life of the Project, which will provide technical and administrative support to the MOH field staff who deliver CS services. The training plan will be implemented by the UDES training units and the central MOH. In the same manner, the IPSS has developed a comprehensive and detailed integrated in-service training plan and supervision activities which will support the staff who work at the IPSS FP and WB clinics and hospital-based child health units.

Under these plans, in-service training and supervision activities on a regular basis for staff at all levels of service are included in all of the Project's components--both technical interventions as well as administrative support systems. Physicians, nurses and other health personnel will be trained to plan, provide and supervise CS interventions-- control of diarrhea with ORT, growth monitoring and nutrition education, proper vaccination procedures and sterile technique, assessment of reproductive risk and provision of FP services, and ARI treatment. In addition, specialized technical training outside of Peru as well as participation in international seminars in FP, DDC, nutrition, immunization and ARI, among others, is included. To enable the MOH to develop a strong disease surveillance and control program, this Project will support specialized training in Peru, the U.S. and third countries. (See below.)

Training courses to support improvements in the MOH's capacity to administer programs are being financed under A.I.D. Project 527-0230. These training courses will continue throughout the life of this Project with funds provided by the MOH. This training is given to the 400 personnel in the Budget Executing Entities (EEP's) who, under the new MOH decentralization plan, are responsible for and are being trained in budget formulation, personnel selection and contract bidding procedures.

In order to guarantee the successful development of the Health Information System (HIS) and the active epidemiological surveillance system nationwide and the availability of the information

required to manage and monitor CS programs (financial, logistic, personnel), A.I.D. will support training costs related to installing and using computers in all 28 UDES. The benefits of using automated data processing equipment and proper selection of trainees will be stressed to UDES Directors while the system is being developed in order to avoid past problems of un - or underutilized computers.

To ensure that the decentralized health delivery system operates effectively, regular supervision visits are essential, from the central level to the UDES and from the UDES to the hospitals, health centers and posts at the peripheral level. Supervision expenses are recurrent costs that will be financed by the MOH and the IPSS. Supervision visits will be carried out according to national norms and will be coordinated among those responsible for technical and administrative project monitoring. A successful supervision program depends, in large part, on the availability of adequate transportation. Accordingly, vehicles purchased under previous A.I.D. Projects will be assigned to UDES to support the MOH's CS program. Also, a needs assessment will be undertaken by the MOH to verify proper vehicle use and to identify additional vehicle needs. A limited number of new vehicles will be financed by A.I.D. and procured in stages, based on the outcome of the needs assessment.

In summary, under this component, A.I.D. will finance: 1) off-shore audio-visual and other training equipment for the MOH and the IPSS; 2) long-term training in public health, reproductive health and FP in Peru and short-term training within and outside of Peru in CS technical areas for MOH and IPSS staff; 3) all in-country and overseas training related to the development and installation of the MOH VEA and HIS systems; and, 4) vehicles for supervision activities. The MOH will finance: 1) all local costs of the supervision plan; 2) the majority of the activities in the training plan; and 3) vehicle operating and maintenance costs. The IPSS will finance in-service training and supervision activities which will support the staff who work at the IPSS FP and WB clinics and hospital-based child health units.

b. Integrated Health Communications

Peru has been using radio and television advertising to promote good health behavior for many years. Under Project 527-0230, A.I.D. financed technical assistance and social marketing research to develop a national campaign to promote responsible parenthood, use of ORT, and vaccination of children, beginning in 1984. A.I.D. also financed television and radio spots and the printing of written materials which were developed and tested by a Peruvian private sector advertising agency, and were aired according to a media plan, designed by the advertising agency, to reach the target audience.

The specific health communications activities to be financed under this Project will be defined in an integrated plan which will be prepared by the MOH and submitted to A.I.D. for approval prior to the disbursement of A.I.D. funds for this purpose. Health communications

activities are likely to include: workshops on popular education methods to promote community participation to increase coverage of CS health services; the production of community level printed materials with health education messages promoting CS activities; social marketing research to serve as a basis for developing printed and radio promotional materials; and the purchase of equipment needed to produce printed and radio promotional materials.

Under this Project, each of the CS interventions--DDC, nutrition, immunizations, FP, and ARI control--will be supported by the development and broadcasting of mass media messages and the promotion of community participation. One of the important lessons learned from previous experience is that media messages alone will not result in changed behavior. They must be supported by personal contacts reiterating these same messages, and supplies and services needed to adopt the new (desired) behavior must be readily available.

A.I.D. is likely to finance: 1) technical assistance required to carry out the workshops, social marketing research, and the production of promotional materials; 2) some of the local costs of the research studies; and, 3) the purchase of equipment required to produce the promotional materials. The MOH is likely to finance the local costs required to implement the workshops and reproduce and distribute promotional materials.

c. Financial and Personnel Management and Logistics

Financial and personnel management and logistics are three critical systems that must function effectively if CS services are to be successfully delivered. Under previous Projects, A.I.D. provided regional and central level technical advisors, equipment and materials, training and supervision to strengthen these support systems. In addition, financial management computer software packages were designed and installed on the central level WANG VS65 system and on microcomputers which are being used by personnel at the Central Budget Unit (UP) offices. Computer software packages for personnel management and logistics also have been developed by the MOH. This Project will support the expansion of the computerized systems for financial and personnel management and logistics to the 28 UDES, through the installation of microcomputers and software packages to connect all UDES and the central level to the same system, and the training of UDES personnel in the use of the automated data processing equipment and software programs. Currently, only the MOH central level and three UDES are utilizing these automated systems.

A preliminary survey of warehouse facilities in several UDES indicated that many warehouses at the departmental level need to be rehabilitated and that facilities were either deficient or totally lacking at the hospital and health center levels. Under the Project, the MOH and the IPSS will undertake a comprehensive assessment of the current status of all their warehouse facilities to identify the rehabilitation and construction requirements related to the storage and distribution of Project-financed commodities for CS services delivery and food provided by A.I.D. under other

Projects for the MOH feeding program. Based on the results of the assessment, the MOH and IPSS will make improvements in warehouse facilities that require rehabilitation, construct facilities where needed at hospitals and health centers, and train warehouse personnel in inventory control and commodity distribution procedures.

In summary, A.I.D. will finance computers, software programs and Peruvian computer systems engineers (see the HIS component below) who will install equipment and train UDES personnel in the use of the financial management, personnel management, and logistics systems computerized programs which have already been developed. The MOH and IPSS will finance: 1) the assessment of the status of warehouse facilities; 2) the rehabilitation and construction of facilities as necessary; and, 3) the training of warehouse personnel.

d. Active Epidemiological Surveillance (VEA) Program

The development of a comprehensive epidemiological surveillance system and appropriately trained epidemiologists are critical to the successful implementation of Peru's health policy and its CS programs. An epidemiological surveillance system will provide information to program planners on the patterns of diseases that cause high mortality and morbidity, as they affect different population groups in different geographic areas. This information will provide a rational basis for systematic planning, design, monitoring, and evaluation of the MOH's disease control and prevention programs, which are critical to improving CS.

This Project will support the development and implementation of a comprehensive national Active Epidemiological Surveillance System (VEA) within the MOH. Three major activities will be carried out: i) an intensive in-country field epidemiological training program (FETP) for up to 35 participants; ii) the installation of a national computerized VEA system, including the training of personnel in the 28 UDES; and, iii) strengthening of the national laboratory system to support VEA and CS activities.

i. Field Epidemiological Training Program (FETP)

In order to establish and sustain a functioning VEA system, a cadre of well-trained medical epidemiologists located in each UDES is required. The U.S. Centers for Disease Control (CDC) has developed and implemented a two-year training program of classroom and field-based coursework for medical epidemiologists in developing countries. CDC will provide a long-term consultant and short-term consultants to adapt the FETP to the Peruvian environment, train four classes of up to eight to nine field epidemiologists each over the life of the Project, and institutionalize the FETP in Peru. Course participants will include 30 MOH physicians with field epidemiology experience, who will be assigned to manage VEA activities in the

UDES upon completion of their coursework, as well as up to five physicians from IPSS and other Peruvian agencies. CDC will provide training materials, computerized epidemiological statistical packages, and access to the CDC worldwide network for epidemiological surveillance, based in Atlanta, Georgia in the U.S. The FETP will support the development of the MOH VEA system through training and surveillance activities carried out by the course participants.

A.I.D. will finance: 1) CDC technical assistance; 2) training supplies and materials; 3) computer equipment and software packages; and, 4) overseas and local training costs. The MOH will be responsible for providing appropriate classroom facilities, selecting appropriate FETP candidates and establishing in each UDES an upgraded epidemiologist position for FETP graduates upon completion of their coursework.

ii. Installation of a National Computerized VEA System

The Project will support the development of a national computerized VEA system, including the establishment of 15 sentinel surveillance sites, an obligatory disease reporting system, and training of auxiliary personnel in surveillance, notification and control of selected diseases that cause high mortality and morbidity, especially those related to Project-supported interventions--immuno-preventable diseases, diarrheal disease and acute respiratory infections that affect infants and children. Nutritional surveillance and FP activities will also be included. Through the national computerized VEA system, MOH staff responsible for the Project will be able to monitor CS Program inputs and the impact of these Programs on improving CS rates.

A.I.D. will finance: 1) the purchase and installation of computer equipment; 2) local costs associated with the development of the sentinel surveillance system; and, 3) all training costs associated with the development and installation of the VEA system. The MOH will: 1) provide appropriate facilities and personnel required to establish the system; and, 2) finance the local costs associated with surveillance activities.

iii. Strengthening the National Laboratory System

The Project will strengthen the National Institute of Health central laboratories, five regional referral laboratories in five UDES, and the 23 remaining UDES laboratories by providing training, equipment and supplies. Training of laboratory personnel will take place in Peru and in the U.S. and will include clinical and epidemiological aspects of diseases, procedures for the collection and transportation of specimens and special laboratory techniques. A.I.D. will finance all the costs associated with this activity, namely, all training costs and the purchase of equipment and supplies.

e. Health Information System (HIS)

The Technical Directorate of Informatics and Documentation (DTID) is responsible for planning and overseeing the automation of all MOH information and management systems and providing computer expertise to support these systems. The MOH's Health Information System (HIS) supports automated data processing of information related to MOH administration, including budgeting, financial management, personnel management and logistics, as well as health statistics and epidemiological information. Redesign and computerization of the MOH's HIS began under previous A.I.D. Projects with A.I.D.-financed technical assistance, commodities, training and supervision. Resources from A.I.D. and other donors were coordinated to support the MOH's National HIS plan, which calls for a decentralized system of microcomputers in each UDES with a larger computer (WANG VS65) at the central office. The MOH established priorities for computerizing MOH administrative systems beginning with financial management. Software packages were developed and are currently being used in some UDES for financial, logistics and personnel systems. A health statistics package is also being developed under A.I.D. Project 527-0230.

This Project will support the expansion of the HIS to all 28 UDES by providing computer equipment and supplies, development of software packages, technical assistance and training. Specifically, A.I.D. will finance: 1) the purchase of computers, supplies and software; 2) the training of UDES personnel; 3) a long-term Peruvian HIS advisor at the central level; and, 4) the services of a Peruvian computer systems engineer for each UDES for one year. The computer systems engineers will install computer hardware and software, establish a computer center in each UDES, and train UDES personnel. Before the end of the one-year period, the UDES will establish a permanent position for a computer systems engineer on its staff, and an individual, financed by the MOH, will be hired to fill the position. The MOH will: 1) provide the facilities for the UDES computer centers; 2) finance the local costs for supervision of HIS activities; and 3) create and finance permanent positions for computer systems engineers for each UDES.

IV. IMPLEMENTATION PLAN

A. Administrative and Monitoring Arrangements

Three institutions will be involved in the implementation of this Project: 1) the MOH, including both the central level and the 28 Health Departments (UDES); 2) the IPSS, including both the central level and the 32 Departmental (and Zonal) Managerial Units (DMUs); and, 3) USAID/Peru.

1. Government of Peru (GOP)

a. Ministry of Health (MOH)

i. Central Level

The MOH shall appoint a National Project Director to serve as the overall coordinator for the Project and the principal MOH counterpart of the USAID Project Manager and the IPSS National Project Director for the day-to-day implementation of the Project. This individual shall also be designated an authorized representative of the GOP for purposes of this Project. He/she shall have central coordination, monitoring and evaluation responsibilities although field operations will be executed by the UDES. Specifically, he/she shall be responsible for, at a minimum: 1) ensuring the timely preparation and submission to USAID of all documentation relating to the meeting of conditions precedent and covenants; 2) ensuring the timely preparation of required USAID program and financial reports; 3) ensuring the timely coordination of inputs and activities among offices and administrative units at the central level of the MOH and between the central level and the 28 UDES; 4) preparing requests for disbursement of MOH counterpart and A.I.D. funds for local cost financing; 5) arranging for the receipt and delivery of all Project-financed commodities at both the central and departmental levels; 6) ensuring the efficient and appropriate use of Project-financed technical advisors, commodities and vehicles; and, 7) ensuring the timely identification and release of trainees for overseas training.

The National Project Director shall be assisted by a Project Management Team, composed of representatives from various offices in the central MOH, who shall have direct responsibility for all aspects of implementation of their specific components of the Project as follows:

1) Diarrheal Disease Control: Director, Control of Diarrheal Diseases Program, Technical Directorate of Special Programs (DTPE);

2) Nutrition: Director, Complementary Feeding Program (PAC), DTPE;

3) Immunizations: Director, Expanded Immunizations Program, DTPE;

4) Family Planning: Director, National Family Planning Program, DTPE;

5) Control of Acute Respiratory Infections: Director, Control of Acute Respiratory Infections Program, DTPE;

6) Integrated Training: Director, Technical Directorate of Human Resources Development (DTRH);

7) Integrated Supervision and Evaluation: Director, Technical Directorate of Programs, Norms and Services (DTPNS);

8) Integrated Health Communications: Director, Office of Community Participation;

9) Financial Management and Logistics: Director, Technical Directorate of Administration (DTA);

10) Active Epidemiological Surveillance Program (Field Epidemilogical Training, VEA Laboratories and Active Epidemiological Surveillance System): Chief, Active Epidemiological Surveillance Unit (DTID); and,

11) Health Information System: Director, Technical Directorate of Informatics and Documentation (DTID).

Each of the individuals responsible for specific Project components shall, at a minimum: 1) ensure the timely coordination of the activities of his/her component with those of the other components and other offices and administrative units of the MOH; 2) provide appropriate counterparts to work with consultants; 3) liaise on a day-to-day basis with USAID staff, including the A.I.D. Management Team and the Regional Coordinators; 4) participate as resource personnel in Project evaluations and audits; and 5) monitor and facilitate implementation of his/her component at the UDES level.

The MOH's Technical Directorate of Administration (DTA) also shall assume overall responsibility for monitoring the disbursement and liquidation of A.I.D. and GOP funds for local cost financing and for monitoring the direct disbursement by USAID of A.I.D. funds for foreign exchange costs under the Project. Specifically, DTA shall, at a minimum: 1) submit requests from the MOH National Project Director for disbursement of A.I.D. funds to USAID; 2) submit requests from the MOH National Project Director for disbursement of GOP counterpart funds through the MOH's Technical Directorate of Planning and Budget to the MEF; 3) prepare consolidated financial reports for USAID and provide staff support to the UDES as necessary to assist them in this process; 4) prepare consolidated financial reports for the MEF; and 5) advise the MOH National Project Director, all members of the MOH Project Management Team, the UDES, and USAID regarding the status of approvals, disbursements, and liquidations of GOP counterpart funds for the Project. In addition, DTA shall be responsible for executing all local commodity procurements under the Project.

The Technical Directorate for Coordination of External Cooperation (DTCCE) shall ensure that the Project is carried out by the MOH in accordance with the terms and conditions in the Project Agreement. In addition, DTCCE shall ensure the timely coordination of inputs and activities

among the various donors who are providing complementary financing to the MOH in several of the areas being financed by A.I.D. under this Project. The Director of DTCCE also shall be designated an authorized representative of the GOP for purposes of this Project. Finally, the MOH's DTPNS shall assume overall responsibility for commodity procurement planning and all monitoring and evaluation activities under the Project.

ii. Departmental Level

Peru is divided into 25 geopolitical Departments, each one with its corresponding UDES. With four UDES in Lima and one UDES in each of the remaining 24 Departments (including Callao), there is a total of 28 UDES. These 28 UDES shall be responsible for implementing all CS activities at the field level under this Project.

The Director General of each UDES shall assume overall responsibility for implementation of the Project in his/her Department. He/she shall appoint a Project Coordinator to assume direct responsibility for the day-to-day management of the Project in the UDES. This individual is likely to be the Director of the General Office for Technical Support within the UDES. Each UDES shall establish a Project Management Team, modelled after the central level, consisting of representatives from various offices within the UDES and peripheral health facilities, who shall have direct responsibility for specific components of the Project. The size and composition of the Project Management Team will vary depending on the size and organizational structure of the individual UDES. Figure 2 shows the typical organizational structure for a large UDES. In small UDES's, there are fewer staff who are responsible for multiple program areas.

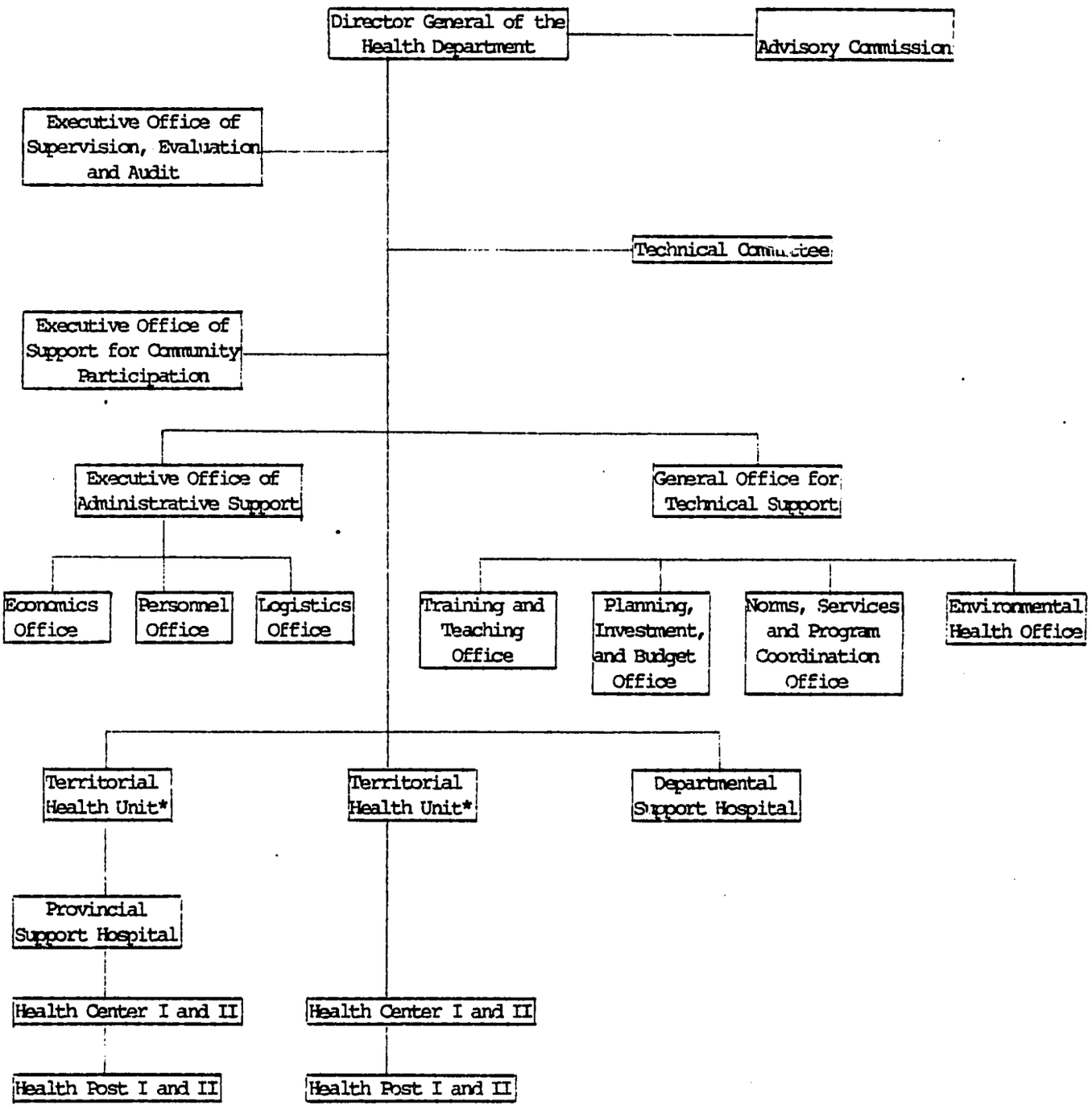
b. Peruvian Institute of Social Security (IPSS)

i. Central Level

The IPSS shall appoint a National Project Director to serve as the overall coordinator in IPSS for the Project and the principal IPSS counterpart of the USAID Project Manager and the MOH National Project Director for the day-to-day implementation of the Project. He/she shall also be designated an authorized representative of the GOP for purposes of IPSS activities under this Project. This individual is likely to be the Director of the National Directorate of Health, who shall report directly to the President of IPSS on all matters relating to this Project.

IPSS will establish a National Directorate for Project Administration made up of the following: 1) the National Project Director; 2) the Directors of the CS and FP Programs; and, 3) a Project Coordination Office for Administration and Accounting. This Directorate shall have central

FIGURE 2. GENERAL ORGANIZATION OF A HEALTH DEPARTMENT (UDES)



* Proposed; not in existence yet.

coordination, monitoring and evaluation responsibilities although field operations will be executed by the DMUs at the departmental level. Specifically, this Directorate shall be responsible for, at a minimum: 1) ensuring the timely submission to USAID of all documentation relating to the meeting of conditions precedent and covenants; 2) ensuring the timely preparation of required USAID program and financial reports; 3) ensuring the timely coordination of inputs and activities among offices and administrative units at the central level of IPSS and between the central level and the 32 DMUs; 4) arranging for the receipt and delivery of all Project-financed commodities at both the central and departmental levels; 5) ensuring the efficient and appropriate use of Project-financed technical advisors and commodities; and 6) ensuring the timely identification and release of trainees for overseas training.

The National Project Director shall be assisted by two individuals: 1) the Director of the Preventive/Promotional Services Directorate who is responsible for all CS interventions (except FP) and PHC services within IPSS; and 2) the Director of the National Family Planning (FP) Program, who is responsible for all FP activities within IPSS. These individuals shall report directly to the National Project Director for all activities under the Project. They shall assume the same responsibilities for their Project components within IPSS as the Directors who are responsible for specific Project components within the MOH, with the former managing all CS activities, with the exception of FP, and the latter assuming responsibility for all FP activities in IPSS under the Project. The Project Coordination Office for Administration and Accounting will be responsible for: 1) coordinating IPSS administrative and financial management responsibilities under the Project; 2) preparing consolidated financial reports and monitoring the financial status of the Project; and, 3) reporting the status of Project activities to the National Project Director, the Directors of the Preventive/Promotional Services Directorate and the National FP Program, the DMUs, and USAID.

ii. Departmental Level

The IPSS is subdivided into 32 Departmental and Zonal Managerial Units, 8 in the greater Lima Metropolitan area (known as Zonal Managerial Units), and one in each of the remaining 24 Departments (known as Departmental Managerial Units). These 32 DMUs shall be responsible for implementing all CS activities at the field level under this Project.

The Director of each DMU shall assume overall responsibility for implementation of the Project in his/her Department. He/she shall chair a multi-disciplinary CS Committee to implement CS activities in all hospitals, polyclinics and medical and factory posts under his/her jurisdiction. Such committees have already been established in all 32 DMUs and have participated in the development of operational plans for CS activities for calendar year (CY) 1988. Each Committee is composed of physician(s), nurse(s), a midwife, a nutritionist, and personnel in statistics, logistics and financial management. Each hospital and polyclinic in each DMU shall assign one individual full-time to manage CS activities. Each medical and factory post shall assign one individual part-time to manage

CS activities. Each CS Committee shall be responsible for coordinating Project planning and implementation within the DMU, between the DMU and the central level of IPSS, and between the DMU and the UDES in the same Department.

2. A.I.D.

The USAID Office of Human Resources (O/HR) shall have overall responsibility within USAID for managing the Project. The Chief of the Health and Nutrition Division within O/HR shall serve as the Project Manager and shall be responsible for the administrative approval of all Project inputs and for the overall monitoring and coordination of the Project. The Project Manager shall be assisted by three full-time Personal Service Contractors (PSCs) who, along with the USAID Project Manager, shall comprise the USAID Management Team. These individuals shall be hired under direct A.I.D. contracts with Project funds designated for this purpose.

The Project Manager shall be assisted in all contracting and procurement actions by the Regional Contracts Officer, located in Quito, and the Mission's Executive Office; all financial matters by the Office of the Controller; all evaluation, donor coordination, and project design/implementation activities by the Office of Program; all training activities by the Training and Social Development Division within O/HR; all logistics matters by the Executive Office; all feeding program activities by the Food for Development Division within O/HR; and all FP activities by the Population Division within O/HR. These Mission staff resources shall be supplemented by AID/W backstop staff in the Office of Development Resources in the Bureau for Latin America and the Caribbean (LAC/DR), various offices within the Bureau for Science and Technology (S&T), and the Office of Data Management and the Office of Contracts and Commodity Procurement in the Management Bureau as well as the Regional Legal Advisor, located in Quito.

3. Project Coordination Committee

To provide policy oversight and overall program review and direction, and to ensure adequate monitoring and evaluation and adequate coordination of activities between the MOH and the IPSS, a Project Coordination Committee shall be established composed of representatives of the MOH, IPSS, and USAID. The Committee is likely to be chaired by the Vice Minister (Health) of the MOH. Representatives from the MOH are likely to include the National Project Director, the Director of the DTA and the Director of the DTCCE. Representatives from the IPSS are likely to include the National Project Director, the Director of the Preventive/Promotional Services Directorate, and the Director of the National FP Program. USAID shall be represented by the Chief of O/HR and the Chief of the Health and Nutrition Division within O/HR (USAID Project Manager). Representatives from other MOH and IPSS central offices, the UDES, DMUs, the USAID Management Team and the Regional Coordinators may also be invited to attend Project Coordination Committee meetings. The Committee shall meet, at a minimum, quarterly, with the first meeting likely to be convened in early January 1988.

B. Implementation Schedule

1. Implementation Strategy

The Project shall be implemented in the Health Departments in accordance with annual operational plans and budgets prepared by the UDES and approved by both the central MOH and USAID. Regional planning/evaluation workshops will be held each year, involving UDES, DMU and central MOH, IPSS and USAID representatives, to facilitate this process. The first three workshops, each focussing on 8-10 UDES, are expected to occur in November 1987. The first year's workshops will have two major objectives: a) to advise all MOH and IPSS personnel about the nature of the Project and their respective roles and responsibilities under the Project; and b) to finalize MOH operational plans and budgets, which will cover activities to be implemented in CY 1988.

The UDES plans and budgets will operationalize, consolidate and integrate the vertical program plans formulated by the central MOH Directors responsible for the CS service delivery and support system programs. Since the UDES have already prepared operational plans and budgets for their regular programs for CY 1988, this exercise should not require a substantial amount of additional work by the UDES. In their operational plans, UDES staff will determine the schedule for the implementation of CS field activities and will identify the target beneficiary populations to be served and the corresponding health posts, health centers, and support hospitals which will be targeted under the Project. The plans will also define the human, physical, and financial resources required to implement the Project. This programming exercise will involve representatives from the IPSS DMUs in the same Departments in order to ensure complementarity between MOH and IPSS services and to enhance the impact of CS services in each Department.

Immunization and FP activities under the Project will be implemented in all 28 UDES simultaneously beginning in the first Project year (PY 1). However, other service delivery and support components of the Project will be phased in, in different UDES, over the first three Project years as follows: eight UDES in PY 1, eight additional UDES in PY 2, and the remaining 12 UDES in PY 3. Thus, by the end of PY 3, all service delivery and support components of the Project will be operating in all 28 UDES. CS activities in all five program areas are being carried out to varying degrees in all of the UDES at the present time. What will be phased in are the additional resources provided by the Project to improve and expand these services.

Table 15 shows an illustrative phased implementation approach for CS Project activities by PY in all 28 UDES. Criteria used in the selection of the initial group of 8 UDES included total numbers of target group beneficiaries (children under five and mothers in rural and marginal urban areas), health services coverage, health status, and management capacity of the individual UDES. UDES with varying degrees of administrative/management capacity were included in the initial group in order to enable Project personnel to gain experience in implementing the program under a variety of conditions before expanding the program to other UDES.

TABLE 15. Illustrative Phased Implementation Approach for Project Activities in the UDES [a]

	PROJECT YEAR (PY)		
	PY 1	PY 2	PY 3
	Puno	Arequipa	Moquegua
	Cusco	Apurimac	Tacna
	South Lima	Callao	Madre de Dios
	Cajamarca	La Libertad	East Lima
	Huanuco	Ancash	Ica
	Loreto	Junin	Amazonas
	Piura	Tumbes	San Martin
	North Lima	Huancavelica	Pasco
			Ucayali
			Lambayeque
			West Lima
			Ayacucho
TOTALS	8	8	12

a/ FP and immunization activities under the Project will be implemented in all 28 UDES simultaneously beginning in PY 1 for the five-year life of the Project. All other service delivery and support activities under the Project will be phased in during the first three PYs.

The IPSS has already prepared a consolidated operational plan for implementation of the Project in CY 1988 at both the central level and the DMUs. This plan indicates target geographical zones for establishing well baby (WB) clinics and FP services in all 32 DMUs. All Project activities will be implemented simultaneously in all 32 DMUs beginning in PY 1, with the exception of FP activities. Implementation of the IPSS FP Program will be phased in, beginning in Lima and Ica in PY 1, expanding to Piura, Cuzco and Iquitos in PY 2, and to the rest of the country by the end of the Project. Annual consolidated plans will be prepared by IPSS throughout the life of the Project. CS activities are being carried out in all DMUs, although on a limited basis. This Project will provide additional resources to the IPSS to facilitate the expansion of CS services in all of its 32 DMUs.

To facilitate coordination between the DMUs and UDES within the same Departments, among the DMUs and UDES in all 25 Departments, and between the departmental and central levels in both the MOH and IPSS, eight Peruvian Regional Coordinators (RCs) will be contracted under the Project for the life of the Project. Beginning in PY 1, the RCs will work intensively with the initial group of eight UDES to assist them in developing and implementing their operational plans for all the service delivery and support programs. Each RC will also work closely with up to three additional UDES to assist them in the design and implementation of their FP and immunization programs and to prepare them for the eventual implementation of all the CS service and support programs under the Project. As the Project is phased into new UDES each year, each RC will assume major responsibility for additional UDES such that by the end of PY 3, each RC will be working intensively with either three or four UDES within one geographic area. Table 16 provides an illustrative plan for geographic coverage by the Regional Coordinators (RCs).

2. Project Start-Up Activities

The first Project year will consist of a three-month start-up phase, from approximately October 1, 1987 through December 31, 1987, followed by 12 months of implementation of field operations, which corresponds to CY 1988. The following activities are expected to be completed or initiated during the start-up phase of the Project:

a. The GOP will meet the initial conditions precedent relating to the submission of a legal opinion and the designation of authorized representatives.

b. The MOH and the IPSS will each designate a National Project Director and the members of the Project Coordination Committee, and procedures for setting agendas, convening meetings, preparing and approving minutes of the meetings, and implementing the Committee's recommendations will be established.

c. The MOH and the IPSS will each secure the required counterpart funding for CY 1988.

TABLE 16. Illustrative Plan for Geographic Coverage by the Regional Coordinators (RCs)

	RC 1	RC 2	RC 3	RC 4	RC 5	RC 6	RC 7	RC 8
	Puno Arequipa Moquegua Tacna	Cusco Apurimac Madre de Dios	South Lima Callao East Lima Ica	Cajamarca La Libertad Amazonas	.uco Ancash San Martin Pasco	Loreto Junin Ucayali	Piura Tumbes Lambayeque	North Lima Huancavelica West Lima Ayacucho
TOTAL	4	3	4	3	4	3	3	4

d. The IPSS will appoint a full-time individual employed by the GOP to the post of Director of its National FP Program.

e. The IPSS will establish a National Directorate for Project Administration and grant it administrative and financial autonomy and independence for all activities under the Project.

f. USAID will hire three PSCs to serve as members of the USAID Management Team.

g. The MOH and USAID will initiate recruitment efforts and arrange for the hiring of eight Peruvian Regional Coordinators.

h. Three regional planning workshops of five days duration each will be held, involving an average of five representatives from each UDES as well as central level IPSS and MOH staff, USAID staff, and staff of the DMUs within the same Departments as the UDES.

i. The USAID Management Team, Regional Coordinators and central MOH staff will make follow-up visits to the initial group of eight UDES, after the regional workshop, to finalize their detailed operational plans and budgets for CY 1988, which will then be submitted to the MOH and USAID for approval.

j. CY 1988 Operational plans and budgets for the remaining 20 UDES will be finalized and submitted to the MOH and USAID for approval.

k. The MOH will verify the location and use of vehicles financed by A.I.D. under Projects 527-0219 and 527-0230 and will undertake a detailed analysis of vehicle availability and additional vehicle needs for CS activities as well as specific requirements under the Project, and will submit this information to USAID along with a plan to ensure the proper use and maintenance of Project-financed vehicles.

l. The MOH will submit to USAID detailed scopes of work and qualifications for the Peruvian computer systems engineers and the Peruvian health information system advisor to be hired with Project funds to support the HIS component.

m. USAID will arrange for the Office of Data Management in AID/W to review and approve the MOH's automated data processing system design and equipment requirements.

n. The MOH will sign a Letter of Understanding with the CDC for the FETP and VEA activities.

o. The MOH will submit to USAID for approval, detailed plans and budgets for the Nutrition and Integrated Health Communications programs.

p. USAID will issue Project Implementation Letters (PILs) explaining the procurement and financial management procedures to be used under the Project.

q. USAID, the MOH and the IPSS will review and finalize the lists of commodities and supplies to be procured during PY one. This exercise will include: 1) the verification of the specifications, estimated prices, and quantities of each item to be procured, taking into account actual inventories of existing equipment and supplies provided by UDES and DMU personnel; and 2) the submission of plans by the UDES and DMUs for the actual distribution of these items in departmental and peripheral health facilities.

r. The MOH and the IPSS will undertake surveys to determine the adequacy of warehousing facilities in the UDES and DMUs which will receive Project commodities, and will take the necessary action to begin the process of constructing new facilities or rehabilitating existing facilities as required.

s. USAID will place orders for vehicles for the Regional Coordinators and technical advisors.

t. Once the relevant conditions precedent have been met, USAID will issue PILs to earmark A.I.D. funds for foreign exchange costs and to commit A.I.D. funds for local currency costs for activities in support of field operations at the departmental level, and will initiate the procurement process for all technical advisors under the Project and all vehicles, commodities, and other supplies to be procured during PY 1.

u. Data will be collected by the MOH and the IPSS to serve as baseline information for evaluation purposes throughout the life of the Project. (See Monitoring and Evaluation Plan.)

3. Schedule of Activities for Operational Year One

By January 1988, most of the conditions precedent to disbursement of A.I.D. funds for activities to be undertaken in PY 1 should be satisfied. During the initial months of CY 1988, MOH and IPSS central level staff and USAID will focus their efforts on: a) finalizing arrangements for contracting the services of the eight Regional Coordinators, the HIS advisor, the FP advisor, the CDC epidemiologist and the three members of the A.I.D. Management Team; b) collecting baseline data for monitoring and evaluation

purposes; c) finalizing commodity lists and specifications and placing orders for commodities; d) securing counterpart funds from the MEF and, for the MOH, the first advance of funds from A.I.D.; e) finalizing the review and approval of the operational plans and budgets of the 28 UDES; f) finalizing the review and approval of the MOH's plans for the Nutrition and Integrated Health Communications programs; g) finalizing the supervision schedule for CY 1988; h) identifying candidates for the first FETP class and for overseas and in-country scholarships; and, i) with the UDES's and DMU's, finalizing the training plan and schedule for CY 1988. It is anticipated that the Project Coordination Committee will hold its first meeting toward the end of January 1988 and that it will meet quarterly thereafter. Also, it is expected that the MOH and IPSS will initiate a program of warehouse improvements beginning in January, which will extend over a period of three to six months. Central level staff will make two supervision visits to all the Departments during CY 1988. The recruitment and hiring of the Peruvian computer systems engineers for the initial group of eight UDES should begin in March/April such that they are on board and have gone through an orientation program prior to the arrival of computers in August/September.

Complementary activities will be taking place simultaneously at the UDES and DMUs. Their major attention will be focused on implementing the CS health services delivery activities scheduled in their operational plans. In addition, the UDES and DMUs will have to devote considerable time and effort to designing, implementing and evaluating a variety of training programs during CY 1988. Similarly, regularly scheduled supervision visits will be undertaken by the UDES and DMUs throughout the year to the departmental and peripheral health establishments. Actual implementation of warehouse improvements will be the responsibility of the UDES and DMUs, and they also will participate in the baseline data collection efforts. Once the first tranche of Project commodities arrives, which is expected by August/September, the UDES and DMUs will be responsible for ensuring their proper and efficient distribution. In November 1988, it is expected that regional planning/evaluation meetings, modelled on those scheduled for November 1987, will be undertaken. These meetings will provide a forum for evaluation of the first year's activities and will also serve as a workshop to prepare operational plans and budgets for PY 2.

Activities in subsequent PYs will be essentially the same as those described for PY 1 except for the start-up activities. Project Coordination Committee meetings on a quarterly basis and annual regional planning/evaluation workshops will be held throughout the life of the Project. As Project implementation progresses, MOH and IPSS central level staff and USAID will devote more of their efforts to monitoring and evaluation of CS program activities. The UDES and DMUs, while continuing to conduct training programs throughout the life of the Project, will increasingly focus their efforts on meeting CS delivery coverage and program targets and the institutionalization of the HIS, VEA, financial management, personnel management, and logistics computer-based information systems.

C. Procurement Plan

1. Technical Assistance

A.I.D. Project funds have been allocated specifically for technical assistance (TA) to the MOH in HIS development, epidemiological training and surveillance, and health communications, and to the IPSS in FP. During Project implementation, additional needs for TA may be identified. Such needs would be financed with A.I.D. Project funds under the contingency line item of the budget. Qualified Peruvian consultants would be recruited and selected by the MOH (or the IPSS) and USAID to provide such assistance and would be contracted by a local Peruvian administrative support contractor who will be responsible for hiring all A.I.D.-funded Peruvian consultants under the Project. (See below.) In those cases where qualified Peruvians cannot be identified, qualified U.S. consultants will be sought. The U.S. consultants would be recruited and selected by the MOH (or the IPSS) and USAID and hired either under direct A.I.D. Personal Services Contracts (PSCs) by USAID or through "buy-ins" by USAID to central AID/W health, population, and nutrition projects or Indefinite Quantity Contracts (IQCs) for evaluation or other required services.

a. Health Information and Other Systems Development

A.I.D. Project funds will be used to hire a long-term Peruvian computer specialist/systems analyst to serve as the HIS advisor for the five-year life of the Project to assist the central level DTID in the MOH to design, implement, and manage a nationwide HIS. While the individual will work primarily on the health statistics aspects of the HIS with the DTID, he will also provide assistance to other offices and units within the central level MOH which are developing or operating computer-based management information systems in the areas of epidemiological surveillance, financial management, personnel management, and logistics.

The central level HIS advisor will be complemented by Peruvian computer systems engineers who will work at the UDES level under the guidance of and with the support of the central level HIS advisor. As Project-financed computers arrive in-country for the UDES, one engineer for each of the UDES will be hired with A.I.D. Project funds for one year to install, operate and maintain the equipment and to train UDES staff in the use and maintenance of the equipment and the application of related software packages. In addition to training personnel in the use of equipment for purposes of the HIS and the epidemiological surveillance system, the engineers will train UDES staff in the use of the financial management, personnel management, and logistics systems computer programs which have already been developed. Before the end of the one-year period, the MOH will establish a permanent position for a computer systems engineer on the staff of the UDES where Project-financed computers have been installed, and an individual, financed by the MOH, will be hired to fill the position before the end of the one-year start-up period. This same approach will be followed for all the UDES as the program is phased in, such that at the end of PY 3, all 28 UDES should have a full-time computer systems engineer on their staff, a

functioning computer center, and operational computer-based systems in health information, epidemiological surveillance, financial management, personnel management, and logistics.

The central level HIS advisor and the computer systems engineers will all be selected by the MOH and USAID and hired by a local Peruvian administrative support contractor, who will be responsible for hiring all A.I.D.-funded Peruvian consultants under the Project. (See below.) It is anticipated that the computer systems engineers will be hired in accordance with the phased implementation strategy for HIS development, namely, eight each in PYs 1 and 2 and 12 in PY 3. (The same individuals may be assigned to work in different UDES in subsequent years after completing their one-year tour in an UDES.)

b. Epidemiological Training and Surveillance

USAID will "buy-in" to the central AID/W Participating Agency Services Agreement (PASA) with the Centers for Disease Control (CDC) of the U.S. to assist the MOH to develop a Field Epidemiology Training Program (FETP) and to strengthen the epidemiological surveillance system (VEA) in the country. Under the PASA, CDC will provide the services of a U.S. long-term epidemiologist for the five-year life of the Project to assist in the design and implementation of an intensive two-year in-country didactic plus practical field training program for epidemiologists, the development of curricula for regional and departmental workshops in basic epidemiological principles for UDES and peripheral level health personnel, and the development of a VEA system for the collection, transmission, storage and analysis of epidemiological information in all 28 UDES and at the central MOH level. CDC will also provide about 1.5 person-months of short-term U.S. technical assistance each year for the five years of the Project or a total of 7.5 person-months to supplement and complement the work of the long-term advisor.

c. Health Communications

A provisional figure of $50,000 has been allocated in the budget for TA in health communications for the five years of the Project to be provided by Peruvian consultants to the central Office of Community Participation in the MOH and the Offices of Community Participation in each of the 28 UDES to conduct research, design and test messages and develop and implement programs to promote community participation in the delivery of health services and in the promotion of preventive health practices. The precise nature and level of TA will be defined in the integrated program plan for this component to be prepared by the MOH and submitted to USAID prior to the disbursement of funds for integrated health communication activities under the Project. The Peruvian consultants would be selected by the MOH and USAID and hired by the local administrative support contractor who will be responsible for hiring all Peruvian consultants under the Project. (See below.)

d. Family Planning

A.I.D. Project funds will be used to hire a long-term Peruvian FP advisor for a minimum of two years to assist the IPSS National FP Program Office to implement, monitor, manage and evaluate the IPSS FP Program under the Project. The advisor will report directly to the newly appointed Director of the National FP Program and will assist him to: develop appropriate Information, Education and Communications (IE&C) plans and programs; design, implement and evaluate FP training programs; identify priority operational research topics; collect and analyze FP service delivery and commodity supply data; and monitor and support the implementation of the FP Program in all 32 DMUs. The advisor will be selected by the IPSS and USAID and will be hired by the local Peruvian administrative support contractor who will be responsible for hiring all Peruvian consultants under the Project. (See below.)

2. Project Management and Support Services

a. USAID Management Team

USAID will hire, under direct A.I.D. PSCs, three expatriate consultants with educational backgrounds and experience in health, nutrition, population or related fields and proven management capability in implementing multi-faceted development projects. Each of these consultants will be hired for the five-year duration of the Project and, together with the USAID Project Manager, will comprise the USAID Management Team for the Project. They will report directly to the USAID Project Manager and will monitor and support the Regional Coordinators to be hired under the Project. They also will facilitate communications and coordination between USAID and the central level MOH and IPSS and between USAID and the UDES and DMUs at the departmental level. In addition, they will assist the USAID Project Manager in carrying out A.I.D.'s responsibilities under the Project with respect to the procurement of commodities and technical assistance services, the conduct of evaluations and audits, the processing of participants for overseas training, the monitoring of conditions precedent and covenants, and the monitoring of disbursements and liquidations of A.I.D. and GOP funds under the Project.

b. Regional Coordinators

A.I.D. Project funds will be used to finance the services of eight Peruvians for the five-year duration of the Project to serve as Regional Coordinators. The candidates for these positions must have an educational background in health planning or public health administration or a related field and experience in planning and managing multi-faceted development projects. They should possess considerable expertise in management, especially in the areas of financial management, supplies and logistics, information systems, training and supervision.

The Regional Coordinators will provide management support and assistance to the UDES to implement the Project. Their responsibilities will include, but will not be limited to, assistance to UDES personnel in: i)

preparing operational plans and budgets; ii) arranging for the distribution of CS program equipment, supplies, contraceptives, and medicines; iii) planning and implementing training and supervision activities; iv) preparing financial management reports and documentation; v) institutionalizing the HIS and VEA systems; vi) improving warehousing and logistics support for the health delivery system; and, vii) maintaining coordination with the DMUs within the same Department and with personnel from such other sectors as Education and Agriculture in the same Department for IE&C and other activities. They will keep the MOH and the IPSS National Project Directors and Component Directors, the USAID Project Manager and the members of the USAID Management Team apprised of CS program progress and of problems encountered in implementation.

At the UDES level, the Regional Coordinators will report directly to the Director General of the UDES and will work on a day-to-day basis with the Project Coordinator, most likely the Director of the General Office for Technical Support and with the members of the UDES Project Management Team. The Regional Coordinators will look to the USAID Management Team and the central MOH for overall direction and support in the performance of their duties. All eight Regional Coordinators will be hired as soon as possible after the Project Agreement is signed. After an initial orientation period, they will be assigned to work with either three or four UDES within the same geographical area. It is expected that up to two Regional Coordinators will reside in Lima. The remaining six Coordinators are likely to reside outside of Lima and will work with UDES within the surrounding geographic area. Every effort will be made to recruit individuals from the locations where they will be posted. These individuals will be selected by the MOH and USAID and hired and supported by the local Peruvian administrative support contractor who will be responsible for hiring all Peruvian consultants under the Project. (See below.)

c. Administrative Support Contractor

Shortly after the Project Agreement is signed, USAID will issue a Request for Proposals (RFP) to contract directly with a local Peruvian organization to provide personnel and financial management services and logistics/administrative support throughout the country for all the Peruvian consultants to be hired under the Project. This includes: i) a HIS advisor for five years to be located at the central MOH level; ii) eight Regional Coordinators for five years, of whom one or two will be based in Lima and the others will be stationed around the country at the UDES level; iii) a FP advisor for a minimum of two years to be located at the central IPSS office; iv) computer systems engineers for one year each to be located throughout the country at the UDES level with eight to be hired in PY 1, eight in PY 2, and twelve in PY 3 (the same individuals may be retained for a three-year period to work in different UDES for one year each); and, v) an as yet undetermined number of short-term Peruvian consultants in such areas as health communications and other technical and administrative fields who will be based in Lima and travel throughout the country. All of the individuals for these positions will be selected by USAID and the MOH, or by the IPSS in the case of the FP advisor, but they will be contracted directly by the Peruvian firm. Procedurally, USAID and the MOH (or the IPSS) will prepare detailed scopes of work and qualifications for the candidates for each position. These will be

given to the firm, which will advertise for the positions, receive, review and screen applications, and submit to USAID and the MOH (or the IPSS) a recommended short-list of candidates. USAID and the MOH (or the IPSS) will interview the candidates on the short-list and/or others who applied as necessary and select the most qualified candidate. USAID will then issue a work order to the Peruvian firm to contract with the individual. The firm will handle all contractual and payroll functions for the consultants as well as all logistics and administrative arrangements to support these individuals, including but not limited to, travel arrangements and reimbursement for job-related expenses, such as vehicle operating and maintenance expenses for those consultants to whom vehicles have been assigned, per diems, and the like. The firm selected for this job should have demonstrated financial solvency and experience in personnel management, financial management, travel, and logistics support. Preference will be given to those firms with an established organizational network throughout the country to support the consultants on-site, provided they also meet the other criteria for selection.

d. Evaluations, Audits and Surveys

All short-term Peruvian consultants required for evaluations, audits, and/or surveys under the Project (see Monitoring and Evaluation Plan) will be selected by the MOH (or the IPSS) and USAID and hired by the Peruvian administrative support contractor. If a Peruvian firm is required to provide audit services, USAID will contract directly with the firm. All short-term expatriate consultants required for these purposes under the Project will be selected by the MOH (or the IPSS) and USAID and hired either under direct A.I.D. PSCs or through buy-ins by USAID to central AID/W health, population and nutrition projects or IQCs.

3. Commodities

Eight categories of commodities will be financed by A.I.D. under the Project: a) local miscellaneous program supplies and materials for both the MOH and the IPSS; b) vehicles and spare parts; c) cold chain equipment; d) needles, syringes and related equipment; e) contraceptives; f) automated data processing (ADP) equipment, including hardware, software, and auxiliary equipment and supplies; g) medical and laboratory equipment and supplies; and, h) audio-visual and other training equipment and supplies. Annex II, Exhibit B provides an illustrative list of the commodities to be procured.

The MOH and IPSS will each be responsible for the procurement of all their own local commodities in accordance with A.I.D. policies and procedures for local procurement. USAID will be responsible for the offshore procurement of all of the remaining categories of commodities listed above. With the exception of the vehicles and cold chain equipment, and possibly syringes, needles and related equipment for which waivers will be sought, it is anticipated that all commodities procured offshore will have their source and origin in the U.S.

a. Vehicles and Spare Parts

The exact number of vehicles to be procured under the Project will be determined once the MOH completes an assessment of vehicle availability and needs and meets the other conditions precedent to the disbursement of A.I.D. funds for vehicles. At a minimum, ten vehicles will be procured as soon as possible after the Project Agreement is signed, one each for the eight Regional Coordinators, the CDC long-term epidemiologist, and the central level HIS advisor. For financial planning purposes, a total of 60 vehicles has been included in the budget. Vehicles will be procured in tranches, in accordance with the overall phased implementation strategy of the Project.

In addition to the ten vehicles noted above, vehicles will be required to support training and supervision activities at the UDES and peripheral health facility levels. Based on experience under previous and on-going health projects, USAID has determined that the most appropriate type of vehicle for this purpose is a four-wheel drive, double-cab pickup truck. This type of vehicle has the requisite large open carrying capacity for handling equipment and for transporting health training and supervisory staff as well as the mobility for off-the-road use.

USAID had previously purchased U.S. vehicles of this type for other health projects and found them unsuitable for project needs because they were difficult to service, local mechanics were unfamiliar with them, and spare parts were not readily available. On the basis of this experience, AID/W approved a waiver for an on-going A.I.D.-financed health project on August 6, 1986, to enable USAID/Peru to purchase 25 Japanese-manufactured, double-cab pickup trucks. USAID plans to seek a similar waiver from AID/W for this Project. Once the waiver is approved, USAID will issue a Project Implementation Order for Commodities (PIO/C) and place an order for these vehicles and spare parts, through the U.S. Embassy in Tokyo, with the Toyota manufacturer in Japan. Based on the USAID's experience under another health project, direct procurement from the local Toyota dealerships is not feasible as they are not capable of fulfilling large orders for this type of vehicle.

b. Cold Chain Equipment

Under the immunizations component of the Project, A.I.D. will finance over $1 million worth of cold chain equipment and supplies for the MOH and the IPSS. "Cold chain" refers to refrigeration and freezing equipment and transport cold boxes used for vaccination programs in developing countries to maintain recommended temperatures for vaccines. The items include refrigerators, freezers, cold boxes, and ice packs.

AID/W confirmed that none of these items with the required specifications are manufactured in or available from the U.S. AID/W also confirmed that several USAIDs purchased cold chain equipment manufactured by Electrolux through AID/W from UNICEF/New York, based on specifications from

the UNICEF/UNIPAC[1/] catalog. Electrolux equipment has been specifically approved by the WHO for cold chain use and is manufactured in Luxembourg and Denmark. The MOH has standarized its equipment and is only using the Electrolux brand. The local distributor provides maintenance, trains MOH personnel in maintenance, and guarantees the availability of spare parts. The distributor has advised USAID that orders should be placed directly with the Electrolux manufacturer in Luxembourg rather than through the local distributor.

In order for USAID to procure these commodities directly from Electrolux in Luxembourg, source/origin, transportation and non-competitive procurement waivers are required. The USAID/Peru Mission Director has authority to approve a source/origin and transportation waiver in this instance, and such a waiver will be sought. However, the value of the procurement exceeds the Mission Director's non-competitive procurement authority. Therefore, approval by the A.I.D. Regional Contracts Officer in Quito of a non-competitive procurement waiver will be sought separately. Once the required waivers are approved, USAID will issue a PIO/C and procure the commodities directly from the Electrolux manufacturer in Luxembourg. Based on the projected obligation schedule for this Project, there will be insufficient A.I.D. funds to purchase all the cold chain equipment in PY 1. Accordingly, the commodities will be procured in tranches. Despite this fact, Project-financed activities under the immunizations component will be implemented simultaneously in all 28 UDES and 32 DMUs beginning in PY 1.

c. Needles, Syringes and Related Equipment

A.I.D. will finance the procurement of needles, syringes and related equipment in tranches during the life of the Project for the immunizations and ARI components of the Project. As discussed in section V.B., Technical Analysis, the MOH is expected to shortly issue its national policy with respect to the use of either disposable or reusable syringes and needles. The MOH policy will follow the WHO and UNICEF recommendations, also endorsed by A.I.D., which states that one sterilized needle and one sterilized syringe should be used for each injection. This means that in addition to adequate training of personnel, monitoring and supervision, related equipment such as destruction kits will be required if disposables are used or sterilizers in the case of reusables. A.I.D. will finance one or the other of these categories of related equipment depending on the MOH's national policy.

AID/W confirmed that no U.S. manufacturer is currently producing reusable plastic syringes and needles nor portable, steam, pressure cooker type sterilizers, which are required in Peru because of the high altitude found in most parts of the country. AID/W advised USAID that the only manufacturer of the reusable plastic syringes and needles is Pharmaplast in Denmark. Also, the only manufacturer of the required sterilizers is the Prestige Group in England. All three items are UNICEF approved and are available from UNICEF through UNIPAC in Copenhagen.

1/ UNIPAC = UNICEF Packing and Assembly Center in Copenhagen, Denmark.

Because of the frequency of A.I.D. procurements from UNICEF worldwide for these types of commodities, AID/W has issued cable guidance on the procedures to be followed. Such procedures require source/origin, transportation and non-competitive procurement waivers. The USAID/Peru Mission Director has authority to approve source/origin and transportation waivers in this instance, and such waivers will be sought if these types of commodities are procured. However, the values of the procurements are likely to exceed the Mission Director's non-competitive procurement authority. Therefore, approval by the A.I.D. Regional Contracts Officer in Quito of non-competitive procurement waivers will be sought separately if necessary. Once the required waivers are approved, USAID will issue a PIO/C worksheet to AID/W for processing and issuance in final form to UNICEF, New York, in accordance with established AID/W procedures for commodity procurements from UNICEF. Alternatively, USAID may procure these items directly from the manufacturers through Mission-issued PIO/Cs.

Disposable syringes and needles are manufactured in the U.S. If the MOH policy requires the procurement of these commodities, it is likely that the Mission will issue PIO/Cs and procure the commodities directly, either through the USAID Executive Office or the A.I.D. Regional Contracts Officer in Quito, depending on the total value of each procurement transaction. Definitive information on the availability of the destruction kits from U.S. manufacturers is not available at USAID at the present time. These items are available through UNICEF in its UNIPAC catalog. Once the appropriate source for these commodities has been determined, USAID will use either the procedures specified above for U.S. procurement or for procurement from UNICEF. It is also likely that destructible plastic syringes and needles may become available from U.S. manufacturers during the life of the Project. If this is the case and the MOH and USAID agree, these items may be procured under the Project.

Needles and syringes are required by the MOH in October 1987 to support a national vaccination campaign. Because funds under this Project will not be available in sufficient time to execute this procurement, arrangements have been made for PAHO to finance this emergency procurement with funds under its existing regional grant with AID/W. Approximately $175,000 worth of needles and syringes will be procured by PAHO. Once the Project Agreement is signed and relevant conditions precedent have been met, USAID will reimburse PAHO through a "buy-in" to the central AID/W grant with PAHO.

d. Contraceptives

A.I.D. will finance the procurement of condoms, pills, and intrauterine devices (IUDs) for the MOH and IPSS FP programs. These commodities will be procured in tranches beginning in PY 1 through the AID/W worldwide central procurement process. USAID will send PIO/C worksheets to AID/W for this purpose. During the first PY, USAID also plans to investigate the possibility of procuring locally produced pills for the MOH and IPSS FP programs. The feasibility of this approach would depend on a number of

factors, including relative prices, proven efficacy of the local commodities, production capacity of the local firms, and waiver possibilities and requirements within A.I.D.

e. Automated Data Processing (ADP) Equipment and Supplies

A.I.D. will finance computer hardware, software, and auxiliary equipment and supplies to support the ADP equipment needs of the MOH under the FETP component and the HIS, VEA, logistics, financial management, and personnel management systems. Specifically, A.I.D. will support: i) the upgrading of the existing WANG VS 65 at the central MOH level; ii) the procurement of additional micro-computers, printers and related equipment and supplies for the computer center at the central MOH; iii) the procurement of portable computers for the epidemiologists under the FETP; and, iv) the procurement of computers, printers, and ancillary equipment and supplies to establish computer centers at all 28 UDES to support the operation of computer-based systems for HIS, VEA, financial management, logistics, and personnel management. Provisional plans call for the procurement of an estimated 125 PC/ATs computers, 74 PC/XTs computers, 90 printers, and ancillary equipment and supplies.

In compliance with A.I.D. Handbook 18, prior to the procurement under the Project of any ADP equipment, the Office of Data Management in AID/W will review and approve all systems development plans and the specifications for all ADP equipment to be procured under this Project. To facilitate this review and approval process, USAID will request the services of a staff member of M/SER/IRM/MPS to visit Peru in November to review the ADP procurement plan for the Project and to finalize specifications and provide firm cost estimates. Once the approval of M/SER/IRM/MPS is secured, USAID will arrange for the procurement of these commodities, along with the other commodities described below, through a Procurement Services Agent (PSA). In accordance with the Project's phased implementation strategy, the ADP equipment and supplies for the Project will be procured in tranches.

f. Medical and Laboratory Equipment and Supplies

A wide range of commodities will be procured in tranches over the life of the Project under this category. They include: i) laboratory equipment and supplies for the central laboratories of the National Institute of Health, the five regional referral laboratories, and the remaining 23 UDES laboratories; ii) specula, IUD insertion kits and minilap kits and medical equipment and supplies for ten Regional FP Demonstration-Teaching Centers and five clinical cancer detection laboratories; iii) infant weighing scales, stethoscopes and ophthalmoscopes for the MOH and IPSS in support of the Nutrition and ARI programs; and, iv) medical and laboratory equipment and supplies for seven hospital-based Regional Training Centers for DDC (five for the MOH and two for IPSS) and also for an additional 110 hospital-based oral rehydration units. Because of the large numbers of individual items and the large variety of different types of commodities to be procured, USAID will procure these commodities through a

U.S. Procurement Services Agent (PSA). It is likely that USAID will select, in conjunction with SER/COM in AID/W, one of the PSAs currently under an Indefinite Quantity Contract (IQC) with AID/W.

g. Audio-Visual and Other Training Equipment and Supplies

A large variety of audio-visual and other training equipment and supplies, including cameras, slide projectors, screens, slide carousels, video and audio cassette recorders, reference library materials, and related equipment and supplies will be financed by A.I.D. for both the MOH and IPSS in tranches during the life of the Project to support many of the components under the Project. As in the case of the medical and laboratory equipment and supplies, because of the large numbers of diverse types of commodities involved, USAID will procure these commodities through a PSA, in consultation with SER/COM in AID/W.

D. Training Plan

As part of this Project, the MOH has prepared a comprehensive Integrated Training Plan, which includes proposed training programs for MOH staff as well as community leaders, teachers, school supervisors, and university professors, covering the five CS intervention areas and health communications. This Plan is shown in Table 17. The Integrated Training Plan reflects the fact that CS interventions will be implemented in an integrated manner at the departmental and peripheral levels. In addition, the Plan recognizes that health communications is a priority support program which cuts across all CS Programs and should also be implemented in an integrated manner. Other component-specific training activities to be conducted by the MOH are also planned for the VEA and HIS sub-components, and these are shown in Table 18. Many of the training activities in Tables 17 and 18 will include representatives from the IPSS. In addition, the MOH is developing a separate plan for a series of training programs for its budget, warehouse, and personnel staff in support of the computerized financial and personnel management and logistics sub-component.

Finally, the IPSS has prepared an Extended Training Plan, which is shown in Table 19. The IPSS Plan includes training activities specifically designed for IPSS personnel which are in addition to those activities within the MOH's Integrated Training Plan in which some IPSS staff will participate. The MOH training activities include Training of Trainers Programs in which IPSS staff will participate. These IPSS staff will then be the trainers in the IPSS-specific training programs. In addition to the activities in the IPSS Extended Training Plan, on-going IPSS in-service training of staff in financial and personnel management and logistics will continue throughout the life of the Project.

Both the MOH and the IPSS plans contain short-term overseas training scholarships and both short-term and long-term in-country training scholarships, all of which will be financed by A.I.D. In addition, A.I.D. will finance specific in-country training activities within the MOH Integrated Training Plan at the central, regional and UDES levels. Finally, A.I.D. will finance all of the MOH's training programs at all levels of the health delivery system associated with the VEA Program and the HIS and training

TABLE 17. Proposed MOH Integrated Training Plan a,b/

TITLE OF TRAINING COURSES	NUMBER OF COURSES	LOCATION	DURATION	PARTICIPANTS No.	PARTICIPANTS TYPE	No. OF COURSES BY PROJECT YEAR (PY) (No. PARTICIPANTS) PY 1	PY 2	PY 3	PY 4	PY 5	FUNDING (US$000) AID	GOP	TOTAL
1. International FP Conference	1	Lima	5 days	120	Professionals c/	—	1 (120)	—	—	—	19	—	19
2. Supervision Skills and Programming	8	Lima	7 days	280	UDES Directors, UDES Supervision Directors & Programmers	4 (168)	1 (28)	1 (28)	1 (28)	1 (28)	51	—	51
3. Training of Trainers	8	Lima	15 days	120	Training Units in UDES	2 (30)	2 (30)	2 (30)	2 (30)	—	73	—	73
4. Pediatric Forum	5	Lima	1 days	1,000	Physicians & Other Professionals	2 (400)	2 (400)	1 (200)	—	—	8	—	8
5. Social Communications Workshop	8	Lima	6 days	224	Health Educators & Others Responsible for CS	3 (84)	3 (84)	1 (28)	1 (28)	—	—	42	42
6. Conference on CS Activities	5	Lima	8 days	250	University Professors	1 (50)	1 (50)	1 (50)	1 (50)	1 (50)	—	44	44
7. Supervision Skills Module Training	56	UDES	8 days	1,680	Professionals & Para-Professionals c/ from UDES, Hospitals, Health Centers & Posts	14 (420)	14 (420)	10 (300)	9 (270)	9 (270)	—	213	213
8. Local Programming	28	UDES	6 days	420	Professionals & Others Responsible for Program Development in Hospitals & Health Centers	14 (210)	14 (210)	—	—	—	39	—	39
9. CS Themes According to Needs of UDES	140	UDES	6 days	4,200	Professionals & Technicians c/	28 (840)	28 (840)	28 (840)	28 (840)	28 (840)	—	231	231
10. Family Planning Seminar	28	UDES	6 days	840	Professionals & Para-Professionals	14 (420)	14 (420)	—	—	—	81	—	81

TABLE 17. (Cont.)

TITLE OF TRAINING COURSES	NUMBER OF COURSES	LOCATION	DURATION	PARTICIPANTS No.	PARTICIPANTS TYPE	No. OF COURSES BY PROJECT YEAR (PY) (No. PARTICIPANTS) PY 1	PY 2	PY 3	PY 4	PY 5	FUNDING (US$000) AID	GOP	TOTAL
11. Demonstration Center FP Skills	15	15 Health Centers	15 days	225	Professionals & Para-Professionals	5 (75)	5 (75)	5 (75)	—	—	63	—	63
12. In-Service CS Education in Hospitals	d/	Hospitals	Continuous	18,450	Professionals & Para-Professionals	50 (3690)	50 (3690)	50 (3690)	50 (3690)	50 (3690)	—	34	34
13. In-Service Other Hospital Activities	5	Hospitals	10 days	100	Professionals	1 (20)	1 (20)	1 (20)	1 (20)	1 (20)	—	41	41
14. In-Service CS Education in Health Centers	d/	Health Centers	Continuous	2,400	Professionals & Para-Professionals	e/					—	99	99
15. CS Activities	d/	Health Posts	Continuous	1,350	Health Post Personnel	e/					—	202	202
16. Continuous Participatory Training in FP Demonstration Centers	d/	Demonstration Centers	15 days	1,200	Professionals & Technicians	e/					103	152	255
17. Seminars in CS Activities	d/	Local Health Centers	6 days	6,000	Teachers & School Supervisors	e/					—	82	82
18. Seminars in CS Activities	d/	Local Health Centers	6 days	2,100	Health Promoters, and Traditional Birth Attendants (TBAs)	e/					—	126	126
19. Control of Diarrheal Disease	d/	Local Health Centers	2 days	3,500	Teachers, TBAs, Promoters & Community Leaders	e/					—	42	42

TABLE 17. (Cont.)

TITLE OF TRAINING COURSES	NUMBER OF COURSES	LOCATION	DURATION	PARTICIPANTS No.	PARTICIPANTS TYPE	No. OF COURSES BY PROJECT YEAR (PY) (No. PARTICIPANTS) PY 1	PY 2	PY 3	PY 4	PY 5	FUNDING (US$000) AID	GOP	TOTAL
20. Cold Chain and Immunization Sterilization Techniques	d/	Local Health Centers	1 day	3,500	Professionals & Para-Professionals & Technicians for for Cold Chain Maintenance	e/					50	—	50
Total Training	293 + Courses			44,459	Training Opportunities for Participants e,f/	138 (6407)	136 (6387)	100 (5261)	93 (4956)	90 (4898)	487	1,308	1,795

SCHOLARSHIPS	LOCATION	DURATION	PARTICIPANTS No.	PARTICIPANTS TYPE	No. OF SCHOLARSHIPS BY PROJECT YEAR (PY) PY 1	PY 2	PY 3	PY 4	PY 5	FUNDING (US$000) AID	GOP	TOTAL
21. Reproductive Risk and FP	Out-of-Country	Short-term (Up to 6 months)	20	Physicians, Nurses & Other Professionals	4	4	4	4	4	132	—	132
22. Masters in Health and Population	In-Country	Long-term (1 year or more)	16	Physicians, Nurses & Other Professionals	4	4	4	4	—	86	—	86
Total Scholarships			36		8	8	8	8	4	218	—	218

a/ A.I.D. will finance all costs associated with the out-of-country and in-country scholarships and selected in-country training at the central and UDES levels; the MOH will finance all other in-country training costs.
b/ Those courses provided to MOH personnel at the central and UDES levels will also include IPSS personnel.
c/ "Professionals" refers to physicians, nurses, midwives or others who are certified or have university degrees.
"Technicians" refers to field workers without a certification or university degree.
"Para-professionals" refers to Auxiliary Nurses and Sanitary Technicians.
d/ Exact information is not yet available.
e/ Number of training opportunities is larger than sum of participants by PYs due to the lack of a complete breakdown of the number of participants by PY.
f/ In many cases, the same person will participate in more than one training opportunity, particularly in the case of continuous in-service training. Thus, the total does not represent the total number of individuals trained, but indicates the total number of training opportunities.

NOTE: This table does not include any of the continuing education courses which will be entirely financed by the GOP and for which budget estimates are included in the budget tables in the Financial Analysis section.

TABLE 18. (Cont.)

TITLE OF TRAINING COURSES	NUMBER OF COURSES	DURATION	LOCATION	PARTICIPANTS No.	PARTICIPANTS TYPE	No. OF COURSES BY PROJECT YEAR (PY) (No. PARTICIPANTS) PY 1	PY 2	PY 3	PY 4	PY 5	FUNDING (US$000) AID	GOP	TOTAL
11. Epidemiological Laboratory Investigation of Disease Outbreaks	3	7 days	Regional	56	Laboratory Technicians	3 (56)	—	—	—	—	11	—	11
Total	86			1,883	Training Opportunities for Participants e/	39 (560)	15 (395)	21 (563)	13 (339)	1 (28)	796	—	796

a/ A.I.D. will finance all the costs of all of these training programs.

b/ Includes up to 5 participants from IPSS and other Peruvian agencies.

c/ "Technicians" refers to field workers without a certification or university degree.

d/ "Professionals" refers to physicians, nurses, midwives, or others who are certified or have university degrees.

e/ In many cases, the same person will participate in more than one training opportunity, particularly in the case of continuous in-service training. Thus, the total does not represent the total number of individuals trained, but indicates the total number of training opportunities.

NOTE: This table does not include an estimated $280,000 worth of overseas training (conferences, workshops, fellowships at CDC, etc.) under the FETP component which will be financed by A.I.D.

TABLE 18. Proposed MOH Training Plan for Field Epidemiology Training Program (FETP), Epidemiological Surveillance (VEA), and Health Information System (HIS) a/

TITLE OF TRAINING COURSES	NUMBER OF COURSES	DURATION	LOCATION	PARTICIPANTS No.	PARTICIPANTS TYPE	No. OF COURSES BY PROJECT YEAR (PY) (No. PARTICIPANTS) PY 1	PY 2	PY 3	PY 4	PY 5	FUNDING (US$000) AID	GOP	TOTAL
1. Field Epidemiology Training Program (FETP) b/	5	2 years	Lima and Field (UDES)	35	Physician Epidemiologists	1 (7)	1 (7)	1 (7)	1 (7)	1 (7)	435	--	435
2. Applied Epidemiology	3	3 days	Lima	84	Physicians & Technicians c/	1 (28)	—	1 (28)	—	1 (28)	20	—	20
3. Notification HIS I	6	3 days	Regional	168	Physicians, Statisticians & Directors of Special Programs	3 (84)	—	3 (84)	—	—	25	—	25
4. Notification HIS II	28	3 days	UDES	675	Physicians	—	10 (225)	9 (225)	9 (225)	—	81	—	81
5. Evaluation of Disease Outbreaks	4	7 days	Regional	112	Physicians & Technicians	2 (56)	—	2 (56)	—	—	23	—	23
6. Sentinel Surveillance	3	7 days	UDES	90	Professionals & d/ Technicians	—	1 (30)	1 (30)	1 (30)	—	37	—	37
7. Diagnosis, Microbiology	4	15 days	Regional	112	Laboratory Technicians	2 (56)	—	2 (56)	—	—	12	—	12
8. Special Laboratory Techniques	2	15 days	Lima	56	Laboratory Technicians	—	2 (56)	—	—	—	42	—	42
9. Basic Computer Technology	28	15 days	UDES	280	Computer Technicians	28 (280)	—	—	—	—	14	—	14
10. Software Application	9	15 days	Regional	252	Computer Technicians	—	3 (84)	3 (84)	3 (84)	—	96	—	96

TABLE 19. Proposed IPSS Extended Training Plan a, b/

TITLE OF TRAINING COURSES	NUMBER OF COURSES	LOCATION	DURATION	PARTICIPANTS No.	PARTICIPANTS TYPE	No. OF COURSES BY PROJECT YEAR (PY) (No. PARTICIPANTS) PY 1	PY 2	PY 3	PY 4	PY 5	FUNDING (US$000) AID	IPSS	TOTAL
1. FP Program	19	Lima Ica	2 days	323	Coordinators of FP Programs & other Professionals c/	3 (51)	4 (68)	4 (68)	4 (68)	4 (68)	—	6	6
2. FP Program	10	Regional d/	5 days	240	DMU, FP & CS Coordinators & Professionals	2 (48)	2 (48)	2 (48)	2 (48)	2 (48)	—	34	34
3. FP Information/ Motivation	13	Regional	1 day	390	Nurses & Midwives	1 (30)	3 (90)	3 (90)	3 (90)	3 (90)	—	6	6
4. FP and Human Sexuality	21	Regional	5 days	630	Professionals	1 (30)	5 (150)	5 (150)	5 (150)	5 (150)	—	19	19
5. Training of Trainers (TOT) in FP	13	Regional	15 days	260	Nurses, Physicians & Midwives	1 (20)	3 (60)	3 (60)	3 (60)	3 (60)	—	22	22
6. FP Orientation	13	Regional	3 days	260	Health & Sex Educators	1 (20)	3 (60)	3 (60)	3 (60)	3 (60)	—	11	11
7. FP Motivation	58	Regional	2 days	1,160	Non OB/GYN Professionals	18 (360)	10 (200)	10 (200)	10 (200)	10 (200)	—	11	11
8. FP Conferences	18	Regional	1 day	3,600	Professionals of the Zonal Hospitals & Polyclinics	2 (400)	4 (800)	4 (800)	4 (800)	4 (800)	—	1	1
9. Refresher Courses for TOT	7	Lima	5 days	140	Nurses, Midwives & Physicians	1 (20)	2 (40)	2 (40)	1 (20)	1 (20)	—	6	6
10. CS Program Management	125	Regional	3 days	3,750	Professionals	25 (750)	25 (750)	25 (750)	25 (750)	25 (750)	—	39	39

TABLE 19. (Cont.)

TITLE OF TRAINING COURSES	NUMBER OF COURSES	LOCATION	DURATION	PARTICIPANTS No.	PARTICIPANTS TYPE	No. OF COURSES BY PROJECT YEAR (PY) (No. PARTICIPANTS) PY 1	PY 2	PY 3	PY 4	PY 5	FUNDING (US$000) AID	IPSS	TOTAL
11. Health Education CS Activities Orientation	125	Regional	3 days	3,750	Teachers & CS Coordinators	25 (750)	25 (750)	25 (750)	25 (750)	25 (750)	—	39	39
12. Program Implementation	125	Regional	3 days	3,750	Auxiliary Nurses & Other Para-Professionals	25 (750)	25 (750)	25 (750)	25 (750)	25 (750)	—	28	28
13. Annual Evaluation Seminar	5	Lima	3 days	300	Coordinators of CS Programs	1 (60	1 (60)	1 (60)	1 (60)	1 (60)	—	25	25
14. Cold Chain Techniques	5	Lima & Regional	3 days	150	Technicians for Cold Chain Maintenance	1 (30)	1 (30)	1 (30)	1 (30)	1 (30)	—	12	12
Total Training	557			18,703	Training Opportunities for Participants e/	107(3319)	113(3856)	113(3856)	112(3836)	112(3836)	—	259	259

SCHOLARSHIPS	LOCATION	DURATION	PARTICIPANTS No.	PARTICIPANTS TYPE	No. OF SCHOLARSHIPS BY PROJECT YEAR (PY) PY 1	PY 2	PY 3	PY 4	PY 5	FUNDING (US$000) AID	IPSS	TOTAL
15. FP, Reproductive Risk, CS Activities	Out-of-Country	Short-Term (up to 6 months)	11	Physicians, Nurses, Midwife and Other Professionals	2	3	3	2	1	72	—	72
16. FP, Reproductive Risk and CS Activities	In-Country	Long-Term (1 year or more)	22	Physicians, Nurses, Midwives and Other Professionals	4	6	5	5	2	91	—	91
Total Scholarships			33		6	9	8	7	3	163	—	163

TABLE 19. (Cont.)

a/ This plan is called an extended training plan because it contains training activities specifically for IPSS personnel which are in addition to those within the MCH's Integrated Plan in which some IPSS staff will participate.

b/ A.I.D. will finance all the costs associated with in-country and out-of-country scholarships; IPSS will finance all other in-country training costs.

c/ "Professionals" refers to physicians, nurses, midwives and others who are certified or have university degrees. "Para-professionals" refers to Auxiliary Nurses and Sanitary Technicians.

d/ Does not include Lima or Ica in this particular course.

e/ In many cases, the same person will participate in more than one training opportunity, particularly in the case of continuous in-service training. Thus, the total does not represent the total number of individuals trained, but indicates the total number of training opportunities.

NOTE: An additional $33,000 in A.I.D. funds has been budgeted for IPSS overseas training in CS subject areas as well as an additional $250,000 in GOP funds for IPSS in-country FP and CS training but have not yet been programmed.

programs in cold chain procedures and sterilization techniques in support of the immunizations component. The costs of all of the remaining training programs under this Project will be borne by the MOH and IPSS.

1. MOH Integrated Training Plan

The MOH's Integrated Training Plan has four main objectives: a) to promote the development of leaders in the health sector by training program and office Directors and the chiefs of all Training Units in problem-solving and decision-making in order to have a multidisciplinary team which can supervise and direct training activities in each UDES; b) to establish a permanent Training Unit in each UDES which will be responsible for training activities in hospitals, health centers and health posts; c) to design, develop and validate training methodologies and modules for in-service training and continuing education to assist the UDES with their training plans; and, d) to promote and support the organization and administration of CS services in the UDES.

Personnel from the IPSS will participate in all the training programs given at the UDES level. The MOH Technical Directorate of Human Resources Development at the central level will provide assistance as needed to the UDES in the development, implementation and evaluation of their training plans and programs. Most of the technical training for CS activities will be conducted through the MOH's existing in-service training program. Training in FP will be conducted in the 10 FP Demonstration Training Centers to be established under the Project. Training in DDC will be given at the nine (four existing and five to be established under this Project) MOH hospital-based Regional Training Centers for DDC.

Project-sponsored out-of-country training will be limited to short-term programs on specific CS topics. Long-term training (one year or more in duration) in FP skills, reproductive health, and public health in established degree programs at Cayetano Heredia University and other institutions and programs in Peru will also be supported under the Project.

2. MOH Component-Specific Training

a. Active Epidemiological Surveillance (VEA) Program

Training in support of the VEA Program includes the FETP and specific training of health personnel in epidemiology, laboratory methodology, and computer training. Under the FETP, the Project will support the training of up to 35 physicians (up to 30 from the MOH and the remainder from IPSS and other GOP agencies) in an intensive two-year in-country didactic plus field-based epidemiology training program with the assistance of the CDC. Eight or nine trainees will be selected each year for the first four years of the Project so that there will never be more than a maximum of 18 trainees at any one given time. In addition to the long-term CDC epidemiologist, two full-time MOH professional staff and MOH support staff will be responsible for implementing the training program. Beginning in PY 3, the graduates of the

program will also serve as extended staff for purposes of training and supervising trainees. Trainees will be selected by a committee made up of experts from the MOH, IPSS, universities, and the CDC epidemiologist. The course curriculum will include weekly didactic seminars open to the public to which guest lecturers will be invited and at which trainees will present the results of their work. Since the FETP is essentially an apprenticeship program, close supervision of trainees will be necessary.

Short-term training also will be provided to personnel at all levels of the health services delivery system in the principles and methods of epidemiology in order to strengthen the capacity of the MOH to collect, tabulate, analyze, report on, and disseminate disease notification data. The FETP will produce the cadre of trained field epidemiologists who will be deployed throughout the country upon their graduation and will constitute the backbone of the VEA system at the UDES and central levels. Training of key departmental and peripheral level staff will strengthen the reporting network. UDES staff will serve as trainers of the staff in the support hospitals, health centers and health posts in those courses dealing with the notification system and the basic principles of epidemiological surveillance. Five modules designed by PAHO/WHO will be used in these latter training programs. In addition, UDES personnel currently working in the Epidemiological Units will be trained in VEA system implementation and the management of epidemics or disease outbreaks in their areas.

The Project will also support both in-country and overseas short-term training of laboratory personnel from the National Institute of Health central and UDES level laboratories which will enhance the analytical capability of the VEA system. Laboratory training for technicians will begin in the National Institute of Health laboratories and the five existing regional referral laboratories. The training will include diagnosis of specific diseases and the principles of microbiology, culture media, and differential diagnosis. Training of other UDES level laboratory personnel will include diagnostic techniques requiring less complex procedures. The result should be a referral system in place from simple to more complex diagnosis. Finally, training of UDES staff in computer technology (see the HIS below) will enable the MOH to systematically generate reliable data at the UDES and central levels and to provide rapid feedback to Program implementors.

b. Health Information System (HIS)

The training programs in support of the HIS consist of two general types: i) basic computer technology; and ii) program application for DDC, nutrition, immunizations, FP, ARI control, VEA, financial management, personnel management, and logistics. The Peruvian computer systems engineers at the UDES level, with support from the long-term Peruvian HIS advisor at the central level, will be responsible for providing all of this training to UDES personnel. Since the computer software packages have already been developed for all of the components except VEA (for which CDC will provide assistance), no training for computer programmers has been included in the Project.

3. IPSS Extended Training Plan

The IPSS Plan contains regional and central level in-country training programs in both technical and administrative aspects of FP and other CS services. Project-sponsored out-of-country training will be limited to short-term programs on specific CS topics. Long-term training (one year or more in duration) in FP skills, reproductive health, and public health and short-term professional courses in FP and other CS related topics in established programs at Cayetano Heredia University and other institutions and programs in Peru will also be supported under the Project.

E. Supervision Plan

Table 20 summarizes the MOH's Integrated Supervision Plan for the five years of the Project. The Plan covers supervision at all levels of the health delivery system, namely, from the central MOH to the UDES, from the UDES to the hospitals, from the hospitals to the health centers, and from the health centers to the health posts. As shown in the Table, the number of individuals on the supervision team and the length of each supervisory visit will vary depending on the level of the delivery system. From one to two visits per year are programmed for all health facilities during the five years of the Project.

The Plan in Table 20 covers all Project activities except for the VEA and HIS programs. A separate supervision plan will be prepared by the MOH for these two programs. Similarly, the IPSS will prepare an Integrated Supervision Plan for the five years of the Project. All costs of supervision under the Project will be borne by the MOH and the IPSS.

F. Monitoring and Evaluation Plan and Financial Reviews/Audits

AID/W requires that all CS Projects include a plan to monitor Project effectiveness and to collect information on selected impact indicators as well as Project inputs and outputs on an annual basis and to report this information to AID/W. To satisfy this requirement, annual surveys and other data collection efforts will be carried out under this Project. In addition, annual regional planning/evaluation workshops and quarterly meetings of the Project Coordination Committee will provide regularly scheduled forums for monitoring and evaluation purposes. The MOH also plans to undertake specific evaluation activities during the Project. Formal external Project evaluations and financial reviews and audits are also provided for.

1. On-Going Monitoring and Evaluation

Because of the level of U.S. Congressional and Administration interest in the CS Initiative and the additional reporting requirements related to the use of these funds, a careful monitoring and evaluation plan is essential. An A.I.D. Task Force on CS was charged with developing a systematic monitoring and evaluation approach for all CS project worldwide. The Task Force has recommended a three-tiered approach to monitoring and evaluation which is described below.

TABLE 20. MCH Integrated Supervision Plan a/

	No. of Indi-viduals	No. of Days Per Visit	Per Diem	Trans-porta-tion b/	Cost Per Visit	No. Visits Per Project Year (PY) 1	2	3	4	5	No. Facilities Per PY c/ 1	2	3	4	5	Cost Per PY (US$) 1	2	3	4	5	Total
1. Central MCH to UDES	4	7	18.5	100	918	2	2	1	1	1	28 (23)	28 (23)	28 (23)	28 (23)	28 (23)	42,228	42,228	21,114	21,114	21,114	147,798
2. UDES to Hospitals	3	3	18	20	182	1	1	2	2	2	125 (75)	125 (75)	125 (75)	125 (75)	125 (75)	13,650	13,650	27,300	27,300	27,300	109,200
3. Hospitals to Health Centers	3	3	18	15	177	1	1	2	2	2	689 (345)	689 (345)	689 (345)	689 (345)	689 (345)	61,065	61,065	122,130	122,130	122,130	488,520
4. Health Centers to Health Posts	1	3	18	5	59	1	1	2	2	2	2738 (1365)	2738 (1365)	2738 (1365)	2738 (1365)	2738 (1365)	80,535	80,535	161,070	161,070	161,070	644,280
TOTAL																197,478	197,478	331,614	331,614	331,614	1,389,798 d/

a/ All costs of this Supervision Plan will be financed by the MCH.

b/ The transportation costs for supervisory visits from the central MCH to the UDES are per individual on the supervisory team. For the remaining categories of health establishments, the cost of transportation is for one vehicle which will be shared by the supervisory team.

c/ Numbers without parentheses represent actual number of facilities in the various categories of health establishments listed. Numbers in parentheses indicate the number of facilities in each category which were used to calculate the costs of supervision. In the case of the UDES, the central MCH will only have to pay the costs of the visits for 23 UDES since the 5 in the Lima/Callao area do not involve any additional costs. For the other health establishments, the numbers shown in this table include those health establishments for which supervision visits will be financed by the central MCH. For the remaining facilities in these categories, the individual UDES will cover the costs of the supervision visits from their own budgets.

d/ With an inflation factor of 5% compounded annually, the total amounts to $1,549,000.

a. All projects, subprojects and grants funded under the CS Initiative will be required to collect and report certain basic information as follows: level of effort/resources as a percentage of total budget allocated and spent on each of the major intervention activities and services provided (input/output information); some measure of program effectiveness using service statistics, sentinel posts or other data sources; and, a narrative description of project activities, including comments on unanticipated effects, innovations, significant findings, or lessons learned.

b. A second tier of projects, including projects with the largest target populations, will be identified for additional and more rigorous monitoring and evaluation. In addition to tier one data, tier two projects will monitor effectiveness and impact indicators via random household surveys. Tier two indicators will be intermediate in nature, for example, immunization coverage rates or use of ORT in the most recent diarrheal episode.

c. Finally, a very limited number of projects, about one in each geographic region, will be selected for more intensive evaluations, including longitudinal studies of the impact on morbidity and mortality. In the case of these third tier evaluations, the plan would build on existing and planned data collection efforts. For example, plans are underway for demographic health surveys in 35 countries, of which Peru has been selected and the survey has been implemented. AID/W is exploring the extent to which the CS evaluations could build on these planned efforts and other data collection efforts.

This Project has been designated by AID/W as a tier two Project for monitoring and evaluation purposes. Table 21 provides illustrative evaluation indicators for the DDC, immunizations, and nutrition sub-components to measure program inputs, outputs, effectiveness and impact. Similar indicators will be developed with consultant input for all the other sub-components of the Project. All of this information will be reported annually to AID/W and will be derived from the following sources:

a. USAID, MOH and IPSS Project files including procurement, training and financial records to derive input and some output data;

b. service statistics, including coverage data, disease incidence by age groups, morbidity, mortality, births, deaths, and the like routinely collected at the departmental and peripheral levels of the MOH and IPSS;

c. random district level household cluster sample Knowledge, Attitude and Practices (KAP) surveys to measure program impact and effectiveness; and,

d. annual program evaluation activities to be undertaken and financed by the MOH under the guidance of the DTPNS at the central MOH to assess program effectiveness.

TABLE 21. Illustrative Evaluation Indicators for the Diarrheal Disease Control, Immunizations and Nutrition Sub-Components

		INDICATORS
I. DIARRHEAL DESEASE CONTROL		
	A. INPUTS	Resources budgeted Annual estimated expenditures No. of ORS packets locally produced by the Project, by size
	B. OUTPUTS	No. of health workers trained No. of individuals taught ORT
	C. EFFECTIVENESS	No. of service units and distribution points with ORS on hand No. and % of health workers demonstrating ORT knowledge and skills No. and % of individuals with knowledge of ORT No. and % of children ever given ORT No. and % of children with diarrhea in last two weeks given ORT
	D. IMPACT	No. of cases of severe dehydration per year Age-specific mortality rate, 0-12 months and 13-60 months Diarrhea-associated mortality rate among children 0-60 months Diarrhea-associated severe dehydration rate among children 0-60 months
II. IMMUNIZATIONS		
	A. INPUTS	Resources budgeted Annual estimated expenditures No. of vaccine doses imported by the Project, by type
	B. OUTPUTS	No. of health workers trained No. of individuals taught about immunization
	C. EFFECTIVENESS	No. of service units vaccines on hand No. of service units with effective cold chain No. and % of children at 12 months having received Polio 1, Polio 3, Measles, Diptheria, Pertussis, Tetanus (DPT) 1, 3 and all immunizations No. and % of women aged 15-45 years having received two doses of Tetanus Toxoid

INDICATORS

D.	IMPACT	No. of cases of Neonatal Tetanus (NNT) No. of cases of measles per year No. of cases of polio per year Age-specific mortality rate, 0-12 months and 13-60 months Measles-associated mortality rate among children 0-60 months Neonatal tetanus-associated mortality rate among children 0-12 months

III. NUTRITION

A.	INPUTS	Resources budgeted Annual estimated expenditures
B.	OUTPUTS	No. of health workers trained No. of individuals taught infant/child feeding
C.	EFFECTIVENESS	No. of children enrolled in growth monitoring No. and % of workers demonstrating growth monitoring and nutrition skills No. and % of children breastfed and eating semi-solids at 6 months No. and % of children identified as high risk who received follow-up since last weighing No. and % of children who are severely malnourished No. and % of children growing as fast or faster than local or UNICEF standard at last weighing
D.	IMPACT	Age-specific mortality rate, 0-12 months and 13-60 months

The collection of service statistics and coverage data will rely on the information routinely collected by all departmental and peripheral health facilities of the MOH and IPSS. As the HIS and VEA systems are phased in and become operational in the MOH, the collection of data should become more reliable, accurate, and timely. The sentinel sites to be established under the VEA system also will provide valuable information on program impact.

The KAP surveys will be undertaken each year in a select number of districts throughout the country. Results of these surveys should be available within six weeks following their implementation. The surveys will identify the reasons associated with non-compliance of vaccination schedules, the use or non-use of ORS/ORT for diarrheal episodes, the proportion of mothers who are correctly mixing ORS, the improper use of antibiotics for diarrheal episodes, misconceptions about FP, FP methods utilization and the like. This information will help validate the aggregated service and coverage statistics by providing specific information about the effectiveness of the CS program interventions at the household level.

The first such survey will be undertaken no later than January 1988 and will serve as the baseline for the Project. The first survey will provide information on target population coverage with respect to the CS interventions against which the impact and effectiveness of the Project can be measured. These surveys are expected to cover information required for all service delivery sub-components under the Project. In addition, during the first six months after the Project Agreement is signed, service statistics relating to the CS Program from all MOH health facilities will be collected, compiled, analyzed, and summarized. The same information-gathering exercise will be undertaken by IPSS. All of the information from the survey and the service statistics will be integrated, analyzed and presented in a consolidated report, with the assistance of a short-term consultant. Using this information, the consultant will also assist the MOH, IPSS and USAID to further describe and define Project incremental and global service delivery output targets for each of the CS programs and to establish specific indicators of program inputs, outputs, effectiveness and impact for all Project interventions in both the MOH and IPSS.

The DTID at the central MOH will be responsible for collecting all the service statistics from MOH facilities and for conducting the KAP surveys, with short-term TA as required to define the survey sample and/or to design the survey instruments. The long-term CDC epidemiologist and the long-term HIS advisor will also participate in the design of the KAP survey instruments and the analysis and interpretation of survey results. MOH personnel will serve as the KAP survey supervisors and interviewers. Training of these individuals and their transportation and per diem expenses will be financed by A.I.D. under the Project. The IPSS FP Program is in the final stages of collecting baseline information which was initiated under its Limited Scope Grant Agreement with USAID. The Preventive/Promotional Services Directorate within IPSS has collected service statistics on the Lima DMUs and plans to expand this effort to all IPSS facilities throughout the country. Short-term TA may be provided to IPSS to facilitate this data collection effort. In addition, qualitative information gathered by Project personnel through routine supervision visits will be fed into this process of data collection. The USAID Project Manager shall be responsible for coordinating the inputs of the MOH, IPSS, and USAID to collect the required information and data and to prepare the annual reports for submission to AID/W.

The annual regional planning/evaluation meetings, which will involve departmental and central level MOH and IPSS staff and USAID representatives, will also provide important information on program effectiveness. It is anticipated that the results of the KAP surveys and other information-gathering exercises will be discussed at these meetings and changes in program strategies and approaches to be implemented in the following year will be agreed to. The quarterly meetings of the Project Coordination Committee will also provide a forum for the monitoring and evaluation of the Project including reviews of implementation plans and of progress in meeting planned targets and objectives.

The above annual KAP surveys and service statistics data collection efforts by the MOH and IPSS may be supplemented by other surveys financed by A.I.D. during the life of the Project. For example, mini-surveys at the household level may be undertaken to verify data on immunizations and other specific CS interventions. A follow-up survey to the 1984 National Nutritional and Health Survey (ENNSA) may be undertaken toward the end of the Project, and/or a follow-up survey to the 1986 National Demographic and Family Health Survey (ENDES) may be implemented in 1991 or 1992, specifically to look at contraceptive prevalence.

2. Formal External Evaluations

Formal external Project evaluations, financed by A.I.D. and involving teams of expatriate and Peruvian consultants are tentatively scheduled to be implemented in PYs 3 and 5. The USAID Project Manager will be responsible for arranging for these evaluations. Each evaluation will require about four weeks of effort by a team of experts in the various CS intervention areas to review secondary source data, conduct interviews, and make field visits. Both evaluations will involve, as resource personnel, representatives of the MOH and the IPSS at both the central and departmental levels and USAID, including the A.I.D. Management Team, as well as resident technical consultants, the Regional Coordinators, and possibly other donor representatives. Either or both of the evaluations may also involve the participation of AID/W personnel. A variety of data will be generated and available for these formal Project evaluations as a result of data-gathering, data analysis, and reporting activities which will take place throughout the life of the Project.

The evaluation in PY 3 will be, for the most part, a Project management review. The overall objectives of this evaluation will be to examine: a) the adequacy of institutional arrangements, systems of operation, and operational plans; and b) progress achieved in providing the required inputs to the Project. Necessary modifications in the Project implementation schedule, institutional arrangements, and the Project financial plan will be made at this time. This evaluation also coincides with the projected final year of the phasing-in of all the CS intervention programs (with the exception of the FP Program in IPSS). It would thus be timely and appropriate for the team to examine progress made in achieving the Project outputs by critically analyzing the annual changes in the CS program impact indicators as compared with the baseline information. The evaluation team will also examine the impact of the MOH-IPSS integration process on the Project and make recommendations for possible necessary changes in Project design or outputs.

The evaluation in PY 5 is scheduled to coincide with the projected completion date of all Project activities. The evaluation will measure the impact of the Project in meeting the CS objectives of the GOP and will examine lessons learned and progress achieved in meeting the goal and purpose of the Project as well as the outputs and End of Project Status indicators.

3. Financial Reviews/Audits

In addition to periodic financial reviews of Project activities by the USAID Controller, the Project has budgeted funds to finance audit services, as necessary, to augment the resources of the Office of the Inspector General of A.I.D. (AID/IG). For planning purposes, audits are tentatively scheduled to be conducted at or near the end of PYs 2, 4, and 5. A.I.D. will finance the costs of these audits.

G. Disbursement Procedures

1. Methods of Financing Foreign Exchange Costs

USAID will assume responsibility for disbursing funds for all foreign exchange costs under the Project. These include overseas training, expatriate consultants and contractors, off-shore commodities, USAID management staff, and evaluations. USAID will procure all of these goods and services using essentially the Project Implementation Order procedure for these foreign exchange costs. Usual disbursement procedures will be included in A.I.D. direct contracts for goods and services. To the extent PSAs are used for commodity procurements, Bank Letters of Commitment (L/COMs) will be used to finance commodity costs only. As shown in Section V.E, Cost Estimate and Financial Plan, no deviation from established A.I.D. procedures is contemplated.

2. Methods of Financing Local Currency Costs

Of the US$19 million to be provided by A.I.D. under the Project, approximately US$5 million will finance local costs. Of this amount, USAID will administer about US$3.1 million, the MOH will administer about US$1.8 million, and IPSS will administer an estimated $100,000 over the five years of the Project.

a. USAID

USAID will be responsible for the procurement of all Peruvian contractors and consultants. USAID will also administer the local costs associated with expatriate technical consultants and contractors including those involved in audit and evaluation activities. The same disbursement procedures described above for foreign exchange costs will apply for these local costs as well.

b. MOH

Of the estimated US$1.8 million to be administered by the MOH for local costs under the Project, the equivalent of approximately US$258,000 will be used to procure local commodities; US$177,000 will finance the travel and per diem of health personnel for annual regional planning/evaluation workshops; $50,000 will cover a portion of the operating costs associated with the HIS; and the remaining US$1,362,000 will finance in-country training activities throughout the country. The MOH Technical Directorate of Administration (DTA) at the central level will be responsible for all local commodity procurements and will directly disburse funds for this purpose. The central level Technical Directorate of Informatics and Documentation (DTID) will be responsible for the development of the HIS and will directly disburse funds for this purpose. The annual regional planning/evaluation workshops will be the responsibility of the central level Technical Directorate of Programs, Norms and Services (DTPNS). Training activities will be conducted by the central level Technical Directorate of Human Resources Development as well as the 28 UDES.

The following procedures will be followed for all local cost financing to be administered by the MOH:

i. The central level MOH and USAID will approve the UDES's annual operational plans and budgets.

ii. The DTA will transmit to A.I.D. a request for an advance of funds covering estimated funding requirements for a period of 90 days.

iii. The USAID Project Manager and Financial Analyst will review the request and prepare a consolidated Public Voucher SF 1034. USAID will then issue a check directly to the DTA in the central MOH, who will deposit the funds in a separate bank account specifically for the Project.

iv. Steps ii. and iii. will be repeated every 30 days for estimated funding requirements for the ensuing 90 days. In addition, a copy of the most recently prepared bank reconciliation statement shall accompany the request for funds.

v. Financial reports also will be submitted to USAID by the central DTA every 30 days to liquidate previous advances at the same time that requests for advances for the ensuing 90 days are submitted to USAID. These reports will cover four categories of expenditures, namely, commodities; training; HIS development and surveys; and planning/evaluation workshops. The reports will provide information on cumulative expenditures to date, approved budgets remaining to be disbursed, and A.I.D. advances which have not yet been liquidated.

vi. The USAID Project Manager and Financial Analyst will review the documents received. The USAID Project Manager will prepare the Public Voucher SF 1034, covering the expenses reported by the DTA. Subsequently, the USAID Project Manager or the Controller's Office will inform the DTA concerning the liquidation reports processed.

Disbursements for training activities at the regional and UDES level are likely to be handled in a number of ways. The central MOH may issue prepaid tickets and per diem advances to individual course participants; the participants may purchase their own tickets and seek reimbursement later from the central MOH; and/or the central MOH may transfer funds to various bank branches in the Departments to be deposited in separate Project bank accounts for the use of the UDES. The central DTA will assume responsibility and accountability for all A.I.D. funds used for local cost financing under the Project.

c. IPSS

IPSS is expected to administer the equivalent of an estimated $100,000 for local costs under the Project, consisting of the equivalent of about $9,000 for local commodities and $91,000 for short-term and long-term in-country scholarships. The Project Coordination Office for Administration and Accounting within the National Directorate for Project Administration will assume responsibility for the disbursement and accountability of all of these funds as well as for the procurement of the commodities. Given the limited amount of funds involved, requests for advances or reimbursements will be sumbitted to USAID on as needed basis directly by the Project Coordination Office.

V. PROJECT ANALYSES

A. Administrative Analysis

The organization, management and staffing of the MOH and IPSS were analyzed to assess their administrative capability to implement the project. The analysis was based on a review of relevant GOP and IPSS documents and USAID project reports and evaluations, and the knowledge and experience of the USAID Project Managers implementing A.I.D.-financed Projects with these institutions, including Projects 527-0219, 527-0220 and 527-0221 in PHC, FP and rural water and sanitation, during the past five years.

1. Ministry of Health (MOH)

a. Organization, Management and Staffing

i. Organization

The MOH is characterized by vertical CS programs at the central level and integrated horizontal programs at the UDES, hospital, health center and health post levels. The CS support functions of training, supervision and monitoring, financial and personnel management and logistics, the HIS, the VEA system, and health communications are integrated at all levels of the system. During the course of Project development, the MOH established a working group composed of all the CS Program Directors at the central level and chaired by the Director of External Technical Cooperation. After initial meetings where overall Project goals, objectives, and budgetary levels were established, USAID staff and consultants worked with individual CS Program Directors and their staffs to design their individual components under the Project. All the individual component plans were then integrated into the final consolidated Project by the working group. The latter also together designed and approved the integrated training, supervision and monitoring, and information system development plans. This working group model at the central level will be maintained during Project implementation to review and approve the integrated operational plans of the UDES, to plan integrated training, supervision, health communications, and information system development activities, to review and approve consolidated UDES commodity needs and procurement plans, and to ensure proper coordination and consolidation of other Project activities where appropriate.

In addition to the above, the Project has been designed to ensure that CS program activities are coordinated and implemented in a cost-effective manner by channeling the majority of resources to the UDES level where the primary responsibility for program design, implementation and evaluation will reside. In 1986, the MOH began to decentralize in an effort to create community health services tailored to and supported by local groups. This move was consistent with Peru's national program of decentralization and the Ministry's philosophy of primary health care (PHC): giving auxiliary health workers the responsibility for executing the bulk of the MOH programs, and CS activities in particular. Operationally, the MOH formed the Health Departments (called Unidades Departamentales de Salud) (UDES) to be responsible for managing public sector health services in their

respective areas. The Department of Lima, because of its large population, has been divided into four UDES; all other departments in Peru have one UDES.

The UDES are in the process of establishing independence from the central MOH, and have been given significant authority over resource allocation, target setting, supplies, logistics and training. UDES have been designated as unidades presupuestarios (UPs) or budgetary units which receive funds directly from the MOH central level and are responsible for budget planning and disbursement of funds to budgetary executing entities (EEPs). The latter are MOH facilities (hospitals or health centers) which implement programs and disburse funds. In addition to these authorities, the UDES have been given a mandate to "assist, advise, supervise and evaluate" their respective health centers and health posts, the two elements of the MOH system with primary responsibility for delivering CS services.

The MOH local infrastructure includes servicios perifericos (peripheral services) and hospitales de apoyo (support hospitals). The operational units providing peripheral services are the modulos basicos (MBs) (basic health modules). MBs consist of health centers with their respective clusters of health posts and the population under their jurisdiction. These basic modules are linked to a support hospital for referral and laboratory support. Logistics and administrative support to the MBs is usually provided directly from the UDES or through a support hospital. MBs within a definable geographical/political area are grouped, for budgetary and administrative purposes, in a unit called the entidad ejecutoria presupuestorial (EEP) (budgetary executing entity). A typical UDES (or one UP) has approximately seven EEPs; several are clusters of MBs while a couple correspond to support hospitals.

The current MOH organizational structure has been established to provide increased support to health centers and health posts, the health establishments with primary responsibilities for delivering CS services. Support for hospital-based care is still an important priority of the MOH, however, and health centers and health posts will continue to compete with hospitals for scarce resources. Since the EEPs for support hospitals were separated from the EEPs of MBs less than two years ago, the peripheral services have received a greater percentage of MOH operating funds. Project Managers will monitor the MOH counterpart contribution by EEPs to verify that the Project is indeed channeling additional financial resources to the peripheral health facilities.

ii. Management

The CS activities that will be implemented under this Project are considered by the MOH, along with other activities, to be Special Programs. Managed under the Technical Directorate of Special Programs (DTPE), each of the Special Programs--DDC, nutrition, immunizations, FP and ARI--is headed by a Director who is responsible for preparing a national intervention plan with a detailed budget, and commodity, training, supervision, health communications and technical assistance requirements. The activities that are programmed are based on the official MOH norms for each program. These norms are frequently reviewed and updated by MOH officials and expert consultants. The Technical Directorate for Programs, Norms and Services (DTPNS) is responsible for developing and disseminating the norms to MOH personnel at all levels of care.

While the national plans for the Special Programs are developed at the central level, it is the responsibility of the UDES to organize, program and carry out the activities. Despite the MOH's fundamental commitment to decentralization, the UDES have received little guidance in establishing their own protocols for administering and managing local programs. They have been given substantial, immediate responsibilities with little time for planning or evaluation. In order to provide UDES personnel the opportunity to adequately review and finalize their 1988 Operational Plans, the Project begins with a three-month start-up period which will include three regional planning workshops for representatives from all UDES. These workshops are scheduled annually, throughout the life of the Project, to provide MOH officials the opportunity to measure the achievement of the performance targets and to finalize the Operational Plans for the following year.

Although the UDES Directors have been delegated greater authority with regard to resource allocation, the lack of experienced, capable managers at the UDES and peripheral levels is a constraint to effective Project implementation. Regional Coordinators, who are skilled Peruvian health administrators with considerable field level experience, will be contracted for the life of the Project to work with the staff of three to four UDES each to facilitate the implementation of the Project. Based on experience in implementing Projects 527-0219 and 527-0230 using a cadre of Regional Coordinators, their work will focus on coordinating the implementation of the activities indicated in the Operational Plans between the UDES administrative support staff, the UDES technical coordinators of CS activities and the staff of the peripheral health facilities. The Regional Coordinators will facilitate the timely programming and receipt of counterpart funds and commodities to support the delivery of CS services, and training and supervision activities. The timely receipt of these funds is critical to the successful implementation of the Project and will be a priority activity of the Regional Coordinators.

In addition to the Directors of the Special Programs and the UDES, other entities have responsibilities for managing activities under the Project. The Technical Directorate of Human Resource Development (DTRH) will manage the MOH Integrated Training Plan activities in coordination with the UDES. This is necessary as several training activities include participants from more than one UDES, and central level coordination will facilitate communication, organization and implementation of inter-UDES training courses.

The Technical Directorate of Informatics and Documentation (DTID) is responsible for managing Project activities related to the health information system (HIS) and the epidemiological surveillance system (VEA). Training courses in HIS and VEA will be managed by DTID, and supervision visits to UDES will be arranged by the DTID, but the majority of supervision activities for HIS and VEA will be financed by the UDES to support field visits of UDES personnel to support hospitals, health centers, health posts and communities. Previous experience implementing A.I.D. project activities with DTID have been successful. Computers are being used to manage finances, personnel and logistics data. Technical assistance to the DTID was recommended due to the complexity of installing a nationwide computer-based

information system. Since UDES have little or no experience using computers, the Project also includes financing contracts of Systems Engineers--for one year of assistance for each UDES--to establish a functioning computer center that serves the needs of the UDES. The MOH has agreed to finance a new position for a Systems Engineer in each UDES to manage the activities of the Project-financed computer center before the Project-financed Systems Engineer completes his/her one year assignment.

The Technical Directorate for Coordination of Foreign Cooperation (DTCCE) will see that the complementary inputs from other international donor projects are coordinated with CS Project inputs. This is especially critical in the case of the multi-donor Immunization Plan, and with regard to complementary contraceptive supplies that will be provided by UNFPA.

Overall management of the Project will be the responsibility of the National Project Director (NPD), who will be, for the purposes of this Project, the Coordinator of all the Directors of the Special Programs that are included in the CS Project, as well as of the other Directors mentioned above, who manage certain Project activities. The NPD will also coordinate with the Technical Directorates of Administration and Planning and Budget regarding financial management of GOP and USAID Project funds and Project commodities, and with the Technical Directorate of Personnel regarding Project requirements for human resources. The selection of the National Project Director will be a key determinant to the successful implementation of the Project. Since there is no Director of DTPE at this time, it is unclear who will be named as Project Director and what position that person would hold. Frank discussions with the Vice-Minister have already taken place, and USAID is confident that a qualified Director will be named who holds an appropriate position with sufficient authority.

iii. Staffing

Community health workers, called either Sanitarios or Auxiliares de Enfermeria, work in the health posts and centers. One UDES estimated that, taken together, they accounted for approximately three times more person-contact time with the community than the physicians and nurses who worked largely in the health centers. They are viewed as the front-line workers for the CS interventions, and are responsible for immunizations and ORT activities. Their role extends beyond service delivery and includes health education and promotion tasks at the community level.

Unfortunately, most of these front-line health workers are ill-prepared for their delegated role in community health service delivery. They not only suffer from poor training and motivation, but most are unsure of their precise job descriptions. They are officially charged with executing the bulk of the MOH's public health program. In their capacity as the interface between the MOH and the public, they must satisfy the numerous demands of program managers for each of the Ministry's Special Programs. Faced with these unreasonable expectations--unable to "do it all," and usually unsure as to how it should be done--many respond by doing little, or in some cases, nothing at all.

A significant minority of these auxiliary health workers are adequately trained and reasonably motivated. Even they, however, suffer from poor definition of their job function, poor supervision and virtually non-existent coordination of the distribution of their time between competing demands. The majority of auxiliary workers are ill-equipped either by training or incentives to carry the burden placed on them by MOH planners at higher levels. The MOH Integrated Training Plan will address some of the basic training needs of these auxiliary health workers who are the principal providers of CS services at health centers and health posts. At the same time, the MOH must explore and implement an incentive system to motivate qualified health workers to serve in the rural areas, where basic health services are almost totally lacking. The assignment of adequate numbers of qualified personnel to peripheral health services that are specifically included in the UDES Operational Plans under this Project will be reviewed with MOH officials on a regular basis during the life of the Project.

In addition to the health workers at the peripheral level, the health professionals--doctors, nurses and obstetrizes (midwives)--must be motivated to provide CS services, especially to the populations at highest risk. Training courses and seminars have been scheduled in the Project Implementation Plan to provide appropriate, up-to-date information on CS interventions to physicians, in particular. Under other A.I.D.-financed projects in Peru, training courses on appropriate management of diarrheal disease and a professional journal on the same subject have demonstrated alternative methodologies to educating physicians and nurses. These activities will be duplicated in FP, ARI, immunizations and nutrition under the Project.

The adequacy of staff and high staff turnover in some of the Directorates and Offices at the central MOH has been a problem under previous A.I.D. projects and is likely to continue to be a problem. Staff turnover at the UDES level is less of a problem. However, for those program areas where the UDES will assume primary responsibility for program planning and implementation, this should not pose a major problem. In those areas where the central MOH will play a key role under the project, provision has been made to provide additional assistance to the MOH through contracts with local and expatriate advisors, e.g. under the information system and VEA components. In addition, outside resources may be required and could be made available under the project to augment the central MOH's capacity to undertake some of the planned training programs. The Regional Coordinators, who will be contracted under the Project, will also serve to augment the human resources available at the central MOH to provide overall program monitoring and coordination and to facilitate implementation by the UDES.

b. Feasibility of the Implementation Plan

The following is a detailed list of actions the MOH is expected to perform to successfully implement this Project. It has been reviewed in light of the MOH performance in implementing A.I.D. Projects 527-0219, 527-0230 and 527-0221 in PHC, FP and rural water and sanitation. The Mission has concluded that the MOH can carry out these tasks. However, the MOH response time is very slow, and assistance will be required to facilitate specific actions.

i. Request, receive, disburse and liquidate the Inti equivalent of $12 million of PL 480 counterpart funds, the Inti equivalent of $13.025 million of Public Treasury funds and the Inti equivalent of $1.8 million of A.I.D. Project grant funds.

ii. Prepare and evaluate UDES operational plans each year at regional workshops.

iii. Organize and carry out training and supervision activities, reassigning vehicles purchased under previous USAID projects to support CS activities, assessing vehicle needs required to carry out Project activities, and preparing an operations and maintenance plan for use of Project-financed vehicles.

iv. Provide specifications for all Project commodities and procure all grant-financed local goods and all counterpart-financed goods.

v. Assess the condition of warehouses and rehabilitate or construct facilities as necessary.

vi. Provide the personnel and facilities necessary to carry out Project activities.

vii. Organize, implement and make use of the results of surveys and studies related to the Project.

viii. Prepare and submit documentation and reports required to implement, evaluate and modify the Project.

i. Financing and Financial Management

By far, the most challenging task that the MOH must carry out to successfully implement the Project is to secure the Inti equivalent of $25,015,000 in counterpart funds to support the activities of the Project. The objective will only be achieved if there is a strong political commitment on the part of the Minister of Health, the Minister of Economy and Finance, the Senate, the Congress and the President. The political commitment to finance health services has been significant under the APRA administration. This commitment is expected to continue.

To secure the Inti equivalent of $12 million in PL 480 counterpart funds, the MOH will have to submit a request and justification for the funds each year. After the full year calendar is approved, the MOH must submit requests to the MEF on a monthly basis and receive, distribute and liquidate funds for each UP before additional funds will be approved the next month by the MEF. It is a rigorous exercise that must be well coordinated within the MOH between the National Project Director and the Technical Directorate for Planning and Budget, which submits the appropriate request documents to the MEF, as well as the DTA, where the funds are received and distributed to the UDES, and then liquidated and accounted for to the MEF. Although the task is complicated, the MOH has been successful in securing the funds, when competent staff have been assigned to the task.

Of the total A.I.D. Grant the MOH will directly manage $1.8 million, mostly to finance training activities, to conduct surveys and to purchase commodities. The MOH DTA is familiar with USAID reporting requirements and procedures. Although the MOH has been slow to render liquidation vouchers, the quality of work has been high. In 1986, USAID issued a Project Implementation Letter under Project 527-0230, advising the MOH that invoices no longer needed to accompany the liquidation forms, but rather only that they be stored at the central level for periodic review by USAID Controller Office staff. The Regional Coordinators will assist the administrative staff of the UDES to keep a separate account of A.I.D. Project grant funds, and to process project-related financial documentation in a timely manner. Members of the Mission's Controller Office will participate in the orientation course for the Regional Coordinators and will provide assistance to them throughout the life of the Project with regard to Project financing and financial management. Also, the continued development of the MOH's nationwide computerized financial management system, which the Project will support, should facilitate timely and accurate reporting and accountability.

ii. UDES Operational Plans and Annual Regional Workshops

Experience with Projects 527-0219 and 527-0230 regarding the content and development of annual operational plans has been taken into account to avoid the problems and delays that were encountered in previous years. USAID will issue a Project Implementation Letter which will specify the minimal amount of information needed for the plans. Meetings will be held with the appropriate UDES staff to explain the required documentation, which will be based on information already collected and used by the UDES for the purposes of budgeting and setting targets. Three regional seminars are scheduled in November. Approximately five representatives from each UDES will participate in one of the week-long meetings. Members of the USAID Project Management Team, the MOH central level Project component Directors and representatives from IPSS will organize, along with the UDES staff, the agenda for the workshops, and will participate in the workshops. USAID and central level MOH staff will make follow-up visits to UDES, concentrating on the eight UDES that will be included more fully in the Project during PY1. Given the increased authority delegated to the UDES Directors, operational plans will be finalized in the UDES on these follow-up visits. This will obviate the need for a substantial review of the plans by the central level MOH staff and will facilitate the approval process, which in the past was one of the major impediments to timely project implementation. (It took almost a year to develop and approve regional operational plans for Projects 219 and 230 because of the complexity and the strict central level control over the organization and content of the plans.)

iii. Training, Supervision and Vehicles

A major problem in the health sector relates to the motivation and retention of qualified personnel, especially in the peripheral health facilities in the outlying areas. Aside from salary increments and financial incentives, which are beyond the purview of this Project, training

and supervision and the provision of adequate transport for personnel (as well as of sufficient commodities and supplies) are areas which contribute positively to worker morale and which are priority activities under the Project. Based on experience under other A.I.D.-financed projects, the MOH is capable of carrying out many of the planned training programs using existing staff and facilities. In those areas where the expertise does not exist, outside assistance either through local universities and other institutes or through U.S. contractors under AID/W centrally-funded projects will be provided to the MOH. In many instances, these outside sources will conduct training of trainers programs for MOH staff who will then be able to continue these programs.

The MOH has agreed to finance all the costs of supervision and has already prepared a detailed supervision plan which extends from the central MOH in a tiered fashion all the way down to the health post level. Finally, under the Project, the MOH will reassign A.I.D.-financed vehicles procured under other A.I.D. projects to appropriate sites and offices primarily outside of Lima to support training, supervision and service delivery activities under the Project. Provided the MOH meets specific conditions precedent related to the submission of a comprehensive analysis of vehicle needs and a vehicle operations and maintenance plan, provision has been made under the Project to procure additional vehicles for the MOH.

iv. Specifications and Procurement of Commodities

The MOH has demonstrated its capability under previous A.I.D. projects to develop specifications for commodities. USAID has facilitated the process by supplying catalogues for products to be procured off-shore. The MOH has also demonstrated its ability to purchase local goods with USAID funds. The procurement of pharmaceuticals and medical, laboratory and office supplies, using GOP counterpart funds, however, will be more problematical and will be closely monitored by USAID and MOH Project Managers. GOP funds for these purchases are usually more plentiful at the end of the calendar year--October-December. A critical Project input that will facilitate this procurement process is the training of administrative staff in the UDES regarding MOH procedures for issuing contracts and purchasing goods. These training courses were carried out in 1987 under Project 527-0230 and will be offered continuously as in-service training courses throughout the life of this Project. Purchases will be made by UDES staff to the extent possible because: the UDES are in a better position to determine actual needs; the distribution chain is simplified when the central level is eliminated; and, when the quantities of goods are small, the procurement/distribution processing time is shortened.

v. Warehouse Rehabilitation and Construction

In general, MOH warehouses are not in good condition, and warehouse personnel lack the training to adequately perform their duties. This will be one of the most difficult deficiencies to correct. The USAID Management Team will assist the MOH staff in organizing and carrying out the required surveys of warehouse facilities. The Regional Coordinators also will focus their efforts in this area to facilitate the logistics activities

related to the Project at the UDES level. As part of the Project, counterpart-financed training courses for MOH warehouse staff have been programmed. These in-service training courses and rehabilitation and construction of warehouses will be closely monitored by the Project Managers.

vi. Logistics System, Supplies and Equipment

The MOH operates a centralized procurement system. A central warehouse located in Lima distributes supplies and equipment to the UDES, which in turn warehouse and distribute them to the hospitals, health centers, and health posts. The system functions with varying degrees of success. Despite major improvements made under Project 527-0230, principally through training of warehouse staff and administration, it is still troubled with an inability to ship goods in a timely manner, a loss of some goods due to pilferage and expiration of drugs because of mismanaged shipping dates, inadequate and inappropriate storage facilities and procedures at many locations, a rigid hierarchy which inhibits lateral transfers of supplies, and a "hoarding" tendency which prevents shipping of supplies to the lowest levels, leaving many health posts seriously undersupplied.

To continue to improve the MOH logistics system, this Project will: 1) finance training and technical assistance for system personnel at all levels on storage, inventory, and movement of goods as part of the information system development component; 2) provide for renovation of MOH warehouse facilities that house Project supplies and equipment to acceptable standards or construction of new ones where needed; and, 3) work toward the provision of sufficient pharmaceutical, contraceptive and other supplies to carry out Project activities at all MOH health facilities.

Supplies and equipment for CS health services are usually adequate at the hospital level and some health centers, with occasional shortages. Many health centers and nearly all health posts are chronically undersupplied with CS medicines and expendable supplies. Sometimes the shortages are not because supplies do not exist in the warehouse, but because the system is incapable of moving them. This Project will help correct this inability to move supplies through personnel training. The Project will ameliorate the supply shortage by financing off-shore commodities (e.g., contraceptives, laboratory supplies, some office supplies), which will be supplemented by other donor and MOH-financed supplies.

vii. Adequate Personnel and Facilities

Facilities required for Project implementation include health posts and health centers (the peripheral facilities where CS health services primarily are delivered), support hospitals (where many FP interventions are delivered), UDES offices, laboratories and warehouses, and central level MOH offices, laboratories and warehouses. The CS Project specifically requires the MOH to provide classroom space at the central level for the VEA FETP course and facilities for computer centers at each UDES, in addition to construction and/or rehabilitation of warehouses at all levels. All of the above have been discussed with and agreed to by MOH officials.

Although no problems are anticipated, the adequacy of the UDES computer centers and the construction and rehabilitation of warehouses will be closely monitored by Project Managers working in collaboration with the Regional Coordinators.

The MOH has agreed to establish and fill two new positions in each UDES during the life of the Project--a higher graded Epidemiologist (FETP graduate) and a Computer Systems Engineer. The addition of these 56 employees (two for each of 28 UDES) is minimal and is not considered to be a significant increased recurrent cost burden. All other MOH Project related personnel are already employed, although the distribution is skewed in favor of large urban centers and hospitals. To achieve Project objectives related to CS service delivery targets, a gradual but significant shift of auxiliary health workers, nurses, midwives and physicians away from hospitals and urban areas in favor of rural health centers and health posts is needed. As the MOH continues to construct peripheral health facilities in priority, rural geographical areas, more staff will be assigned to this level. Training courses scheduled in the MOH Integrated Training Plan will be targeted to these front-line workers, since they are the primary providers of CS services.

viii. Surveys and Studies Related to the Project

In order to evaluate the achievement of Project performance targets and the impact of Project activities, the Project design includes annual cluster sample KAP surveys of randomly selected communities, annual meetings to assess the degree to which operational plan targets were met, and operations research studies to improve the delivery of CS services. Technical assistance will be needed to organize the surveys and studies and analyze the resulting data. The appropriate technical assistance will be secured through AID/W centrally or regionally funded projects, such as PRICOR, ADDR and REACH, or through other mechanisms, such as IQC'S or purchase orders. The MOH has the capability to carry out the field work related to the surveys and studies, if adequate training is provided to the interviewers and data processors. Both the Regional Coordinators and the Computer System Engineers will facilitate the implementation of these activities. The USAID Management Team will coordinate closely with representatives from UNICEF, UNFPA and PAHO regarding the collection and analysis of data in order to consolidate as much as possible the number of data-gathering activities and minimize the amount of time and number of MOH employees required to carry out the activities. Because the donor agencies are supporting several of the same Special Programs, there will be opportunities not only to share information, but to carry out activities jointly.

ix. Documentation and Reports

With the introduction of computers, the MOH has begun to use word processing equipment to facilitate preparation and processing of official correspondence and documents. The MOH central level staff, however, has been reduced, while the workload has not. The USAID Project Management Team will collaborate closely with MOH counterparts to set priorities and deadlines for submission of official letters and documents for both USAID and

the MOH. In a like manner, the Regional Coordinators will facilitate the communication flow between the central level and the UDES and within the UDES. Problems regarding communication of data and information, which the MOH Project officials encounter daily, are being addressed, but will not be solved soon. By installing modums in the UDES computers, information can be sent directly over the telephone line from the UDES' computer to one at the central level. This mechanism is already in place in the UDES of Piura and has facilitated the timely reporting of data, such as vaccination campaign coverage results. The installation of computer equipment and training of MOH personnel in its use will improve the MOH's ability to prepare reports and transfer information from the lower levels to the central office and vice versa.

2. Peruvian Social Security Institute (IPSS)

The IPSS National Health Services Directorate manages a tiered health service delivery system, including hospitals, polyclinics, medical posts, and factory posts. It has moved recently to a decentralized system in which the Preventive/Promotional Unit of the Directorate will manage all CS activities, with the exception of Family Planning, and will train and supervise the 32 CS Committees, one for each of the IPSS Departmental Management Units. Family Planning is the responsibility of a separate office within IPSS. For purposes of this Project, however, IPSS will have one National Project Coordinator in the central IPSS office.

As in the case of the MOH, Project activities will be undertaken by the Departmental organizations, namely the MUs, which like the UDES, have considerable authority with respect to resource planning and target setting and even more autonomy than the UDES with respect to resource allocations and financial disbursements. In general, IPSS is better staffed than the MOH, primarily due to higher salaries, and has already designated and assigned staff to be responsible for CS activities.

Historically, IPSS has not offered many CS services. Its coverage only recently extended to include maternity care for dependents and children under age 18. IPSS participated in the national vaccination campaigns conducted by the MOH, borrowing the necessary supplies and equipment. It is beginning to implement other CS activities as an integral part of its health program. In particular, IPSS is making significant progress in expanding FP services in IPSS facilities. Generally speaking, the major constraints to increased and expanded CS services coverage in IPSS is the lack of adequate supplies and equipment and of properly trained personnel. Accordingly, this Project will support IPSS, in a modest way, in these two critically important areas.

Based on our experience with IPSS under Project 527-0230 and the Limited Scope Grant Agreement with the Family Planning Program Office, the Mission is confident that IPSS is fully capable of carrying out its responsibilities under the Project. While there are some problems in selected locations in some of the CS support systems, in general, the IPSS management systems are somewhat more strongly institutionalized than in the MOH and are considered fully adequate for the needs of this Project.

3. MOH and IPSS Integration

The integration of the two organizations, mandated in mid-1986, is proceeding slowly. Although Project goals and objectives need not be modified by the pace of integration, Project implementation will be adjusted, if necessary, by what happens as integration proceeds.

The Project provides for close coordination and collaboration between the two organizations both at the central as well as at the departmental levels. The Project Coordination Committee will consist of senior decision-makers from both the MOH and IPSS. Both the USAID Management staff and the Peruvian Regional Coordinators will facilitate coordination and communication at all levels of the health care system. Many of the training programs, including the FETP, will involve both IPSS and MOH employees in combined classes, and the annual regional planning and evaluation meetings will likewise include both IPSS and MOH central and field level staff. Finally, both organizations will participate in the development and installation of the nationwide health information system and VEA information system to ensure that a system is put in place which generates national statistics on a timely and systematic basis.

4. Summary

Lessons learned from experience over the past five years in implementing a variety of A.I.D.-financed projects with the MOH and IPSS have been taken into account in designing this Project. The second component of the Project, namely, strengthening decentralized support systems for sustainable CS services, was developed specifically to address the weaknesses in the support systems that limit the expansion and improvement of CS services delivery. The Project builds on management/administrative improvement efforts initiated under Projects 527-0219 and 527-0230 and will provide adequate technical assistance, training, and management support personnel to facilitate the implementation of the Project. The focus at the UDES level as the primary arena for Project activities and the allotment of a modest amount of A.I.D. funds to be managed by the MOH have been built into the Project to avoid some of the administrative/management deficiencies at the central level. Based on our experience to date, the organizational/administrative structure for Project implementation, and the nature of the Project-financed inputs to be provided to the implementing agencies, the Mission has concluded that this Project is administratively feasible.

B. Technical Analysis

The technical analysis for this Project addresses the feasibility of the technologies to be used to improve and expand CS service delivery and to continue the process of institutional strengthening. With the possible exception of the use of needles and syringes for immunization and ARI control activities, all of the technologies to be included in this Project are being used in Peru at this time. (The needles and syringes issue is currently under discussion.)

1. Diarrheal Disease Control (DDC)

Treatment of diarrheal illness with antibiotics and antidiarrheics is widely practiced in Peru although the technically more appropriate, more cost-effective treatment for most diarrhea episodes is oral rehydration therapy (ORT), using a combination of fluids and continued feeding to prevent dehydration and malnutrition. Acceptance of ORT by the medical community is increasing and has reached significant levels in the last two years.

Increased use of ORT to treat diarrheal illnesses will be promoted under the Project. The promotion of ORT in Peru will draw on the findings of research projects carried out in Peru by the IIN and UPCH, with assistance from U.S. Universities. One important finding was that Peruvian mothers continue to breast-feed and give more fluids to children during episodes of diarrhea, a practice that health workers will be taught to reinforce under the Project. In addition, pre-packaged oral rehydration salts (ORS) will be provided at oral rehydration units in health centers, health posts and other specific community locations where a person trained to properly mix and administer them will be available. Improved IE&C messages and more culturally appropriate interventions also will be developed and implemented based on the forthcoming results of both an operations research study to develop a home remedy, soup-based ORS and research to develop and promote new weaning foods.

Finally, local production of ORS will be improved and increased. Discussions have been underway between the managers of LUSA, the major local public sector manufacturer of ORS, and the contractor under the AID/W centrally-funded Project SUPPORT for several months regarding technical assistance to set up an improved system of quality control and a loan to purchase a new mixing and packaging machine. LUSA has already formulated its ORS using the more palatable and stable citrate base formula. With the planned assistance from Project SUPPORT, the quality of locally produced ORS should meet the strict requirements of the WHO standards. In addition, continuous quality control checks by the Peruvian National Center for Quality Control for Medicines, Foods and Drugs will be encouraged. In short, the ORT interventions proposed under the DDC sub-component of this Project are feasible and cost-effective.

2. Nutrition

Monitoring the growth of children less than five years of age is one of the technologies that will most likely be used to improve the nutritional

status of Peruvian children. A growth chart is used to indicate over time (usually at one month intervals) the weight and/or height of a child. It is used by health workers to identify children who are malnourished or faltering in weight gain, so that their mothers can be advised early on about appropriate feeding regimes. The growth chart is also used as a teaching tool and often contains many nutrition messages and other data, including the child's immunization record, his mother's method of family planning, and/or the age of the next youngest sibling.

The official Peruvian growth chart has been modified several times during the past four years. At one point, the MOH produced two growth charts--one for boys and one for girls. In December 1986, the latest chart was made official, and 1.5 million copies were printed under a previous A.I.D. health project. Unfortunately, the systematic use of growth charts by health workers is limited at the present time. Under this Project, the growth charts will be field-tested to determine the extent to which: a) mothers and caretakers understand the information contained on the chart; b) the charts are read by mothers or caretakers; c) health workers understand how to use the charts correctly; and, d) health workers carry out regular growth monitoring activities. Of particular concern is whether or not mothers understand the colors used on the charts to indicate nutritional status (green for well-nourished, red for danger and malnutrition). Information gathered from these studies will be used to design appropriate materials for the integrated health communications sub-component and training course materials and curricula to teach health workers how best to use the growth charts. Another possible use of growth charts under consideration is to use the data on them to target the families who should receive supplementary food.

Technically, a growth chart is a relatively complicated, sophisticated tool with many potential applications. At present, it is used routinely in Peru as the official immunization record that must be presented to school officials in order to enroll six-year olds for first grade. Since a large number of mothers already have growth charts and are familiar with them, the additional investment to teach health workers and mothers how to use them and have the mothers suggest ways to improve them is appropriate and cost-effective.

In order to measure the weight and height of children, it is likely that the Project will finance the purchase of portable weighing scales and height measuring boards that are sufficiently light-weight to be carried to rural villages for growth monitoring at well-baby (WB) clinics. More sturdy equipment might be purchased for health establishments to support regularly scheduled WB clinics. Under previous Projects, USAID financed portable weighing scales purchased from England and the U.S. Specifically, one thousand 25 kg. scales for growth monitoring programs and 500 10 kg. scales for TBAs to use to weigh newborns were provided to the MOH under A.I.D. Project 527-0219 and were distributed to the UDES in late 1986. Experience with the U.S. scales is limited and will be compared to that of the British model before additional scales of either brand are purchased.

In order to carry out the 1984 ENNSA study, the CDC provided portable weighing scales from England and height boards that were made in Peru. The portable height board was designed to be carried to the field. More sophisticated and expensive models are available from the U.S.; however, based on cost and maintenance considerations, the most appropriate and cost-effective model is the Peruvian one.

Arm circumference bands have also been used in Peru to screen children for severe malnutrition during disasters. Since the measuring of arm circumference is not a precise method, it will not be used regularly to monitor growth as a substitute for measuring height and/or weight.

The other technologies that are likely to be included in the nutrition sub-component of the Project are appropriate foods for nutritionally vulnerable groups--pregnant and lactating women, infants and children less than five years old. Appropriate breast-feeding practices also will be promoted. Weaning food uses and practices in Lima, Ancash, Cajamarca and Apurimac have been analyzed. New blended weaning foods have been developed in Cuzco and Ancash and are being promoted. More research is needed and will be undertaken with support under this Project and possibly under AID/W centrally-funded projects to identify the most nutritious, cost-effective weaning foods for specific localities and to develop effective strategies to promote the adoption of these foods by mothers with small children. Also, the eating habits and practices of pregnant and lactating women will be investigated to determine the extent to which cultural food beliefs result in the nutritional deficiencies commonly found in women. Thus, all the technologies likely to be employed under the nutrition sub-component will be based on research findings and/or actual field experience which will ensure the appropriateness and cost-effectiveness of the approaches taken.

3. Immunizations

All immunizations to be used in this Project are safe, effective and currently in use in Peru, and the immunizations program will draw on and benefit from the significant advances in global immunization research. For example, vaccine regimes have changed recently to include four polio vaccines--at birth, two, four and six months of age. An improved measles vaccine to be given to six-month olds (rather than nine-month olds) will be studied and, if successful, introduced in place of the old vaccine. New vaccines are being tested for different diarrheal diseases and could be incorporated into the program in the future.

The advantages and disadvantages of disposable and reusable syringes and needles have been vigorously debated. Often, disposable syringes and needles are reused in developing countries because of the lack of resources. Disposable supplies, however, cannot be sterilized. On the other hand, while reusables can be sterilized, oftentimes they are not because of the lack of proper equipment, training, and/or supervision. Also, prior to the recent manufacture of plastic reusables, the price of disposables was considerably less than that of reusables.

In order to prevent contamination and the possible spread of hepatitis B and Acquired Immune Deficiency Syndrome (AIDS) through immunizations, WHO and UNICEF recently came out with a recommendation, also endorsed by A.I.D., which states that one sterilized needle and one sterilized syringe should be used for each injection. This means that in addition to adequate training, monitoring and supervision of personnel, related equipment such as destruction kits should be used if disposable syringes and needles are employed or sterilizers in the case of reusables.

The MOH is expected shortly to issue its national policy with respect to the use of either disposable or reusable syringes and needles. In Peru, health officials have reason to believe that disposable supplies are only being used once and are then discarded, and the MOH wants to continue to reinforce this appropriate use of disposables during the September-October 1987 vaccination campaign. Accordingly, until the MOH issues its national policy within the next three months, all personnel have been advised to use disposable syringes and needles and to break them (render them unusable) once they are used. UNICEF has supplied destruction kits to be used by health workers for this purpose.

Under the Project, A.I.D. will finance syringes and needles and related equipment (either sterilizers or destruction kits) to assist the MOH to implement its national policy. The latter will be discussed among all the donors providing support to the MOH's Immunization Program to ensure that all donor agencies adopt the same policies and procedures. Whichever alternative is chosen, this Project provides for adequate training, supervision, and proper equipment to ensure that the WHO/UNICEF/A.I.D. -endorsed policy will be carried out. Of significance is the fact that the development of a disposable needle (E-Z-ject) that self-destructs after one use has been underway for several years. As soon as they are commercially available, they could be purchased under the Project and would resolve the debate over the most appropriate technology for Peru.

The cold chain equipment which will be purchased under the Project has been designed specifically for use in the vaccine cold chain. Refrigerators are made to store vaccines (as opposed to food or bottled refreshments). Due to their high cost and unproven technology in rural, highland Peru, solar refrigerators were rejected in favor of an electric/kerosene model. One of the most important considerations regarding the appropriateness of the cold chain equipment is the local maintenance capability. The MOH has standardized its equipment and is only using Electrolux brand. The local distributor provides maintenance, trains MOH personnel in maintenance, and guarantees the availability of spare parts.

4. Family Planning (FP)

This Project will support the provision of the standard variety of modern contraceptive methods: oral contraceptives (Femenol, which is a low-dose estrogen pill), intra-uterine devices (IUDs) (Copper T-380, a recently improved Copper-T style which provides protection for 10 years as compared to the earlier Copper-T 200 model which provided four years of protection)), condoms, and female voluntary surgical contraception (VSC), using either "mini lap" or laparoscopy techniques for women who are in a high

risk reproductive category. Contraceptive foam and vaginal foaming tablets (VFT) will be financed by UNFPA and will also be included in the total mix of methods offered at MOH and IPSS facilities. These methods are all well beyond the experimental stage, and their safety and effectiveness under a variety of conditions are known and are a function of such user characteristics as age, health, parity, education, personality, cultural background and user application. Continuation of effective use will depend, in part, on effective initial physician assessment, patient education, counseling and clinic follow-up by clinical and other service personnel. Training in this area is included in the Project for all levels of personnel.

A new contraceptive technology which may be relevant to this Project is the subdermal hormonal implant, Norplant. It has been undergoing field trials in numerous countries for some time and was approved for public use in several countries. Should it be approved for use in Peru during the life of the Project, it could be incorporated into the Project.

5. Acute Respiratory Infection (ARI) Control

Early diagnosis and treatment of moderate and severe ARI is the principal objective of the Project's ARI intervention. Simplified diagnostic charts have been developed to train auxiliary and community volunteer health workers and educate mothers to identify the three levels of ARI and appropriate treatment, and in the case of health workers, how to make referrals to higher level health establishments. By promoting community participation to actively carry out related public health activities (e.g., promoting immunizations and breast-feeding of newborns), the ARI program should indirectly affect the mortality rate due to ARI by preventing or reducing the severity of ARI cases.

Basic equipment to be purchased under the Project includes stethoscopes and ophthalmoscopes, which are necessary for the diagnosis of ARI. The MOH norms for antibiotic treatment follow the WHO internationally accepted standards and are appropriate for this Project. Special care will be taken under the Project to properly train health workers and the caretakers of ill children in the correct dosage and administration of all pharmaceuticals. MOH norms will be widely distributed and their implementation closely monitored.

6. Integrated Health Communications

Because of the broad socio-cultural diversity found in Peru, it is difficult, if not impossible, to design a successful national health communications campaign with standardized messages for the entire country. Accordingly, this Project will provide assistance to strengthen the capabilities of personnel at the UDES and local levels to develop health communication messages that promote increased community participation. The integrated health communications activities will emphasize locally produced and printed materials, such as posters and calendars, and the production and broadcast of radio spots on local stations. The UDES's of Lima are expected to continue to broadcast health promotion messages on television for the urban viewers. Experience, however, has shown that it is very difficult to create T.V. materials that are relevant to the entire country, and that, in general,

national mass media campaigns are not a viable alternative. UNICEF will supplement the resources provided under this Project by providing technical assistance in "popular education", which includes activities such as street theatre, puppetry and mothers' club parades.

7. Increasing Service Delivery

The CS services to be delivered under the Project are the same MCH services that the MOH has been providing through its integrated MCH Program since 1979. During that time, many improvements in the delivery of MCH services have occurred. Coverage rates for immunizations have increased considerably over the past three years. FP services are in greater demand than ever before. Deaths due to dehydration during the summer diarrheal season have decreased steadily over the past three years. The technologies being used are sound. More training and education are needed, however, to increase their acceptability by both providers and users, and to ensure that they are delivered and used appropriately. Coverage rates also need to be increased. Mothers and their children who live in rural sierra and jungle communities are at greatest risk. Yet they are the least likely population groups to be served by the MOH or the IPSS. Increasing coverage among this target group, using available technology, is feasible.

As MOH-IPSS functional integration continues, and as the IPSS registers greater numbers of women and children patients, the IPSS will begin to cover the urban-based population once covered by the MOH. The IPSS has technically qualified personnel and sufficient resources to establish and operate WB clinics at IPSS facilities. The emphasis on training of IPSS professionals and paraprofessionals under the Project will also strengthen IPSS' ability to increase service delivery.

In order to increase and extend CS service delivery to the unserved populations, the MOH will have to shift both personnel and financial resources out to the rural zones to reach the isolated communities. This, in fact, is the goal of the MOH and its National Health Policy. Much of the needed personnel reassignment is underway. The MOH plans to work with community organizations to support CS activities and to promote active community involvement in improving the well-being of mothers, infants and young children, and thus increase total population coverage for CS services. The support systems discussed in the next section, however, will have to be operating effectively in order to fully achieve the objective of increased and improved delivery of CS services to the target populations.

8. Systems Improvement

In March 1987, a Ministerial Resolution was signed which described the organization and functioning of the UDES and delegated increased budget authority to the UDES Directors. By supporting the decentralization of planning and budgeting authorities to the departmental level, the Project will strengthen the institutional capacity to deliver CS services in a sustainable manner.

Systems improvements that support the delivery of CS services were initiated under A.I.D. Projects 527-0219 and 527-0230. Typewriters, calculators and cash registers were purchased for UDES, hospitals and health

centers. Staff from the accounting, logistics and personnel offices were provided training several times over the past three years, and improvements in financial management documentation have been noted by MOH supervisors. The first phase of establishing a national automated HIS has been completed. A WANG system integrated with a network of microcomputer centers has already been installed at the central level and in three UDES. Software programs have been developed and are being used for financial management, logistics and personnel management. A.I.D. will continue to support the investment made in improving these support systems under this Project. The Central WANG system, complemented by a network of microcomputers, has been deemed appropriate by computer experts familiar with the Peruvian environment.

The national epidemiological surveillance system is not yet operational. Fifteen sentinel surveillance sites must be established, and data must be regularly gathered and analyzed to monitor CS activities. Establishing this surveillance system--VEA--and training a cadre of well-qualified field epidemiologists will enable the MOH and the IPSS to target resources more effectively. Eradication of the wild polio virus will depend on the ability of health workers to use the VEA system to quickly identify all polio cases and provide vaccines in a timely fashion.

The logistics system must also be improved to guarantee the sustainable delivery of CS services. Warehouse improvements are required, and personnel need continuous, in-service training. Financial support to transport goods to their final destination must be available in a timely manner. Improvements in the delivery of FP supplies, immunization supplies and vaccines, ORS and ARI medicines will be implemented at the central and departmental levels with the assistance of Project-financed Regional Coordinators.

Training and supervision of appropriately selected personnel are required in order to assure that maximum benefits are derived from the investments in hardware and software. To ensure that appropriate personnel are adequately trained to make full use of the system and that operation and maintenance are adequate, Project-financed Peruvian computer systems engineers will be hired for one year for each UDES after which a permanent position will be established in each UDES and the MOH will finance these personnel as permanent employees. In addition, the Project will finance a Peruvian HIS advisor at the central level for the life of the Project.

9. Summary

The technologies to be used under this Project to provide health services and to strengthen the institutional capability of the MOH and IPSS to provide CS services have all been tested worldwide, used widely and found acceptable and cost-effective. All the technologies have been used previously and have been supported by numerous A.I.D. and other donor projects, and are currently in use in Peru. The only controversial question -- the use of disposable versus reusable needles and syringes -- is being closely examined by GOP, A.I.D., PAHO and UNICEF health authorities and should be resolved within the first months of the Project.

C. Social Soundness Analysis

This Project will assist the public health system (the MOH and IPSS) in Peru to strengthen its capability to deliver improved CS health services through a more comprehensive, expanded and sustainable health care system. To achieve this, it will be necessary to continue institutional strengthening of the MOH and IPSS, train personnel in the delivery of services in the areas of DDC, nutrition, immunizations, FP, and ARI, provide equipment and supplies, and continue to educate and inform the public in ways appropriate to a socially and culturally diverse and geographically dispersed target population. This section examines: the socio-cultural context in which the project will operate; the nature of community participation; the socio-cultural feasibility of the Project's proposed interventions, especially the five major CS interventions; project beneficiaries; and, the anticipated impact of the Project.

1. Socio-Cultural Context

Peru, the fourth largest and fifth most populous country in Latin America, is characterized by extreme geographic and cultural variations. Its land area is approximately 1.28 million Km^2, with only a small percentage of it arable, and its population in 1987 is estimated to be 20.7 million. It is divided into three clearly defined regions: a) the coast, which includes approximately 52% of the total population and 11% of the land; b) the sierra, with about 37% of the population and 26% of the land; and c) the jungle, with only 11% of the population but with 63% of the land. Each region has its own ethnic groups and culture. A recent World Bank report indicates that, of the total population, almost half is classified as indigenous. Approximately 10% is of European (primarily Spanish) origin, with a small number of Asians. The remaining one-third is of European/Indian mixture. According to the same report, "the majority of the Indians (who live in the sierra and jungle regions, but have also migrated to the cities in recent years) are deeply attached to their ancient cultural patterns and not fully integrated into the economic, social, and political life of the country."1/ Peruvians of European and Asian origin live primarily in the coastal cities (mostly in Lima), where they dominate much of the political and commercial activity of the country.

According to the latest data available from the National Statistics Institute, the Peruvian population is relatively young, with 40% less than 15 years old, and predominantly urban, with 68% located in urban centers as compared with 32% in the rural areas. Over the years, there has

1/ There is substantial variation among the Indian groups, however. Among the largest groups are the Quechuas and Aymaras, who live in the mountain region. The major groups in the jungle areas include the Campas, the Shipibo, and the Machinguengas, who have even less contact than the Andean Indians with mainstream Peruvian culture.

been and continues to be a growing trend to migrate to urban areas. As a result, today about 28% of the total population lives in the Lima and Callao metropolitan area. Because of the migratory flows at both the inter-regional and intra-regional levels, the distribution of the Peruvian population has experienced significant changes between 1940 and 1987. In the early 1940's, 65% of the Peruvian population lived in rural areas. By 1987, the situation was reversed, with 68% of the population living in urban areas. This urbanization process resulted in the growth of large settlements called pueblos jóvenes, where low-income families are not absorbed directly into the modern sector and live under very precarious socio-economic conditions with little or no access to social service. It is useful, therefore, to begin with a brief comparison of pueblos jóvenes and rural communities to highlight various social and cultural characteristics, including health practices pertinent to the provision of health services to both populations.

Pueblos jóvenes, while socially and economically marginal, are generally located near some type of health service. They are relatively easily reached by health officials, and community members can more easily seek assistance from nearby health posts, centers and hospitals. They also constitute a physically coherent unit that can act as a lobbying body to pressure government institutions to provide services. In the environment of the cities, the residents of pueblos jóvenes tend to be much more open and less constrained by traditional codes, mores and family relations. Common interests tend to become more important than family ties. Pueblo joven residents are directly involved in a process of drastic change, are more receptive to new technologies, and play a more active role in shaping their own lives. In short, they constitute a political force which seeks change and need not travel very far to state its case before the centers of power. Thus, pueblo joven residents are likely to be more receptive to CS health messages and services than the rural poor, if not more politically insistent that the services be made available.

Rural communities, on the other hand, are invariably more isolated geographically from government services. In fact, the most significant characteristic of these communities -- in contrast to pueblos jóvenes -- is their isolation, which keeps them out of the mainstream of national events. The bulk of the rural population is divided into outlying dispersed settlements that are often disconnected from the activities of their municipal centers, except through participation in weekly market days. Rural residents are united by family ties, economic activities, and traditional rituals and political organization. In highland Perú, communities are often made up of a single family grouping called an ayullu, an institution which has been in existence since pre-conquest times. In the high and low jungle areas, communities are even more dispersed, often consisting of household clusters dispersed over a wide geographical range. As a result, isolated rural communities tend to be less dynamic and open to change than pueblos jóvenes and are more rigidly tied to traditional practices. Health officials, to be successful, must work within the parameters of local linguistic and social organizational patterns. Quite simply, because of social, cultural, economic, and geographical (logistic) factors, the obstacles to successful health care delivery are greater in rural communities than in urban marginal settlements.

Aside from the difficulties encountered in dealing with such diversity, the traditional conservatism of peasants and indigenous people has often been cited as an explanation for unsuccessful outreach programs in all sectors. Over the years, a sizeable catalogue of negative cultural values of the peasantry has been assembled, largely by social scientists, portraying them as distrustful, uncooperative, authoritarian, apathetic, fatalistic, unwilling to take risks, and lacking good economic sense or entrepreneurship, among other characteristics. These characterizations are not entirely wrong, but like many generalizations and partial truths, they are often exaggerated to the point where the blame for unsuccessful health (and other) programs is placed on the urban poor and villagers. However, whether one is dealing with pueblos jóvenes or rural communities, it would be more accurate to describe the Project's target groups as pragmatic and opportunistic, anxious to fend off disease and receptive to practices which serve that purpose once they are shown to be effective. While it is true that people in marginal rural and urban communities manifest to some extent the alleged negative characteristics, it is also true that they exhibit these characteristics for reasons of their own survival. They are seldom irrational and will invariably respond positively to real benefits. All too often, the services and goods that the poor are expected to accept are faulty or inappropriate, a situation that unfortunately has plagued the health sector. Under these circumstances, what may be described as uncooperative or apathetic, for example, may be nothing more than merited distrust and reinforcement of a lack of confidence borne of past experience.

In fact, not all obstacles to service delivery lie within the community; many exist within the MOH and IPSS. For example, physicians are frequently criticized for their attitude toward, and treatment of, poor people as being professionally distant, authoritarian and condescending, if not outright rude. It appears that where better and productive community level relationships do exist, it is with nurses and health auxiliaries who work with the Mothers Clubs and local Health Committees. In general, too few MOH and IPSS staff have the knowledge, skills and training needed to work successfully at the community level. And, although both organizations require that their staff work at the community level, the means to do so (transportation, training, adequate per diems, supplies, and equipment) are frequently not made available or are inadequate. Additionally, because the National Health Policy states that community organization activities must come from the community, it is at times misinterpreted by some MOH and IPSS staff as a reason not to do anything, but to passively wait for the community to approach them. Under these circumstances, it is tempting to apply the negative description of Peru's indigenous population to the presumably more sophisticated groups who fault this population for their alleged unproductive cultural values.

Another MOH and IPSS obstacle is their bureaucratic structure which in itself can stymie local community interest and organizational activity. The problem, frequently, is not with the local rural and marginal urban communities, both of whose organizational capabilities or potential have

often been disparaged. Too often, traditional attitudes of bureaucracies result in a failure to mobilize the "can-do" esprit which often exists in poor communities, wherever located. In fact, many of the pueblos jóvenes are marked by a high degree of organizational capacity. For example, it is necessary, by law, for them to elect community leaders, which they do. In addition, numerous other locally organized groups exist which are centered on sports and specific community organized projects, such as roads, potable water, and schools. The evidence suggests that too often it is precisely bureaucratic attitudes and practices that stifle the organization of marginal people, and are counterproductive with respect to the positive results of health and other programs on marginal populations. The Peruvian poor have provided numerous instances of their organizational ability in the form of Mothers Clubs, cooperatives and other community associations. Inasmuch as harmful bureaucratic inclinations are more likely to be found at the headquarters rather than field level, Project design, which features decentralized implementation, places the burden of performance on the least bureaucratic elements of the sector. In fact, the decentralization engaged in this Project builds on GOP, MOH and IPSS objectives and on a basic, highly popular goal and policy of the GOP.

In summary, health care issues, including service delivery and utilization, have been strongly affected by rural-urban migration and rural-urban differences. The rapid growth of the urban population in the last three decades is due, in large part, to migration to the urban centers, especially Lima, from the rural areas. The rapid influx of migrants to these areas results in high levels of demand for all health services, including CS interventions. Differences between the urban and rural areas in terms of health care are: a) the urban population has much more access than the rural population to health services which are more heavily concentrated in Lima and a few other urban centers; b) the urban population has many more sources of health information than do residents of small towns and rural areas; and c) while rural areas have tended to maintain traditional values and standards of behavior, the cultural "dynamism" of the larger cities, especially Lima, has resulted in a mixture of beliefs and conduct that wants, and even demands, more modern health care. Through its decentralized approach, putting more of the decisions in the hands of those who are to implement the program and, thereby, reaching out more effectively to dispersed communities, the Project responds to the disparities among its target groups.

2. Community Participation

In September 1985, the MOH published and widely distributed its National Health Policy, which also applies to the IPSS. This document sets forth a reformulation of Peru's health policy, stressing the importance of social and political factors in health care delivery systems. According to its policy, the MOH wants to "facilitate the participation of the people, as objects and subjects of the objectives of all health concerns, in such a way that the people themselves manage, supervise, and control the health system." The MOH terms this process of transferring a large portion of the responsibility for health care to the people "the democratization of health."

Seven guidelines are presented in this new approach to health care, with a top priority being to promote "mobilization and participation of the organized population at all strata and at all levels of the health system." The Policy calls for people at all levels, as members of community-based organizations, to take an active role in identifying the health problems of their communities and in ensuring that appropriate health services are provided.

The recent reorganization of the MOH provides for Advisory Committees of local residents, who will play a significant role in determining local needs and the manner of health care delivery at the UDES, health center and health post levels. Given the history and proven capability of both marginal urban residents and the rural poor to organize themselves to impact positively on the acquisition and delivery of various public services, these Advisory Committees should help improve the public sector health service delivery system.

3. Socio-Cultural Feasibility

The acceptability of the CS services to be offered under the Project to both MOH and IPSS health care providers and the client families, is wide-ranging, with ORT for diarrheal disease control and growth monitoring of healthy children generally the least acceptable, and antibiotic treatment for control of ARI the most acceptable. The level of acceptability for these CS services is affected by regional and urban-rural differences, education, and age, among other factors.

a. Diarrheal Disease Control

Peru has a high incidence of diarrhea and requires a constant supply of salts (ORS) for oral rehydration therapy (ORT) year round. At certain times of the year, such as the summer on the coast, rates of diarrheal disease increase even more, as does the demand for ORS. In general, pre-packaged ORS is known and is used more in urban areas. The majority of mothers in all locations continue to feed their children traditional homemade soups during diarrheal episodes.

ORT to treat dehydration caused by diarrhea was introduced nationally into Peru by the MOH in 1980. The highly publicized campaign promoting a locally produced ORS encountered major resistance from the pharmaceutical industry and the medical community. With a change in the Minister of Health in 1982, the program became dormant. From 1983 to 1986, new efforts were made to promote ORT. New approaches in mass media promotion of ORT, emphasizing the efficacy, acceptability and cost-effectiveness of the therapy were developed. TV and radio messages on recognition of dehydration and the proper mixing of ORS were broadcast from December 1984 through mid-1985. A training program aimed at physician-nurse teams from hospital pediatric wards was started in order to broaden acceptance of ORT in the medical community and assure that ORT was taught to medical students and interns during their hospital rotations. And, a significant quantity of ORS was purchased by USAID for the MOH and was distributed during this period to MOH health establishments throughout the country.

Unfortunately, the deaths in March 1986 of four children who were given ORS in a hospital in Lima were highly publicized. Salts were recalled, and mothers expressed reluctance to use ORS. Problems then developed with the ORS provided to replace the brand of ORS associated with the March deaths, which reduced confidence in the technology even further. To counteract this problem and continue to educate the public about diarrhea-related dehydration, radio and TV spots were developed in July 1986 to advise mothers to give more liquids to children suffering from diarrhea and to continue breast-feeding. The signs of dehydration were explained, and mothers were urged to seek medical attention immediately if dehydration signs were observed.

Toward the end of 1986, the acceptability of ORT began to gradually increase among both health providers and client families, assisted in part by the training of physician-nurse teams from approximately 36 hospitals throughout the country. The courses, on management of diarrheal disease, were conducted by the Cayetano Heredia Hospital Rehydration Unit staff. In addition, over 250 other health professionals attended a week-long seminar on dietary management of diarrhea in December 1986. To further inform the medical community, the first issue of a Peruvian child survival journal, Niños, was published in May 1986 on the topic of management of diarrheal disease, and over 15,000 copies were distributed to public and private sector physicians across the country.

During the summer diarrheal season (December 1986 - March 1987), the MOH once again used radio, TV and newspapers to promote messages about avoiding dehydration due to diarrhea and encouraging prolonged breast-feeding of newborns, including during episodes of diarrhea. Also during this time, the local ORS producer, LUSA (Laboratorios Unidos, S.A.), changed to the new citrate-based formula and updated the package design. The new formula is more palatable, which helps increase user acceptance, and, because it is more stable, has a longer shelf-life.

Both private and public health sectors have been involved in operational research to determine culturally acceptable alternatives to ORS, such as soups, which would be readily available in the case of a diarrheal episode. Results from this on-going research will be used in future national and regionally specific IE&C campaigns. Messages will stress the importance of preventing dehydration when a child has diarrhea by giving either ORS or home remedies, and of continuing feeding, especially breast-feeding, during diarrheal episodes. It is important to promote both ORS and home remedies for the prevention of diarrhea-related dehydration in order to address regional differences and individual preferences for treatment options.

In summary, the training efforts, which focused on physicians and nurses, particularly those working at teaching hospitals where interns study pediatrics, have resulted in an increased awareness and acceptance in the medical community of the efficacy of ORT, including both fluids and appropriate feeding practices during episodes of diarrhea. Trained physicians and nurses now need to train health auxiliaries to use ORT. Use of ORT by the medical community and mass media campaigns has definitely increased

mother's awareness and use of ORS. These efforts now need to be expanded to include education about the preparation and use of suitable home remedies and one-on-one training of mothers by health workers on how to mix and administer ORS properly. With these efforts, ORT acceptance and use will continue to increase.

b. Nutrition

The nutrition activities most likely to be supported under the Project include: i) using growth charts to monitor the development of children less than five years old; ii) providing supplementary food to families with children at highest risk for malnutrition; iii) promoting appropriate breast-feeding practices; and iv) educating mothers regarding the timely introduction of nutritious blended weaning foods. These activities have been supported by A.I.D. under projects in both the public and private sectors, but the acceptability of the interventions by the target population in rural and marginal urban communities is variable and not well understood.

The idea of bringing a well baby to a health establishment on a regular basis to be weighed and measured is a foreign concept--time-consuming and costly--to poor mothers, who cannot always afford to bring their sick children to health establishments. On the other hand, families with children at high risk of malnutrition will participate regularly in growth monitoring programs that provide supplementary food, if their participation requires minimal time and cost. Nutrition interventions involving growth monitoring under the Project, therefore, will be organized at health establishments where supplementary food can be provided through feeding programs that target families of infants and children at highest risk of malnutrition.

Exclusive breast-feeding of newborns is not widely practiced in Peru. In urban health establishments, especially in hospital maternity wards, water, teas, and bottled infant formula are given to many infants at birth, even before the mothers have an opportunity to begin breast-feeding. It is a common belief that breast-milk is not sufficient and must be complemented by additional liquids to prevent dehydration, especially during hot weather. Factors which influence the duration of breast-feeding among women include: i) geographical location--rural mothers breast-feed for longer periods of time than urban mothers; ii) mothers' employment situation--urban mothers who do not have day-care facilities available at their place of work are among the first to stop breast-feeding; and, iii) the attitudes of the health professionals who care for pregnant mothers and newborns--doctors and nurses significantly influence the attitudes and practices of mothers, as do infant formula company sales representatives.

In mid and late 1986, the MOH aired television and radio spots promoting breast-feeding. Under this Project, additional promotional messages aimed at urban mothers will be developed and broadcast using women from different socio-economic backgrounds as models. Women who are political leaders or wives of political leaders would be excellent role models and could

have a significant impact on improving breast-feeding practices, especially in urban areas. Under the Project, social marketing research will be conducted to determine the attitudes and beliefs that inhibit breast-feeding, the content of messages that will promote improved breast-feeding practices, and the most appropriate spokeswomen to promote the messages.

Professional level educational materials also need to be developed for health workers and medical and nursing students that will provide scientific evidence regarding the efficacy and the advantages of exclusive and prolonged breast-feeding. As in the case of the DDC Program, health professionals at hospitals with busy maternity wards, where student doctors learn obstetrics, will be the focus of breast-feeding promotion activities. Rooming-in of infants with their mothers in maternity wards of MOH and IPSS facilities will be actively promoted, and infant formula companies will be prohibited from promoting their products in hospitals. The formation of support groups, such as the La Leche League, will be encouraged to assist lactating mothers.

Weaning foods and weaning practices vary throughout the country but are deemed to be less than adequate since the highest rates of malnutrition are found among children of weaning age (between six and 24 months old). Because they have not developed all of their teeth, children in this age group cannot eat adult foods and need specially prepared, soft foods that are high in protein and calories which are required for optimal growth and development. Studies of weaning practices in rural and urban areas indicate that a wide variety of foods that could be used as weaning foods are available in urban areas, while in rural areas, the problem is more often a lack of any type of food, especially appropriate weaning foods. Even when appropriate foods are available, they are often too expensive to be purchased by poor families. Several weaning food studies have been conducted and recipes have been developed for specific locations. Based on the lessons learned from developing and promoting these new weaning foods, other recipes will be developed and promoted in geographic areas with the highest rates of childhood malnutrition. In addition to teaching mothers the importance of providing nutritional weaning foods to reduce mortality and morbidity, nutrition education messages also will promote proper hygiene and food storage practices, since studies have shown that the introduction of weaning foods is often associated with diarrheal disease caused by contaminated foods and utensils.

c. Immunizations

High immunization coverage, especially in marginal urban areas, is a good indicator of parents' acceptance of immunizations to prevent childhood diseases. Immunizations are somewhat less well-accepted in a few jungle and sierra areas where some Indian populations believe they can hurt and even kill the child. (Some basis for this belief does exist in that the vaccine cold chain did not always operate effectively, and bad vaccines were inadvertently used in the past.) General acceptance by both the medical community and parents, however, is so high that after two national campaigns

(October through December 1985 and September through November 1986), a nationwide 80% coverage of children under five was achieved. In fact, through surveys carried out after the 1986 National Vaccination Campaign, it was found that a majority of the children who had not been vaccinated had been ill during the campaign days. MOH norms, which previously prohibited the vaccination of children who had fevers, diarrhea or other illnesses, are being modified at this time. However, coverage was lower in some sierra areas where heavy rains made roads impassable and where the population is widely scattered and does not cluster in small towns. Additional evidence of the high degree of acceptability of immunizations is a new regulation issued by the MOE in 1987 which requires children who register for school to present proof of complete vaccination coverage.

The MOH will continue to use campaigns to maintain high immunization coverage rates, but rather than promote national level campaigns, UDES level campaigns will be encouraged to better meet local needs and circumstances, such as weather conditions and local holidays. At the same time, the cold chain will be strengthened and the logistics system improved. In this way, vaccinations will be available on a regular basis at all peripheral health establishments so that immunizations can be provided on demand.

Besides immunizations for polio, measles, diptheria, whooping cough and tuberculosis for children under five, immunization coverage against tetanus for pregnant women will also be promoted to prevent neonatal tetanus deaths in newborns. The incidence rates of newborns dying of neonatal tetanus are not well documented and merit further investigation. Higher rates are reported by public health officials who work in jungle regions. Coverage against tetanus for pregnant women has been very low, approximately 12%. One of the principal reasons for such low coverage is that the women themselves do not know or have not been educated to understand the importance of this vaccine to prevent "the seventh day death" of newborns caused by tetanus. Also, while health professionals do understand the need for tetanus immunizations, the vaccine is frequently not available. The MOH has made increased tetanus immunization of pregnant women who live in high risk areas a priority in its immunization strategy. Low coverage does not appear to be caused by social customs or values.

d. Family Planning

Strongly correlated with socio-cultural differences between urban and rural residents are patterns of knowledge, attitudes, and practices regarding fertility and family planning. For example, more urban women than rural women know about more methods of family planning, especially modern methods. And, the total fertility rate in Lima is less than in other urban areas, where it is still less than in rural areas. Furthermore, women in rural areas, and recent migrants to the urban areas, begin childbearing years earlier and continue later than urban women. Traditional and herbal family planning methods have been available for a very long time, but modern methods were first introduced into the public sector delivery system in 1980 by the MOH under an A.I.D. Project. Since then, use of all family planning methods has grown to a current 46% of women of reproductive age (WRA). Of the WRA, a sizeable 65% have at one time or another used some family planning method.

Use of modern methods has steadily increased from 11% in 1978 to 17% in 1981 and 23% in 1986. The demand for services is higher than the use rate due to the inability of the health care system to meet that demand. Health care providers are, in general, supportive of most family planning methods, although individual preferences may lead them to promote certain methods more strongly than others. Family planning is a widely accepted and practiced concept, despite some anti-family planning influences in the country. Political support for family planning, however, has grown significantly. In late 1986, the President, for the first time in the history of Peru, made a number of strong public statements in favor of family planning. A Presidential Commission on Population was formed; an emergency plan of action developed; and, a demographic goal set to lower the fertility rate from 4.5 to 3.7 by 1991.

Various family planning IE&C campaigns have been conducted using mass media, such as television, radio, and billboards, as well as printed matter such as pamphlets and posters. Recent campaigns have been developed using both foreign and/or Peruvian professionals from private sector advertising and marketing firms and social marketing experts. Messages have been targeted primarily to couples and adult women, and to date, fewer have been directed specifically toward adult males. The principal message concept of responsible parenthood (have the number of children you can care for) is acceptable and well-received. Religious groups have criticized, upon occasion, the use of modern FP methods to practice responsible parenthood, but agree that responsible parenthood itself is a desireable end. IE&C campaigns have increased public awareness that methods are available through public sector institutions to space or limit the size of a couple's family. The use of more effective modern methods has been emphasized in these campaigns. Preliminary results of the last contraceptive prevelance survey (1986 ENDES) indicate that more women are using modern methods of contraception than ever before. With strong visible governmental support and continued culturally specific IE&C campaigns, FP services should be even more successful in the future.

e. Control of Acute Respiratory Infections

ARI is the number one cause of morbidity in children less than one year old, and treatment for ARI is the principal reason for visits to health establishments by children under five. The primary causes of ARI (inadequate, cold, overcrowded and poorly ventilated housing, cold and damp weather, inadequate clothing and malnutrition) do not fall, essentially, within the mandate of the MOH and IPSS. Accordingly, the MOH and IPSS approach to reducing deaths from ARI is to promote early detection and treatment. Since this program was initiated a year ago, with limited but continuing public education, it is still too early to assess its socio-cultural acceptability. The program identifies ARI at three levels of severity: the first requires simple home treatment, the second requires antibiotics, and the third stage necessitates hospitalization. Because it is the easiest to treat, the most critical stage is the first. Mothers must be trained to recognize and correctly treat it. Antibiotic treatment, appropriate

for the next stage of ARI, is a common intervention for numerous illnesses and is readily given by health providers and accepted by the population. (Parents expect to receive a prescription for antibiotics and usually will make the purchase at the health establishment pharmacy. Problems arise when the medicine is not available, a not infrequent occurrence.) Hospital care is less feasible because access to it is limited in many areas and is costly.

In summary, CS health services are socio-culturally acceptable in Peru as indicated by the high demand for such services. Currently, the public health care system does not meet that demand, but will be better able to do so with appropriate inputs provided by this Project.

4. Project Beneficiaries and Impact

The immediate Project beneficiaries are the infants, children under five, and women of fertile age (WFA) in the target populations of the MOH and IPSS, especially those living in rural and marginal urban areas. Of the 12,021,660 and 5,876,000 individuals in the MOH and IPSS target groups, respectively, who constitute 86% of the total Peruvian population, approximately 40%, or 7,159,064, are children age five or under and WFA. In most cases, the same individual will benefit from more than one CS health care intervention.

This Project will have the range of impacts that are generally associated with the improved and expanded availability of CS health care services. For example, the family planning users can be expected to experience health benefits through: a) a reduction of the incidence of complications during pregnancies; b) improved infant health brought about by adequate and sustained breast-feeding made possible by increased spacing between pregnancies; and c) improved family nutrition in general, brought about through the birth of fewer children, which should also reduce the incidence of malnutrition in children. It can also be anticipated that more families will be able to enjoy a higher standard of living due to having fewer children. There should be fewer workers seeking employment and increased social services. Crowding in low-income areas should be lessened, and more children will be able to continue further in school. Family planning also has a very positive impact on the role of women. By providing women the opportunity to plan and control the number and spacing of births, it provides them the opportunity not only to be more effective in their roles as wives and mothers, but also to devote time and energy to different roles and activities. In particular, it helps the economic situation of women, particularly those who are heads of households, by allowing greater opportunities for employment. In addition, the Project's mass media and other IE&C activities will reach a much broader group of persons, such as males in the MOH and IPSS target populations, both men and women outside the MOH and IPSS target populations, and community organizations which want information on family planning. The beneficial effects of a lowered population growth rate on the opportunities for overall economic and social development and on the environment are well-known and established.

Other CS health interventions also have a notable spread effect. Immunizations will not only help the recipient directly, but also by lowering the general level of the diseases in the community, they help reduce the possibility that non-vaccinated children will contract those diseases. And, any reduction of ARI among the target population will save lives and contribute to the reduced incidence among other family members.

Other individual beneficiaries of the Project include approximately 750,000 members of various community groups and organizations (e.g., Mothers Clubs, cooperatives, church, school and parent groups, sports clubs, youth organizations and others) who will benefit directly from the community health education activities of the Project, and approximately 70,000 MOH and IPSS staff (namely, physicians, nurses, midwives, health auxiliaries, administrative and mangement staff, technicians and others) who will receive training to deliver improved CS health services. This training, along with adequate equipment and supplies to be provided under the Project, will result in enhanced job performance and personal satisfaction.

A major focus of this Project is institutional development, including an increasingly larger commitment by the GOP to finance recurrent health care costs. It is, therefore, expected that, by the end of the Project, functioning systems with trained personnel and adequate supplies and equipment will be in place to continue delivering CS health services after this Project ends. Institutional development also will occur at the community level due to the emphasis on community involvement. As a result, many communities should further develop and strengthen the organizational skills required to work with GOP institutions to acquire needed social and health services.

5. The Role of Women

The involvement of women will be critical to achieving the objectives of this Project. This includes not only their roles as mothers and wives but also as service providers in both the formal and informal health delivery systems and as community leaders and members. Women can serve as effective intermediaries between the MOH and IPSS and the community in establishing dynamic community-based distribution programs and effective health communications networks. Female outreach workers are often more effective than males in reaching the target population of children and mothers with CS services. In many communities, there are existing institutional networks created by female grassroots organizations that have demonstrated their ability to effectively mobilize the community to undertake a wide variety of programs which these organizations are well-equipped to manage. In short, this Project has been designed to maximize the participation of Peruvian women in the delivery of improved CS services and to take advantage of the multiple roles they serve in order to promote the kind of changes needed to attain this goal.

6. Summary

The socio-cultural context of Peru is multi-faceted, with enormous regional and urban-rural variations that affect and complicate the

delivery of child survival health services. The 1985 GOP National Health Policy emphasizes the need for, and value of, local community participation in the assessment of health problems and the formulation of solutions, and requires the MOH and IPSS health system staff to support local participation and to increase the involvement of local residents. The Project's decentralized emphasis recognizes disparities, reduces the negative impact of unresponsive bureaucracy and implements a nationally supported GOP, MOH and IPSS policy.

All the CS health care services provided under the Project are socio-culturally acceptable. Many have been utilized for some time in Peru. ORS and traditional homemade soups are well known and widely used. The relationship between adequate growth and development and proper feeding is fairly well known and will be further promoted under the Project. Immunizations against common childhood diseases is also a widely accepted health intervention. The level of knowledge of FP is high, and the current demand for such services far surpasses the system's existing capacity to satisfy it. Antibiotic treatment for ARI in the second stage is an accepted treatment; a recently implemented program is designed to educate parents to recognize and treat ARI at an earlier stage. In conclusion, the programs and activities to be implemented under the Project are socio-culturally feasible and sound and should have a significant impact on the health status of the Peruvian population.

D. Economic Analysis

1. Introduction

From an economic perspective, the principal objective of the Project is to improve human capital through the provision of health and FP services. While each of the Project's sub-components (DDC, immunization, etc.) has distinguishable effects on human resources and the economy, these effects are not easily measurable in the Peruvian context. A brief description of the information that would be necessary to carry out an economic cost-benefit analysis for this Project will illustrate the point.1/

The immunization, ARI control, nutrition, and DDC programs aim at reducing the target group's mortality and morbidity rates associated with their related diseases. There are several economic effects linked with these activities. First, by reducing mortality rates, individuals served by the Project are provided with the opportunity to lead longer productive lives. The net economic contribution of these individuals to society will depend on factors such as life expectancy, morbidity risks associated with other diseases, consumption, employment and educational opportunities over their lifetime. Second, by reducing morbidity rates, foregone productivity resulting from disease episodes and their treatment costs borne by society will be reduced. For each individual served, there is a stream of net contributions to society, which must be weighed against explicit and implicit costs associated with the Project. The economic benefits from the FP program result from the reduced consumption, health, housing and education expenses

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1/ Preliminary guidelines on data and methodologies needed to evaluate the cost-benefit and cost-effectiveness of specific elements of the Project, are on file at USAID/Peru.

and other investments required to support the increase in population levels that would have occurred without the Project, as well as better maternal andinfant health which result from birth spacing. These benefits need to be weighed against program costs and national production foregone since the potential size of the labor force would be reduced.

A survey of Peruvian health data provided little useful information to carry out an economic cost-benefit analysis of the scope described above. Nonetheless, general information about treatment costs is available and was utilized to identify and illustrate some of the financial savings for a portion of Peru's health care system and for Peruvian families assisted by the Project. The following sections summarize the analysis for some of the Project's service delivery and systems improvement activities. Clearly, A.I.D. experience with CS activities around the world has shown them to be cost-effective in reducing mortality in infants and children. This experience, particularly in the context of the Peruvian environment, including past and on-going A.I.D.-financed projects and the MOH's priorities and preferences, provided the basis for the selection of Project activities.

2. Diarrheal Disease Control Program

As a result of this program, some 6.2 million cases of severe dehydration of children under five years of age will not have to be treated in the Peruvian health system.1/ This would result from the successful application of the oral rehydration therapy (ORT) promoted by the program. Of these avoided cases, about 30%, or 1.8 million cases, would have been treated in the MOH system.2/ When the reduced number of potential treatment cases in the Ministry's system is adjusted by the expected increase in the application of ORT treatments (about 1 million) by the MOH system, the net reduction of treatment cases as a result of this Project sub-component amounts to about 800,000 cases. This figure can be utilized to estimate savings that would accrue to the MOH system. The average consultation cost in the MOH system is about $3.50 per visit.3/ Thus, implementation of the DDC program would result in financial savings of about $2.8 million over the life of the Project. Savings would also accrue to other health institutions such as the IPSS system and private clinics. There are no data readily available on treatment costs for these institutions. If the program continues beyond the life of the Project, financial savings would be expected to continue.

Families would also save by not incurring medical expenses. The average cost of visiting a MOH clinic in Peru is about $7.00 per visit.4/ This average cost includes service rates, transportation costs, and foregone earnings. Thus, the 6.2 million cases that would not have to visit clinics for severe dehydration treatment would save about $43.4 million over the life of the Project. This is only a rough figure since the average cost per visit is not weighed according to the share of visits for each fee in the sample used to estimate it. Moreover, the estimated savings that would accrue to the MOH cannot be added to the savings that would accrue to families served since these include clinic fees. However, the conclusion is clear -- the financial benefits of this component are substantial.

1/ Source: 1986 Health Sector Analysis (ANSSA), November 1986.
2/ Source: 1986 Health Sector Analysis (ANSSA), November 1986.
3/ Source: 1986 Health Sector Analysis (ANSSA), November 1986.
4/ Source: 1986 Health Sector Analysis (ANSSA), November 1986.

3. Immunizations Program

This program also can be evaluated on the basis of financial savings generated in favor of the MOH. The program aims at significantly reducing the numbers of cases of measles, whooping cough, tetanus, polio, tuberculosis, and diphtheria. Adopting the conservative assumption that the treatment for each of these diseases requires five visits to the MOH system (polio treatment is longer and costlier), then financial savings can be estimated on the basis of morbidity-mortality statistics, the visits associated with them, and an average cost per visit. The most recent data[1/] show that the combined mortality rate for the targeted diseases is about 4.8 per thousand, with a combined morbidity rate of about 14.2 per thousand. Thus, the financial savings to the MOH associated with the elimination of the 66,900 morbidity-mortality cases each year would be $5,853,750 for the five-year life of the Project.[2/] This figure would represent the saved costs by virtue of the number of avoided visits (1,672,500) associated with the program. Avoided visits can also be utilized to estimate personal savings. Using the average cost of $7.00 per visit, family savings would be $11,707,500 for the life of the Project.

4. Family Planning Program

This program aims at supporting the GOP's plans to reduce the fertility rate from 4.2 to 3.7 children per woman by 1991. This would result in a reduction of about 100,000 births. The savings associated with these births averted can be estimated by adopting the assumption that each of these infants would require about five visits to the MOH system per year. Thus about 500,000 visits per year would not take place, saving about $1.75 million per year in health care costs. Family savings could reach $3.5 million per year when the avoided yearly visits are multiplied by average family costs per visit.

5. Health Information System (HIS)

The unavailability or paucity of data is being partly addressed by one of the Project's major activities, which consists of developing and maintaining a HIS. The system will be designed to enable the health planners and implementors to monitor and evaluate the cost-effectiveness of their programs. This will be a key element in ensuring that increased resources, reflecting the renewed GOP emphasis placed on health expenditures, are utilized efficiently. (GOP health budgetary allocations increased in 1986 and 1987 after declining for five years.) The HIS will collect and analyze data on each of the program sub-components under the Project. Emphasis will be placed on financial costs, program coverage and compliance rates.

6. Summary

The financial savings identified for some of the Project's activities are merely illustrative, but supportive of the need to carry out the Project. Available data are too broad to provide a sound basis to sharpen conclusions about the economic and financial benefits of the Project. Nonetheless, reaching a conclusion that the Project can be justified on cost-effectiveness criteria would be supported by a detailed study of CS

1/ Source: ANSSA, November 1986.
2/ Population under 5 = 3,520,980; therefore, 19 cases per thousand population under 5 = 66,900 cases per year x 5 visits per year = 334,500 visits per year or 1,672,500 visits for the life of the Project.

services at a private mining company in Peru. The study[1/] concluded that the introduction of CS services in the firm's clinic would generate net financial savings for health services to the firm. In fact, first year savings alone would almost match first year costs associated with the firm's services program.

The foregoing discussion provides indications of savings which would result from the Project. The analysis, as mentioned, is partial and indicative. Among other gaps, there is no estimate of the public investment required, for example, to provide housing and related services or to create jobs for the population increases that would have occurred without the Project. The magnitudes involved in these prospective costs are enormous. Clearly, one aspect of a benefit-cost analysis which social sector interventions confront is the need, in a comprehensive analysis, to take account of the long-term benefits which these interventions would generate. In any case, the indicative savings (confined to the life of the Project), the substantial implicit benefits, especially in the long-term, and A.I.D.'s experience worldwide and in Peru, all reinforce the judgement that the CS activities to be undertaken in this Project are economically justifiable.

E. Cost Estimate and Financial Plan

1. Financial Analysis

The total cost of this five-year project is estimated to be US$44,015,115, of which US$19,000,000 will be financed by A.I.D. and the equivalent of US$25,015,115 will be financed by the GOP. The GOP contribution for this Project represents additional resources over and above the regular budgets of the MOH and IPSS. Total project costs by funding source and foreign exchange (FX) and local currency costs (LC) are summarized in Table 22.

TABLE 22. Summary of Total Project Costs by Funding Source and Foreign Exchange (FX) and Local Currency Costs (LC)
(US$000)

	FX	LC	Total	%
A.I.D.	13,972	5,028	19,000	43
GOP	--	25,015	25,015	57
Total	13,972	30,043	44,015	100

1/ Source: TIPPS Project, "Costs and Benefits of Implementing Child Survival Services at a Private Mining Company in Peru", 1987.

As shown in Table 22, the GOP will finance a larger percentage (57%) of total Project costs than will A.I.D. (43%), significantly exceeding the required 25% counterpart contribution to the Project. The GOP's contribution will be derived from two sources: a) an estimated US$12,000,000 from PL 480 local currency generations from the sale of imported food commodities; and, b) an estimated US$13,015,115, which represents 30% of total Project costs, from the GOP Public Treasury. The GOP counterpart contribution for the Project is expected to be made available as shown in Table 23.

TABLE 23. Total GOP Counterpart Contribution by Calendar Year (CY) and Funding Source (US$000)

Year	PL 480	GOP Treasury	Total
CY 1988	3,000	1,125	4,125
CY 1989	3,000	1,638	4,638
CY 1990	2,500	3,302	5,802
CY 1991	2,000	3,004	5,004
CY 1992	1,500	3,946	5,446
TOTAL	12,000	13,015	25,015

As seen in Table 23, the required GOP counterpart contribution for the Project will be made available each year by a combination of PL 480 and GOP Public Treasury resources. PL 480 resources will be made available annually on a declining scale, beginning with the equivalent of US$3.0 million in CY 1988 and gradually declining over the years to US$1.5 million in CY 1992, the last year of the Project. GOP Public Treasury funds will be made available to the Project annually on an increasing basis, beginning with US$1.1 million in CY 1988 and amounting to US$3.9 million in CY 1992.

Five summary financial tables are provided on the following pages: Table 24 summarizes total Project costs by inputs, funding source and foreign exchange and local currency costs; Table 25 presents a breakdown of total Project costs by Project components, funding source and foreign exchange and local currency costs; Table 26 summarizes A.I.D. Project costs by inputs and Project components; Table 27 shows total Project costs by inputs, Project year and funding source; and Table 28 summarizes projected obligations and earmarkings/commitments of A.I.D. Project funds by U.S. fiscal year (FY).

The local currency budgets prepared by the MOH for A.I.D. and GOP financing were based on prevailing market prices during the period March-June 1987. These budgeted local costs were then converted to U.S. dollars at the exchange rate of I/.20 = US$1.00. All financial tables reflect the impact of anticipated inflation on prices for each line item over the life of the Project (LOP). A five percent cumulative inflation rate was used, calculated annually, for all A.I.D. and GOP-financed foreign exchange and local currency costs, except for first year costs which are based on current market prices. The total inflation adjustment amounts to US$1.3 million for the A.I.D. grant and US$2.3 million for the GOP counterpart contribution. A contingency line

item, amounting to $1,753,000 or approximately four percent of total Project costs, has been included in the LOP budget. Individual component budgets reflecting both the base cost estimate and the annual inflation adjustment for both the A.I.D. and GOP contributions are included in Annex II.C. In addition, USAID will directly administer US$17.1 million or 90% of the total A.I.D. contribution of US$19,000,000. The MOH will directly administer US$1.8 million or 9.5% of the A.I.D. contribution, in addition to the equivalent of approximately US$24 million of GOP counterpart resources. IPSS will directly administer the remainder, i.e., $100,000 of A.I.D. funds and the equivalent of US$1 million of GOP counterpart funds.

Project Year (PY) 1 as shown in the budget tables corresponds to the period October 1987 through December 1988. The remaining PYs are on a calendar year basis. A.I.D. Project costs by PY represent anticipated earmarkings or commitments of A.I.D. funds through Project Implementation Orders (PIOs) and Project Implementation Letters (PILs). GOP Project costs by PY represent anticipated disbursements of funding.

Information for the development of cost estimates for equipment and supplies to be procured under the Project came from a variety of sources, including: a) consultant reports; b) supplier catalogs, including United Nations procurement publications; c) local supplier quotations; d) AID/W responses to Mission inquiries; e) assistance from the USAID Procurement Office; f) consultations with MOH officials and review of their preliminary budgets; and g) USAID experience gained from recent procurements of similar items.

Information for the development of cost estimates for technical assistance came from: a) USAID experience with prior health projects and other mission projects; b) consultations with MOH officials and review of their preliminary budgets; and c) on-site visits by CDC representatives from the U.S. for the preparation of a technical assistance package for the Field Epidemiology Training Program (FETP). Finally, a review of the cost factors used by the MOH for the Integrated Training and Supervision Plans was made to determine their reasonableness.

As indicated in Table 24, of the total A.I.D. contribution of US$19 million, approximately US$14 million (74%) has been budgeted for foreign exchange costs, primarily consisting of medical and laboratory equipment and supplies, vehicles, contraceptives and data processing equipment in addition to overseas training, evaluation, USAID management staff and expatriate technical assistance. The remaining US$5 million (26%) will finance local currency costs related primarily to Project monitoring and support activities and the MOH's integrated training program, with the balance budgeted for local commodities, local Peruvian consultants, monitoring and support, and contingency.

The GOP counterpart contribution of the equivalent of US$25,015,115 will exclusively finance local currency costs of the Project. Table 24 shows that of the total GOP contribution, US$17.4 million (70%) has been budgeted for operating expenses and Project monitoring and support activities, while the balance of the equivalent of US$7.61 million (30%) has been budgeted to cover the in-country training program, local office equipment, medical and laboratory supplies, and contingency.

TABLE 24. TOTAL PROJECT COSTS BY INPUTS, FUNDING SOURCE AND FOREIGN EXCHANGE(FX) AND LOCAL CURRENCY (LC) COSTS

(US$000)

INPUTS	AID Fx	AID LC	TOTAL AID	TOTAL GOP	GRAND TOTAL
A. Training	518	1,362	1,880	3,285	5,165
1. Overseas	518	0	518	0	518
2. In Country	0	1,362	1,362	3,285	4,647
B. Technical Assistance	1,105	452	1,557	0	1,557
1. Expatriate Advisors	1105	0	1105	0	1,105
2. National Advisors	0	452	452	0	452
C. Commodities	10,296	440	10,736	3,905	14,641
1. Vehicles	939	0	939	0	939
2. Medical,Lab.& Other Equip.	2,860	0	2,860	0	2,860
3. Office Equipment	6	55	61	41	102
4. Computers	936	0	936	0	936
5. Supplies	1,618	120	1,738	3,864	5,602
6. Contraceptives	3,933	0	3,933	0	3,933
7. Other	4	265	269	0	269
D. Other Costs	1,056	2,447	3,503	17,396	20,899
1. USAID Management Staff	826	274	1,100	0	1,100
2. Audits and Evaluations	230	400	630	0	630
3. Operating Expenses	0	50	50	14,026	14,076
4. Monitoring and Support	0	1,326	1,326	3,266	4,592
5. Other	0	397	397	104	501
Sub-Total	12,975	4,701	17,676	24,586	42,262
E. Contingency	996	328	1,324	429	1,753
Grand Total	13,971	5,029	19,000	25,015	44,015

TABLE 25. TOTAL PROJECT COSTS BY PROJECT COMPONENTS, FUNDING SOURCE AND BY FOREIGN EXCHANGE (FX) AND LOCAL CURRENCY (LC) COSTS (US$000)

PROJECT COMPONENT	AID FX	AID LC	AID TOTAL	GOP TOTAL	GRAND TOTAL
A. Expansion of CS Services by MOH					
1. Diarrheal Disease Control	117	56	173	819	992
2. Nutrition	216	114	330	40	370
3. Immunizations	2,590	114	2,704	0	2,704
4. Family Planning	3,012	321	3,333	0	3,333
5. Acute Respiratory Infect.	211	0	211	1,943	2,154
Sub-Total	6,146	605	6,751	2,802	9,553
B. Expansion of CS Services by IPSS a/					
1. Family Planning	1,106	52	1,158	154	1,312
2. Other Child Survival	583	0	583	355	938
Sub-Total	1,689	52	1,741	509	2,250
C. Systems Strengthening					
1. Field Epid. Trg. Prog.	1,431	441	1,872	44	1,916
2. VEA Laboratories	752	4	756	0	756
3. Epidemiolog. Surveillance	0	346	346	0	346
4. Health Info. System	831	501	1,332	0	1,332
5. Integrated Trg. Prog.	132	523	655	2,861	3,516
6. Integ. Supervision Prog.	0	0	0	1,549	1,549
7. Transportation	939	0	939	374	1,313
8. Health Communications	0	323	323	974	1,297
Sub-Total	4,085	2,138	6,223	5,802	12,025
D. General Project Support					
1. USAID Management Staff	826	274	1,100	0	1,100
2. Audits & Evaluations b/	230	305	535	0	535
3. Operating Expenses c/	0	0	0	13,652	13,652
4. Monitoring & Support d/	0	1,326	1,326	1,717	3,043
5. Other (FP Survey) e/	0	0	0	104	104
Sub-Total	1,056	1,905	2,961	15,473	18,434
E. Contingency	996	328	1,324	429	1,753
Grand Total	13,972	5,028	19,000	25,015	44,015

a/ In addition, A.I.D.-financed local commodity and training costs for IPSS totalling about $100,000 are included under other line items in the budget.
b/ Additional funds for evaluations are included in the Immunizations ($62,000) and Health Information System ($34,000) budget components.
c/ US$374,000 of GOP operating expenses is contained in the Transportation budget component.
d/ An additional US$1,549,000 of GOP funds for Monitoring and Support is included in the budget for the Integrated Supervision Program. This line item includes GOP costs such as radio time for health communications as well as other program support costs for other components.
e/ A.I.D. costs for this survey are included in item A.4. above.

TABLE 26 - TOTAL AID PROJECT COSTS BY INPUTS AND PROJECT COMPONENTS

(US$000)

		EXPANSION OF C.S. SERVICES							RECENT. SYSTEMS FOR SUSTAINABLE C.S. SERVICES								
	INPUTS	Diarrhea Control	M Nutrition	O Immunizatio	M Family Planning	Acute Resp. Infections	I. P. Family Planning	S. S. Other CS	Epidem. Surveill	VEA Laborator.	Field Epidem. Training	Health Information Systems	Health Commun-ications	Training	Transpor-tation	GENERAL PROJECT SUPPORT	GRAND TOTAL
A	Training	0	0	53	0	0	73	33	346	38	682	0	0	655	0	0	1,880
	1. Overseas	0	0	0	0	0	73	33	0	34	246	0	0	132	0	0	519
	2. In-Country	0	0	53	0	0	0	0	346	4	435	0	0	523	0	0	1,362
B	Technical Assistance	0	0	0	0	0	51	26	0	0	1,079	293	188	0	0	0	1,637
	1. Expatriate Advisors	0	0	0	0	0	0	26	0	0	1,079	0	0	0	0	0	1,185
	2. National Advisors	0	0	0	0	0	51	0	0	0	0	293	188	0	0	0	452
C	Commodities	173	330	2,598	3,018	211	1,033	524	0	718	112	874	215	0	939	0	10,736
	1. Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	0	939	0	939
	2. Medical,Lab.& Other Equip.	99	165	1,152	82	185	31	518	0	629	0	0	0	0	0	0	2,868
	3. Office Equipment	55	0	0	0	0	0	6	0	0	0	0	0	0	0	0	61
	4. Computers	0	0	0	0	0	0	0	0	0	105	831	0	0	0	0	936
	5. Supplies	14	165	1,438	6	26	0	0	0	89	0	0	0	0	0	0	1,738
	6. Contraceptives	0	0	0	2,930	0	1,003	0	0	0	0	0	0	0	0	0	3,933
	7. Other	4	0	0	0	0	0	0	0	0	7	42	215	0	0	0	268
D	Other Costs	0	0	62	315	0	0	0	0	0	0	166	0	0	0	2,961	3,523
	1. USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,180	1,180
	2. Audits and Evaluations	0	0	62	0	0	0	0	0	0	0	34	0	0	0	535	630
	3. Operating Expenses	0	0	0	0	0	0	0	0	0	0	58	0	0	0	0	58
	4. Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,326	1,326
	5. Other	0	0	0	315	0	0	0	0	0	0	82	0	0	0	0	397
	Sub-Total	173	330	2,784	3,333	211	1,158	583	346	756	1,872	1,332	323	655	939	2,961	17,676
E	Contingency	15	27	226	278	18	86	52	29	65	154	116	27	56	81	86	1,324
	Total Project Costs	188	357	2,930	3,611	229	1,243	635	375	821	2,026	1,448	350	711	1,020	3,047	19,020

TABLE 27. TOTAL PROJECT COSTS BY INPUTS, PROJECT YEAR[a/] AND FUNDING SOURCE
(US$000)

	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
INPUTS	A. I. D.	G. O. P.	A. I. D.	G. O. P.	A. I. D.	G. O. P.	A. I. D.	G. O. P.	A. I. D.	G. O. P.	A. I. D.	G. O. P.
A Training	372	573	525	671	392	671	361	660	230	710	1,880	3,285
1. Overseas	105	0	90	0	100	0	114	0	109	0	518	0
2. In Country	267	573	435	671	292	671	247	660	121	710	1,362	3,285
B Technical Assistance	338	0	407	0	245	0	314	0	252	0	1,557	0
1. Expatriate Advisors	218	0	197	0	197	0	263	0	229	0	1,105	0
2. National Advisors	120	0	210	0	48	0	51	0	23	0	452	0
C Commodities	3,147	1,048	2,713	985	2,296	1,398	1,714	231	866	242	10,736	3,925
1. Vehicles	398	0	252	0	297	0	0	0	0	0	939	0
2. Medical, Lab. & Other Equip.	1,239	0	615	0	430	0	332	0	244	0	2,860	0
3. Office Equipment	36	41	21	0	4	0	0	0	0	0	61	41
4. Computers	501	0	431	0	2	0	1	0	1	0	936	0
5. Supplies	368	1,007	540	985	394	1,398	201	231	244	242	1,738	3,864
6. Contraceptives	563	0	793	0	1,102	0	1,110	0	365	0	3,933	0
7. Other	58	0	62	0	66	0	69	0	13	0	268	0
D Other Costs	567	2,460	945	2,874	657	3,636	606	4,084	728	4,422	3,503	17,396
1. USAID Management Staff	200	0	210	0	220	0	250	0	238	0	1,180	0
2. Audits and Evaluations	70	0	110	0	154	0	98	0	198	0	630	0
3. Operating Expenses	16	2,043	17	2,349	18	2,853	0	3,199	0	3,581	50	14,025
4. Monitoring and Support	239	388	253	496	265	759	278	795	290	829	1,326	3,266
5. Other	42	29	355	29	0	23	0	10	0	12	397	104
Sub-Total	4,424	4,081	4,591	4,530	3,589	5,705	2,995	4,096	2,877	5,375	17,676	24,556
E Contingency	308	78	305	83	227	100	181	82	302	86	1,324	429
Total Project Costs	4,732	4,159	4,895	4,613	3,817	5,805	3,176	4,978	2,379	5,461	19,000	25,015

a/ PY 1 = October 1987 - December 1988
PY 2 = January 1989 - December 1989
PY 3 = January 1990 - December 1990
PY 4 = January 1991 - December 1991
PY 5 = January 1992 - December 1992

TABLE 28. Projected Obligations and Earmarkings/Commitments of A.I.D. Project Funds by U.S. Fiscal Year (FY)
(US$000)

U.S. Fiscal Year / Project Year a/	FY 87 --	FY 88 (PY 1)	FY 89 (PY 2)	FY 90 (PY 3)	FY 91 (PY 4)	FY 92 (PY 5)	TOTAL
1. Beginning of Year Balance	-	2,600	2,735	1,264	1,847	2,379	--
2. Obligations b/	2,600	4,867	3,425	4,400	3,708	-	19,000
3. Earmarkings/Commitments c/	-	4,732	4,896	3,817	3,176	2,379	19,000
4. End of Year Balance	2,600	2,735	1,264	1,847	2,379	-	--

a/ PY 1 = October 1987 - December 1988.
PY 2 = January 1989 - December 1989.
PY 3 = January 1990 - December 1990.
PY 4 = January 1991 - December 1991.
PY 5 = January 1992 - December 1992.

b/ Obligations correspond to U.S. fiscal years.

c/ Earmarkings/commitments correspond to PYs.

Table 25 shows that US$8.5 million or 45% of the A.I.D. grant has been budgeted to support the expansion of CS services being provided by both the MOH and the IPSS. Of this amount, the immunizations and family planning programs will receive about US$7.2 million or 85% of the A.I.D. contribution for service expansion activities. The remaining US$10.5 million of the A.I.D. grant will finance costs associated with strengthening the MOH's and IPSS's support systems (US$6.2 million), general Project support costs (US$3 million), and US$1.3 million for contingency. Of the total GOP contribution, about US$15.5 million or 62% will cover general Project support costs (primarily operating expenses), another $6.2 million or 25% will cover costs associated with strengthening of the support systems in the MOH and the IPSS, and about $3.3 million or 13% will support CS services expansion activities.

Table 26 shows the nature of A.I.D. inputs for each component of the Project. Commodities by far constitute the largest input with almost US$11 million of the total US$19 million budgeted for this category. Table 27 summarizes total Project costs by inputs, source of funding and Project year (PY). A.I.D. Project costs are expected to be highest in the first three Project years. This corresponds to the phased implementation strategy whereby all Project activities will be phased into all 28 UDES by the end of PY 3. The majority of commodity procurements will occur in the first three PYs. A.I.D. annual expenditures will begin to decline in PYs 4 and 5. In contrast, annual GOP expenditures are expected to increase from about US$4 million in PY 1 to US$5.8 million in PY 3 with a levelling off at about US$5.0 million - US$5.4 million in PYs 4 and 5.

Table 28 shows the projected obligations and earmarkings/commitments of A.I.D. Project funds by U.S. fiscal year (FY). Since the Project Agreement will be signed in September 1987, the last month of U.S. FY 1987, no earmarkings/commitments of A.I.D. funds are anticipated in U.S. FY 1987. During the 3-month start-up phase from October 1987 - December 1987, actual disbursement of A.I.D. funds will be limited to a few pre-implementation activities such as regional meetings to develop the CY 1988 operational plans and budgets for the UDES. Beginning in October 1987 and extending into early CY 1988, a significant number of earmarking/commitment documents should be issued to initiate the procurement of commodities and services.

Under the MOH Expansion of CS Services Component, A.I.D. will finance related technical assistance in health communications, epidemiological surveillance and statistical reporting for all five CS programs -- DDC, nutrition, immunizations, FP and ARI control. In addition, A.I.D. will finance: 1) the purchase of equipment and supplies for five Regional Training Centers for DDC and 110 hospital-based health units under the DDC sub-component; 2) equipment and operations research studies on weaning foods for the nutrition sub-component; [1/] 3) supplies such as needles and syringes, sterilizers, and cold chain equipment and spare parts for the immunization sub-component; 4) contraceptive supplies, audio-visual and family planning laboratory equipment, short-term training outside of Peru, and long-term, in-country training for the family planning sub-component; and, 5) laboratory supplies, medical supplies including needles and syringes, and

[1/] The nature and levels of financing for nutrition and health communication activities are provisional only.

equipment including sterilizers, stethoscopes, and ophthalmoscopes for the ARI control sub-component. In addition, under the DDC component, funds under the AID/W centrally-funded Project SUPPORT will provide credit for the purchase of equipment by the local manufacturer of ORS to increase production capacity and technical assistance to improve quality control and packaging. This support is in addition to the resources provided by A.I.D. under this Project. The MOH will finance, for all CS programs: 1) in-country training and supervision at all levels of service; 2) all recurrent costs (including the purchase of ORS and medicines in the case of the DDC and ARI sub-components, respectively) for all CS programs except the nutrition sub-component for which the MOH is likely to cover the recurrent costs only for growth monitoring activities; and, 3) local costs related to community education and mass media promotion. In addition, for the immunization sub-component, the MOH will finance the purchase of vaccines and vaccination cards.

Under the IPSS Expansion of CS Services Component, A.I.D. will finance for the FP sub-component: 1) FP medical and audio-visual equipment; 2) contraceptive supplies; 3) the services of a long-term Peruvian advisor for a minimum of two years; and, 4) selected in-country and short-term training outside Peru. For the other CS Services sub-component, A.I.D. will finance: 1) baby scales, stoves, and cold chain and other equipment and medical supplies for the WB clinics and hospital-based child health units; 2) audio-visual equipment for two hospital-based Regional Training Centers for DDC; and, 3) selected in-country and short-term training outside Peru. The IPSS will, for the FP and Other CS Services sub-components, finance all local costs including personnel, in-service training and supervision including in-country travel and per diem, logistics, supplies, monitoring, and vehicle operating expenses. In addition, the IPSS will finance medicine and supplies for the DDC and ARI control sub-components.

Under the Strengthening of Decentralized MOH Support Systems for Sustainable CS Services component, A.I.D. will finance all foreign exchange costs related to the purchase of equipment and supplies, including: 1) audio-visual and training equipment for training and supervision activities; 2) equipment needed to produce health communications materials; 3) computers and software needed for financial and personnel management, logistics and health statistics systems; 4) training supplies and materials and computer equipment and software packages for the FETP; 5) computer equipment for the national VEA system; 6) equipment and supplies for the VEA laboratories; 7) computers, supplies and software for the HIS; and 8) vehicles to be used for training and supervision activities. A.I.D. will also finance foreign exchange and local currency costs for TA, including: 1) short-term consultants in communications; 2) Peruvian systems engineers to install computers for financial and personnel management, logistics, the HIS and VEA systems; 3) TA from the CDC for the FETP and VEA components; and, 4) the services of a long-term Peruvian HIS advisor. A.I.D. will finance the foreign exchange costs of all overseas training for both MOH and IPSS staff in technical CS areas, as well as local currency costs for selected in-country training and to facilitate the development of the newly designed support systems of VEA and HIS. The MOH and IPSS will finance local recurrent costs for such routine and regularly scheduled activities as in-service training and supervision visits, as well as other local costs, including: 1) health communications workshops; 2) reproduction and distribution of health promotional materials; and, 3) the assessment and improvement of warehouse facilities.

In addition, A.I.D. will finance Project management, monitoring and support costs including three PSCs who will comprise the USAID Management Team, the costs of annual Project workshops, the services of eight Peruvian Regional Coordinators, audits, external evaluations, and special annual surveys.

Table 29 outlines the planned methods of implementation and financing for the Project as required by A.I.D. These planned methods of financing conform to the preferred methods established by A.I.D. policy. As indicated previously, USAID will directly administer a large percentage of the A.I.D. grant funds. With respect to the A.I.D. funds that will be directly administered by the MOH for local costs, disbursement and reporting procedures covering their use have been developed, and the USAID Controller's office has approved the procedures. A description of these procedures appears in the Implementation Plan.

2. Recurrent Costs and Other Financial Issues

Project recurrent costs are incremental expenditures associated with Project activities that must be made on a regular basis during the Project to achieve Project objectives and after the Project to sustain Project accomplishments and continue activities. During the life of the Project, both A.I.D. and the GOP will be financing recurrent costs of the Project. All of these recurrent costs are additional to the regular budgets of the MOH and IPSS. Under the Project, the principal financial expenditure categories (see Financial Tables) that cover recurrent costs fall under In-Country Training, Commodities and Other Costs. The recurrent cost categories under Commodities are: a) medical and laboratory supplies and medicines; b) office supplies; c) computer supplies; and d) contraceptives. The recurrent cost categories under Other Costs include: a) operating expenses; and b) monitoring and support.

Recurrent costs under the Project can be identified for each component. For example, ORS for the DDC component, laboratory and computer supplies for the VEA component, computer supplies for the HIS component, needles, syringes and vaccines for the Immunizations component, drugs for the ARI component, and contraceptives for the FP component are all recurrent costs which must be financed to continue these programs once the Project ends. Operating expenses over and above the regular budgets of the MOH and IPSS which must be borne under the Project and continued after the Project ends, include salaries for 35 new positions for epidemiologists under the FETP component and 28 new positions for computer systems engineers under the HIS component, per diem and related travel expenses for supervision and training and for MOH personnel to implement vaccination campaigns, vehicle and equipment operating and maintenance costs, and office supplies and other inputs to maintain the decentralized support systems for VEA, HIS, logistics, financial and personnel management. Table 30 shows the estimated recurrent costs during the five-year life of the Project by PY.

The recurrent cost estimates in Table 30 show an average annual level of approximately US$6.4 million during the life of the Project. This level of recurrent costs must be financed after the Project ends in order to sustain the accomplishments under the Project, to continue the service delivery programs, and to maintain all the decentralized support systems. This recurrent cost level is a relatively small share (about 3%) of the total 1987

TABLE 29. Methods of Implementation and Financing for the A.I.D. Grant

Method of Implementation	Method of Financing	Estimated Budget (US$000)
A. Training		
1. Direct AID Contracts (PIO/Ps).	Direct Payment	518
2. HC Implementing Agency Direct Implementation, Local Cost Financing.	Direct Implementing Agency Reimbursement	1,362
B. Technical Assistance		
Direct AID Institutional Contract and a PASA.	Direct Payment	1,557
C. Commodities		
1. Direct AID Institutional Contracts, including a PSA, except for Contraceptives.	Direct Payment and Bank L/COM (PSA)	6,536
2. AID/W Global Procurement of Contraceptives.	OYB Transfer	3,933
3. HC Implementing Agency Procurement, Local Cost Financing.	Direct Implementing Agency Reimbursement	267
D. USAID Management Staff		
Direct AID Personal Services Contracts.	Direct Payment	1,100
E. Other Costs		
1. HC Implementing Agency Direct Implementation, Local Cost Financing. a/	Direct Implementing Agency Reimbursement	227
2. Direct AID Institutional Contracts for Project Regional Coordinators, Audits and Evaluation	Direct Payment	2,176
3. Contingency	---	1,324
	TOTAL	19,000

a/ Includes travel and per diem for annual regional meetings and HIS software development.

MOH budget. This amount represents a minor additional expenditure burden on overall Central Government expenditures. Nonetheless, this situation may change, if and when the GOP goes ahead with its planned transfer of hospital facilities to the IPSS. The proposed reorganization will have as yet undefined budgetary implications for the MOH. It is not clear what portion of the MOH budget would be initially transferred to the IPSS and which portion, if any, would be lost. Another important consideration relates to the fact that several of the recurrent cost items, namely contraceptives, vaccines, needles and syringes, must be imported. The GOP has demonstrated its commitment in this area by currently providing highly favorable exchange rates for the importation of pharmaceuticals and other related medical equipment. However, to the extent that the GOP is unable to finance these costs with its own resources once the Project ends, it will have to look to the international donor community for financial assistance to cover these costs.

TABLE 30. Estimated Recurrent Costs of the Project
(US$000)

	PY 1	PY 2	PY 3	PY 4	PY 5	TOTAL
A. In-Country Training	840	1,106	963	907	831	4,647
B. Commodities						
1. Contraceptives	563	793	1,102	1,110	365	3,933
2. Medical and Laboratory Supplies and Medicines	1,466	1,587	1,858	501	499	5,911
3. Office Equipment	77	21	4	--	--	102
4. Computer Supplies	6	7	8	8	10	39
C. Other Costs						
1. Operating Expenses	2,059	2,366	2,871	3,199	3,581	14,076
2. Monitoring and Support	388	496	759	795	828	3,266
TOTAL	5,399	6,376	7,565	6,520	6,114	31,974

The relatively small recurrent cost/MOH budget ratio reflects a joint USAID/MOH decision to implement a CS Project that would minimize additional expenditure burdens on the MOH, and would maximize the use of resources already available to the Ministry. This approach is based on findings in the 1986 Health Sector Analysis (ANSSA) that show a reduction in expenditures in non-salary recurrent costs such as drugs, fuel, and maintenance in response to budget constraints arising out of the economic recession over the 1980-84 period and has remained at this level up to the present time. The share of

MOH expenditures for supplies decreased from 19.2% of total expenditures in 1980 to 15.1% in 1984. The share of wage expenditures rose from 71.1% to 79.5% over the corresponding period and has remained at this level up to the present time. One of the principal implications of this shift in budgetary funding has been a reduction in the productivity of human resources working for the MOH.

The Project's strategy to maximize the use of resources available to the MOH and to minimize recurrent costs responds to but does not resolve the fundamental financial problems faced by the MOH. These problems should be addressed in any effort aimed at substantially increasing the level of public sector health care services in Peru. The following is a brief description of the most important financial problems confronting the MOH.

First, the MOH is currently under-funded and cannot provide adequate levels of services to its target population. While the MOH accounts for about 27% of health sector expenditures, its target group (12.02 million) accounts for almost 58% of the population. Whether the response to this problem is to increase MOH funding or to reduce the size of the target population by encouraging a broader role for private sector health care, or both, currently available MOH resources are not adequate to sustain, let alone increase the current level of health services, despite the fact that the MOH budget has increased, as a percent of the total GOP budget, during the past several years.

Second, the allocation of financial resources within the MOH still heavily favors curative as distinct from PHC services, despite recent efforts to alter this imbalance. According to HSA estimates, the MOH spends about one-fourth of its budget on PHC; the rest is spent on secondary and tertiary services. This pattern of allocation is widely acknowledged to be one of the costlier and more inefficient ways to provide public health care services. Inefficiencies and high costs can result from several sources. For example, the use of highly trained and expensive personnel such as doctors to provide services that less trained individuals can provide is a costly approach to services delivery. Also, excess demand for curative services, by virtue of the unavailability of lower level services, usually results in long waiting lines (high opportunity labor costs).

Third, and as mentioned above, the economic recession of the early 1980s forced a reduction in public sector expenditures, including health. The result of budgetary pressures was a reduction of MOH expenditures on goods and services in order to minimize personnel reductions. This resulted in a situation where the health facilities were staffed but did not have adequate drugs and other supplies needed to provide services.

Fourth, the service fee structure in MOH facilities encourages the over-utilization of hospital-based care. Hospital stays in MOH facilities are twice as long as in comparable countries. The HSA estimated that a 50% reduction of hospitals stays would obviate the need to expand physical facilities for the foreseeable future.

The situation with respect to the IPSS is somewhat different. Only a small part (7%) of the IPSS budget comes from the GOP as a direct outlay for budget support (as opposed to contributions the GOP makes as an employer), with the major part (93% from 1975-1984) derived from contributions of the

insured and the companies/organizations for which they work. As discussed in the Background section, the overall financial status of IPSS has been negatively affected by the large debt owed to it by employers in both the GOP and the private sector. However, the IPSS has instituted new debt collection measures and is making progress in reducing its debt. It has considerably improved its ability to collect payments from employers and employees through a new computerized system initiated about one year ago in Lima and Cuzco, and plans are to expand this new system nationwide.

The IPSS has only recently begun to deliver CS services as a result of the inclusion of additional family members in its target population. Under the Project, modest support will be provided to IPSS to expand its CS services program. The additional recurrent costs associated with this relatively modest expansion are small when compared to the overall IPSS budget, and the IPSS should have no problem in assuming these costs once the Project ends. However, as in the case of the MOH, the impact of the MOH-IPSS integration process on the financial status of IPSS is uncertain. This will have to be closely monitored during Project implementation over the next five years to assess the ability of IPSS to adequately cover the recurrent costs of its CS program.

Clearly, the overall financial agenda in the health sector will take on increasing importance as the population grows and the demand for health services increases. While the GOP has already decided to enhance the role of PHC in its provision of services, the implementation of that decision will require substantial changes in the financial management of MOH and IPSS resources. The GOP decision to transfer MOH hospitals to the IPSS has considerable long-term potential to improve the financial management of curative facilities, to enable the MOH to concentrate its efforts on PHC, and to impact favorably on GOP recurrent costs in the health sector. This Project will make a useful contribution toward some of the required changes, including the assumption by the GOP of a higher proportion of the burden of recurrent costs. In addition, this Project is designed to have a beneficial impact on health sector recurrent costs by requiring only modest additional financial resources while, at the same time, introducing low-cost technologies to decrease demand for expensive hospital-based curative care, impacting favorably on the population growth rate and thus reducing the rate of growth of demand for health services, and, finally, developing a service delivery system that is more cost-effective and efficient than is the current infrastructure for health care services delivery. Finally, it is anticipated that A.I.D. funds will be made available, either through the contingency line item of this Project and/or through AID/W centrally-funded projects, to support studies of health care financing issues which will evolve as the MOH-IPSS integration process proceeds.

F. Environmental Analysis

This Project falls under Section 216.2(c) (viii) of A.I.D.'s Environmental Procedures which excludes the requirement of an Initial Environmental Examination or any other environmental documentation for "programs involving nutrition, health care or population and family planning services...".

VI. CONDITIONS, COVENANTS AND NEGOTIATING STATUS

A. Conditions Predecent to Disbursement

1. Conditions Precedent to First Disbursement

Except as the Parties may otherwise agree in writing, prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, Peru will furnish to A.I.D., in form and substance satisfactory to A.I.D.:

a. a legal opinion of the Legal Counsel of the Ministry of Foreign Relations, or other counsel acceptable to A.I.D., to the effect that this Agreement has been duly authorized and/or ratified by, and executed on behalf of Peru, and that it constitutes a valid and legally binding obligation of Peru in accordance with all of its terms; and,

b. a statement of the name of the person holding or acting in the office specified in Section 8.2, and of any additional representatives, together with a specimen signature of each such person specified in such statement.

2. Conditions Precedent to Initial Disbursement for the Ministry of Health (MOH)

Except as A.I.D. may otherwise agree in writing, prior to the first disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made for activities involving the MOH, except for the procurement of technical consultants, regional coordinators, the A.I.D. Management Team, and vehicles to support these individuals, and the convening of regional planning workshops, Peru, through its MOH, shall furnish to A.I.D., in form and substance satisfactory to A.I.D.:

a. the name and title of the individual within the MOH who shall serve as the National Project Director; and,

b. the names and titles of the individuals within the MOH who shall serve as members of the Project Coordination Committee.

3. Condition Precedent to Disbursement for the Health Departments in Calendar Year 1988

Except as A.I.D. may otherwise agree in writing, prior to the disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made for activities in a specific Health Department in calendar year 1988, except for the procurement of technical consultants, regional coordinators, the A.I.D. Management Team, and vehicles to support these individuals, and the convening

of regional planning workshops, Peru, through its MOH, shall furnish to A.I.D., in form and substance satisfactory to A.I.D., an operational plan and budget for calendar year 1988 for that Health Department, the format and content of which shall be described in a Project Implementation Letter.

4. Condition Precedent to Subsequent Disbursements for the Health Departments After Calendar Year 1988

Except as A.I.D. may otherwise agree in writing, prior to the disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made in any year after calendar year 1988 for activities in a specific Health Department, Peru, through its MOH, shall furnish to A.I.D., in form and substance satisfactory to A.I.D., an annual operational plan and budget for that Health Department for that calendar year, the format and content of which shall be described in a Project Implementation Letter.

5. Conditions Precedent to Initial Disbursement for the Peruvian Institute of Social Security (IPSS)

Except as A.I.D. may otherwise agree in writing, prior to the first disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made for activities involving the IPSS, except for the procurement of technical consultants, regional coordinators, the A.I.D. Management Team, and vehicles to support these individuals, and the convening of regional planning workshops, Peru, through its IPSS, shall furnish to A.I.D., in form and substance satisfactory to A.I.D.:

a. the name and title of the individual within the IPSS who shall serve as the National Project Director;

b. the names and titles of the individuals within the IPSS who shall serve as members of the Project Coordination Committee; and,

c. evidence that the IPSS has established a National Directorate for Project Administration and granted it independence and autonomy for the administrative and financial management of the Project.

6. Condition Precedent to Disbursement for Family Planning Activities in the Peruvian Institute of Social Security (IPSS)

Except as A.I.D. may otherwise agree in writing, prior to the disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made for family planning activities in the IPSS, Peru, through its IPSS, shall furnish to A.I.D., in form and substance satisfactory to A.I.D., evidence that a full-time technically qualified individual employed by Peru has been appointed to the post of Director of its National Family Planning Program.

7. Conditions Precedent to Initial Disbursement for Vehicles

Except as A.I.D. may otherwise agree in writing, prior to the first disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made for the procurement of vehicles, except those for technical consultants and regional coordinators, Peru, through its MOH, shall furnish to A.I.D., in form and substance satisfactory to A.I.D.:

a. evidence that the vehicles purchased with A.I.D. funds for the MOH under A.I.D. Projects 527-0219 and 527-0230 have been assigned to and are being used by appropriate personnel at the departmental level in support of child survival activities;

b. evidence that a detailed analysis has been undertaken to support and justify the MOH's request for vehicles to be procured with A.I.D. funds, including a list of the locations and the titles of the personnel to which the vehicles will be assigned; and,

c. a plan to ensure the proper use and maintenance of the vehicles to be procured with A.I.D. funds.

8. Condition Precedent to Subsequent Disbursements for Vehicles

Except as A.I.D. may otherwise agree in writing, prior to any subsequent disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made for vehicles, except those for technical consultants and regional coordinators, Peru, through its MOH, shall furnish to A.I.D., in form and substance satisfactory to A.I.D., evidence that the vehicles previously procured with A.I.D. funds are assigned to and are being used by the personnel for whom they were originally procured, or such other personnel as agreed to in writing by A.I.D., that they are being appropriately used to support Project activities, that sufficient Peru funds are available to operate them, and that they are being adequately maintained.

9. Condition Precedent to Initial Disbursement for Computers

Except as A.I.D. may otherwise agree in writing, prior to the first disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made for the procurement of computers and related software and auxiliary hardware, Peru, through its MOH, shall furnish to A.I.D., in form and substance satisfactory to A.I.D., detailed scopes of work and qualifications for the Peruvian computer systems engineers to be hired for the Health Departments and for the Peruvian health information system advisor to be hired for the central level.

10. Condition Precedent to Subsequent Disbursements for Computers

Except as A.I.D. may otherwise agree in writing, prior to any subsequent disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made for the procurement of computers and related software and auxiliary hardware, Peru, through its MOH, shall furnish to A.I.D., in form and substance satisfactory to A.I.D., evidence that permanent positions have been established and Peru funds budgeted for computer systems engineers, and that progress is being made to hire individuals to fill these positions in each of the Health Departments where A.I.D.-financed computers have been installed.

11. Conditions Precedent to Disbursement for the Field Epidemiology Training Program

Except as A.I.D. may otherwise agree in writing, prior to the disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made for the Field Epidemiology Training Program, Peru, through its MOH, shall furnish to A.I.D., in form and substance satisfactory to A.I.D.:

a. evidence that the MOH has negotiated and signed a written Letter of Understanding with the Centers for Disease Control (CDC) of the United States which specifies, among other things, the obligations of the MOH and CDC to provide staff, space, services, funds, and equipment and to institute those modifications necessary to implement the Field Epidemiology Training Program, according to a mutually agreed upon schedule; and,

b. evidence that sufficient space and adequate numbers of qualified personnel employed by Peru have been assigned to work on the Field Epidemiology Training Program under the Project.

12. Condition Precedent to Disbursement for Nutrition

Except as A.I.D. may otherwise agree in writing, prior to the disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made for nutrition activities in the MOH, Peru, through its MOH, shall furnish to A.I.D., in form and substance satisfactory to A.I.D., a detailed program description, implementation plan, and budget for nutrition activities to be undertaken by the MOH during the life of the Project.

13. Condition Precedent to Disbursement for Health Communications

Except as A.I.D. may otherwise agree in writing, prior to the disbursement of funds by A.I.D. under this Project, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made for

health communications activities in the MOH, Peru, through its MOH, shall furnish to A.I.D., in form and substance satisfactory to A.I.D., a detailed program description, implementation plan, and budget for health communications activities to be undertaken by the MOH during the life of the Project.

B. Covenants

1. Covenant as to External Evaluation

Peru agrees to participate in periodic external Project evaluations by assigning senior representatives of participating entities as resource personnel for the Evaluation Teams.

2. Covenants as to Monitoring and Evaluation

To ensure adequate monitoring and evaluation and adequate coordination of Project activities between the MOH and the IPSS, Peru shall:

a. carry out a scheduled monitoring program which shall include periodic site visits at all levels of the health delivery system by appropriate personnel to ensure the proper implementation of Project activities; and,

b. arrange for key central and departmental level officials of the MOH and the IPSS, the A.I.D. Project Manager, members of the A.I.D. Management Team, and others as appropriate, to hold periodic review meetings for the purpose of evaluating Project progress and requirements.

3. Covenant as to Funding

Peru agrees to provide sufficient annual budget allocations following completion of A.I.D. financing to ensure continuity and sustained child survival services through the MOH and IPSS, including sufficient resources to maintain the health information, epidemiological surveillance, financial and personnel management and logistics systems, and adequate supervision, training and health communications activities.

4. Covenant as to Automated Data Processing Equipment

Peru agrees to ensure that all automated data processing equipment, including computers and related software and auxiliary hardware, financed under the Project are assigned to and used by appropriate personnel in support of those activities for which they were procured; that adequate Peru funds are budgeted to operate and maintain the equipment; and that appropriate personnel are trained in the use and maintenance of the equipment.

5. Covenant as to Other Equipment and Commodities

Peru agrees to adequately maintain all other equipment and non-expendable commodities financed under the Project and to provide periodic training programs for equipment operators and maintenance personnel.

6. Covenant as to Pharmaceuticals, Contraceptives and Medical Supplies

Peru agrees to provide all health services delivery facilities of the MOH and the IPSS with adequate pharmaceuticals, contraceptives and medical supplies to effectively carry out Project activities.

7. Covenant as to Warehouse Facilities

Peru agrees to provide adequate Peru budgetary resources to construct or rehabilitate and maintain as necessary all warehouse storage facilities of the MOH and the IPSS in which commodities procured with both A.I.D. and Peru funds in support of Project activities are stored.

8. Covenant as to Personnel

Peru agrees to assign adequate numbers of qualified personnel at the central, departmental and peripheral levels in the MOH and the IPSS to effectively carry out Project activities.

9. Covenant as to Training

Peru agrees to make every reasonable effort to require that each person trained overseas, regardless of the duration of training, and each person trained in long-term in-country training programs of one year or more in duration under the Project, works in activities related to his/her field of training in Peru for not less than two times the length of time of his/her training program, provided, however, that in no event shall the individual be allowed to work in activities related to his/her field of training for less than one year from the date of the individual's completion of training, unless the Parties otherwise agree in writing.

10. Covenants as to Family Planning Activities

Peru agrees that none of the funds made available under this Grant for family planning activities may be used to finance any costs relating to:

a. the performance of abortion or involuntary sterilization as a method of family planning;

b. the motivation or coercion of any person to undergo abortion or involuntary sterilization;

c. biomedical research which relates, in whole or in part, to methods of, or the performance of, abortion or involuntary sterilization as a method of family planning;

d. the active promotion of abortion or involuntary sterilization as a method of family planning; nor

e. the procurement of any equipment or materials for the purpose of abortion or involuntary sterilization.

C. Negotiating Status

The Project as described in this Project Paper has been designed collaboratively by staff of the MOH, IPSS and USAID. The Project, including the conditions and covenants, has been fully discussed with and concurred in by appropriate GOP officials. The GOP supports the Project as designed, and there is no reason why the Project cannot proceed to implementation as soon as the Project Agreement is signed. Neither changes in existing GOP legislation nor new legislation is required to implement the Project as described.

PERU - CHILD SURVIVAL ACTION

527-0285

VII. ANNEXES

ANNEX I
Exhibit A
Page 1 of 5

ACTION: AID-2 INFO AMB DCM CHRON

VZCZCPFO695
PP RUZHFE
DE RUEHC #8044/01 2022114
ZNR UUUUU ZZH
P 212112Z JUL 86
FM SECSTATE WASHDC
TO AMEMBASSY LIMA PRIORITY 8246
BT
UNCLAS STATE 228044

AIDAC

E.O. 12356: N/A
TAGS:
SUBJECT: DAEC REVIEW OF THE PERU CHILD SURVIVAL ACTION PID, 527-0295

1. THE SUBJECT PID WAS REVIEWED ON JUNE 13, 1986. USAID MAY PROCEED WITH PROJECT DEVELOPMENT. HOWEVER, THE FOLLOWING ISSUES/CONCERNS SHOULD BE ADDRESSED IN THE PROJECT DESIGN.

2. PROJECT OUTPUT TARGETS. THE PP SHOULD FULLY JUSTIFY THE MAGNITUDES/LEVELS OF THE EOPS AND OUTPUT TARGETS ESTABLISHED FOR THE PROJECT AS A FUNCTION OF THE RESOURCE LEVELS WHICH WILL BE MADE AVAILABLE. WE RECOGNIZE THAT THE PROJECT WILL SUPPORT ON-GOING GOP INITIATIVES IN IMMUNIZATION AND DIARRHEAL DISEASE CONTROL. HOWEVER, TO THE EXTENT FEASIBLE, THE TARGETS SHOULD BE DEFINED TO SHOW THE DIRECT IMPACT OF THIS PROJECT. WHERE THIS IS NOT POSSIBLE, THE PP SHOULD CLEARLY IDENTIFY THE OTHER SOURCES OF SUPPORT, EG. INTERNATIONAL DONORS, PVOS, AND HOW THEY WILL CONTRIBUTE TO ACHIEVEMENT OF PROGRAM OBJECTIVES. USAID SHOULD ENSURE THAT THE EXISTING DATA SOURCES WHICH IT WILL USE TO ESTABLISH BASELINE DATA ARE CONSISTENT WITH THE EVALUATIVE INDICATORS WHICH WILL BE MEASURED BY THE SENTINEL SYSTEM REPORT. THE TARGETS SHOULD BE CLEARLY DEFINED TO SHOW WHETHER THEY ARE GLOBAL OR INCREMENTAL TARGETS. (WE UNDERSTAND THAT THE PID TARGET OF 330,000 FAMILY PLANNING ACCEPTORS IS AN INCREMENTAL TARGET, BUT THIS IS NOT CLEARLY STATED.) USAID SHOULD NOTE THAT AID IS EXPECTED TO REPORT IN DETAIL TO THE CONGRESS ON THE IMPACT OF ITS CHILD SURVIVAL PROGRAMS. THEREFORE, THE TARGETS ESTABLISHED FOR THE PROJECT MUST BE BOTH MEASURABLE AND ACHIEVABLE.

3. PROJECT COMPLEXITY. THE DAEC EVALUATED THE ISSUE OF PROJECT COMPLEXTITY FROM THE STANDPOINTS OF (1) THE NEED FOR THE PROJECT COMPONENTS AND (2) THE PROJECT'S ORGANIZATIONAL/ADMINISTRATIVE FEASIBILITY. WE NOTE THAT WHILE THE PROJECT SEEMS COMPLEX, ITS COMPONENTS EITHER DIRECTLY SUPPORT THE FOUR ELEMENTS OF AID'S CHILD SURVIVAL STRATEGY, ARE NECESSARY TO SUCCESSFULLY

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IMPLEMENT THE STRATEGY IN PERU, OR WILL MAKE LESS CONTRIBUTIONS TO IMPROVING AND INSTITUTIONALIZING THE CHILD SURVIVAL INITIATIVE OVER THE LONGER TERM, E.G. THE PROJECT'S APPLIED RESEARCH COMPONENT. FURTHER, THE MISSION HAS ALREADY REDUCED THE SCOPE OF THE PROJECT WHICH HAD ORIGINALLY BEEN PROPOSED AS A SECTOR PROJECT. THEREFORE, WE ARE NOT REQUIRING THAT THE NUMBER OF PROJECT COMPONENTS BE REDUCED. HOWEVER, USAID SHOULD CAREFULLY EXAMINE THE ORGANIZATIONAL/ADMINISTRATIVE ASPECTS OF THE PROJECT DURING INTENSIVE REVIEW. A MANAGEMENT SYSTEMS SPECIALIST SHOULD BE INCLUDED IN THE PP DESIGN TEAM. THE PROJECT'S MANAGEMENT BURDEN ON THE MISSION SHOULD ALSO BE CAREFULLY ASSESSED. WE NOTE THAT THE PROJECT PROPOSES TO INCORPORATE MECHANISMS WHICH WILL REDUCE USAID'S MANAGEMENT BURDEN. THESE INCLUDE: (A) A TURNKEY TECHNICAL ASSISTANCE CONTRACT FOR ALL PROJECT TECHNICAL ASSISTANCE TO THE MINISTRY OF HEALTH (MOH) AND TO PVOS; AND (B) FINANCING OF ALL GOP LOCAL CURRENCY COSTS FROM COUNTERPART FUNDS. PROJECT DESIGN EFFORTS SHOULD TRY TO IDENTIFY ADDITIONAL MEANS TO REDUCE THE ADMINISTRATIVE BURDEN ON THE MOH AND THE MISSION WITHOUT FOREGOING RESPONSIBILITY FOR PROJECT IMPLEMENTATION. THE PP SHOULD SPECIFY HOW THE TURNKEY T.A. CONTRACTOR WILL BE ACCOUNTABLE TO AID FROM THE FINANCIAL AND DECISION-MAKING STANDPOINTS.

3. ROLE OF THE PRIVATE SECTOR. THE PROJECT STRATEGY IS TO WORK THROUGH BOTH PUBLIC AND PRIVATE SECTOR CHANNELS. NEVERTHELESS THE PID DOES NOT CLEARLY INDICATE THE MAGNITUDE OF THE ROLE OF THE PRIVATE SECTOR. THERE IS A PRESUMPTION IN FAVOR OF UTILIZING PRIVATE SECTOR MECHANISMS (AND FURTHER DEVELOPING PRIVATE SECTOR SERVICE DELIVERY CHANNELS) WHERE POSSIBLE. THE PP SHOULD CLEARLY IDENTIFY THE ROLE AND CONTRIBUTION OF PRIVATE SECTOR ORGANIZATIONS. THE PROJECT'S FINANCIAL PLAN SHOULD CLEARLY DISTINGUISH BETWEEN AID'S CONTRIBUTION TO THE GOP AND TO PRIVATE SECTOR ORGANIZATIONS.

4. COST RECOVERY. THE MISSION SHOULD ENCOURAGE THE GOP TO RECOVER COSTS TO THE DEGREE POSSIBLE. THE MISSION REPRESENTATIVE NOTED THAT: THE PRIMARY AREA FOR COST RECOVERY IS FOR CURATIVE (HOSPITAL PROVIDED) SERVICES; COST RECOVERY IS A SECTORAL ISSUE WHICH IS OUTSIDE THE SCOPE OF THE PROJECT; AND THE MISSION IS PURSUING THE ISSUE AS PART OF ITS OVERALL POLICY DIALOGUE WITH THE GOP. IT WAS NOTED THAT THE GOP DOES CHARGE FOR ORS AND PHARMACEUTICALS BUT NOT FOR IMMUNIZATIONS. GIVEN THE IMPORTANCE OF ASSURING TIMELY AVAILABILITY OF FUNDING FOR THE PROPOSED DOLS 6 MILLION PHARMACEUTICAL FUND AND THE STRONG INTEREST OF THE AID ADMINISTRATOR IN THE

ISSUE OF COST RECOVERY, IT AS AGREED THAT A SMALL OPERATIONS RESEARCH ACTIVITY WOULD BE INCLUDED IN THE PROJECT TO ASSESS THE EFFECTIVENESS OF THE GOP'S PHARMACEUTICAL COST RECOVERY EFFORTS.

5. AVAILABILITY OF FUNDS UNDER CENTRALLY-FUNDED PROJECTS. IT WAS AGREED THAT LAC WILL SEEK AN EARLY DECISION ON THE LEVEL OF FUNDS TO BE PROVIDED BY S&T FOR THE PROJECT SO THAT THE PROJECT DESIGN CAN INCORPORATE SUCH DECISION.

6. PARI-PASSU DISBURSEMENTS. THE PP WILL THOROUGHLY DESCRIBE HOW THE PROPOSED PARI-PASSU DISBURSEMENT MECHANISM WILL WORK.

7. PP DESIGN. IT WAS AGREED AT THE DAEC THAT THE MISSION WILL SEEK ANY NECESSARY ASSISTANCE IT MAY REQUIRE TO DEVELOP AN EVALUATION PLAN THAT IS RESPONSIVE TO AID CONCERNS IN THE AREA OF CHILD SURVIVAL. IT WAS ALSO CLARIFIED THAT THE MISSION HAS THE REQUIRED CAPABILITY TO DESIGN THE TRAINING PLAN.

8. PRE-PROJECT COSTS. IT WAS AGREED THAT THE MISSION COULD USE PD&S FUNDS FOR A 12-MONTH CONTRACT FOR A DIARRHEAL DISEASE CONTROL ADVISOR THROUGH THE PAN AMERICAN HEALTH AND EDUCATION FOUNDATION (PAHEF).

9. COUNTERPART FUNDING. THE MISSION STRATEGY OF REQUIRING THAT THE GOP COVER ALL LOCAL CURRENCY COSTS FOR THE PUBLIC SECTOR FROM COUNTERPART FUNDS IS STRONGLY ENDORSED. WE NOTE THAT THIS MAKES TIMELY AVAILABILITY OF COUNTERPART FUNDING CRITICAL TO THE SUCCESS OF THE PROJECT. THE MISSION REPRESENTATIVE IDENTIFIED SEVERAL ELEMENTS WHICH INDICATE THAT THE GOP WILL HAVE A SUFFICIENT RESOURCE COMMITMENT (DOLS. 12 MILLION EQUIVALENT) TO PROCEED WITH THE OBLIGATION OF FUNDS FOR THIS PROJECT. THESE ARE:

(1) PROJECT APPROVAL WILL BE CONDITIONED ON GOP COMMITMENT TO PROVIDE COUNTERPART AS EVIDENCED BY A LETTER OF APPLICATION FROM THE MINISTRY OF HEALTH AND A SIDE LETTER FROM THE MINISTRY OF ECONOMY AND FINANCE;

(2) THE GOP HEALTH BUDGET WAS INCREASED FROM 4.5 PERCENT TO 6.4 PERCENT OF THE CENTRAL GOP BUDGET IN FY 1986. THIS INCREASE WOULD BE ADEQUATE TO PROVIDE COUNTERPART FUNDS IF IT CAN BE MAINTAINED AT THE FY 1986 LEVEL IN REAL TERMS;

(3) THE PL-480 TITLE I MEMORANDUM OF UNDERSTANDING LAYS OUT GOP COMMITMENT OF DOLS. 12 MILLION FOR CHILD SURVIVAL. DURING THE PAST THREE YEARS APPROXIMATELY DOLS 2 MILLION PER YEAR HAVE BEEN PROVIDED FROM PL 480 TITLE I COUNTERPART FOR THE HEALTH BUDGET;

(4.) A SEPARATE FUND WILL BE SET UP IN THE MINISTRY OF ECONOMY AND FINANCE FROM WHICH ALL COUNTERPART WILL BE

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I BURSED;

(5). A NEW FINANCIAL MANAGEMENT MECHANISM HAS BEEN SET UP UNDER PROJECT 527-0230. ABOUT 700 ACCOUNTANTS HAVE BEEN TRAINED IN THE NEW FINANCIAL MANAGEMENT SYSTEM. THE MISSION IS CAUTIONED THAT IT SHOULD NOT RELY ON PL 480 OR ESF LOCAL CURRENCIES TO COVER COUNTERPART REQUIREMENTS. WE NOTE THAT GOP IS UMJBSI0&KDGK COVENANT THAT THIS SHIFT WILL OCCUR. FINALLY, WE ARE CONCERNED ABOUT THE POSSIBLE RECURRENT COST IMPLICATION OF THE WORLD BANK PROJECT WHICH IS CURRENTLY BEING REDESIGNED. THE MISSION IS REQUESTED TO APPRISE AID/W OF RECURRENT COST IMPLICATIONS OF THE REVISED PROJECT. IF APPROPRIATE, AID/W WILL DISCUSS THIS ISSUE WITH U.S. EXECUTIVE DIRECTOR OF THE IBRD;

10. AID FUNDING LEVEL. THE MISSION IS AUTHORIZED TO PROCEED WITH PROJECT DESIGN AT THE PROPOSED LEVEL OF FUNDING. WE NOTE, HOWEVER, THAT THERE WILL BE A LARGE MORTGAGE FOR THIS PROJECT AND THE FUNDING LEVEL FOR THIS PROJECT REMAINS A KEY ISSUE. GIVY' THE CURRENT CONCERNS ABOUT THE FEASIBILITY OF FUTURE OBLIGATIONS IN PERU BECAUSE OF BROOKE-ALEXANDER, THIS IS A HIGH RISK STRATEGY. WE RECOGNIZE THAT IT MAY BE DIFFICULT TO REDUCE THE AMOUNT BUDGETED BECAUSE THE AID CONTRIBUTION FOR T.A. AND TRAINING FINANCES INPUTS FOR WHICH THERE IS A REQUIREMENT FOR A MINIMUM CRITICAL LEVEL. THE PROJECT SHOULD BE DESIGNED SO THAT PRIORITY LINE ITEMS, EG. TECHNICAL ASSISTANCE, WILL BE FUNDED FIRST AND SO THAT COUNTERPART FUNDS WILL BE AVAILABLE TO BRIDGE GAPS IN AID DOLLAR FUNDING. FOR EXAMPLE, THE FEASIBILITY OF HAVING THE FY-87 OBLIGATION OF FUNDS SUFFICIENT TO INITIALLY FINANCE THE T.A. CONTRACT FOR A MINIMUM OF 18

BE EXPLORED. WE NOTE THAT IF THE GOP MAKES REGUL IEPAYMENTS AND STAYS OUT OF 6200 THE RISK OF A LARGE MORTGAGE WILL BE REDUCED.

11. REDELEGATION OF PROJECT APPROVAL AUTHORITY. AUTHORITY TO APPROVE THE PROJECT PAPER (PP) IS DELEGATED TO THE MISSION. HOWEVER, GIVEN CURRENT UNCERTAINTIES REGARDING THE FY 1987 AID BUDGET, PRIOR TO PP APPROVAL THE MISSION IS REQUESTED TO CONSULT WITH THE BUREAU REGARDING THE FISCAL YEAR FUNDING REQUIREMENTS OF THE PROJECT, THE ANTICIPATED PERU OYB IN FY 87 AND 88 AND THE STATUS OF PERU PAYMENTS TO THE US GOVERNMENT. AUTHORIZATION SHOULD BE BASED ON MUTUAL AGREEMENT THAT THE FINAL FINANCIAL PLAN IS REASONABLE CONSIDERING THOSE FACTORS WHICH AT THIS TIME ARE UNCERTAIN. IT SHOULD BE UNDERSTOOD THAT PROJECT COMPONENTS AND THE OVERALL PROJECT DESIGN WILL BE SUBJECT TO CHANGE DEPENDING ON THE ACTUAL FUNDING LEVELS, WHICH CANNOT BE DETERMINED NOW. THEREFORE, THE PROJECT DESIGN PROCESS SHOULD PROVIDE ENOUGH FLEXIBILITY TO ACCOMMODATE AND BE CONSISTENT WITH DIFFERENT FUNDING OPTIONS. THESE OPTIONS WILL BE DETERMINED AT A LATER DATE IN THE CONTEXT OF THE AGENCY'S FY 87 AND 88 BUDGET AND OTHER FACTORS (E.G. BROOKE-ALEXANDER AND THE CONSIDERATIONS DISCUSSED UNDER PARAGRAPH 10 ABOVE) WHICH MAY AFFECT THE PROVISION OF ASSISTANCE TO PERU. SHULTZ

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5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to: (A) FAA funds generally; (B)(1) Development Assistance funds only; or (B)(2) the Economic Support Fund only.

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FY 1987 Continuing Resolution Sec. 526. Has the President certified to the Congress that the government of the recipient country is failing to take adequate measures to prevent narcotic drugs or other controlled substances which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully?	No.
2. FAA Sec. 481(b). (This provision applies to assistance of any kind provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance from the Child Survival Fund or relating to international narcotics control, disaster and refugee relief, or the provision of food or medicine.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government), has the President in the March 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without	Yes, President certified in 1987 INCSR, that Peru complied with Subsection (a) and Congress did not disapprove such certification.

Congressional enactment, within 30 days of continuous session, of a resolution disapproving such a certification), or has the President determined and certified to the Congress on any other date (with enactment by Congress of a resolution approving such certification), that (a) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to prevent illicit drugs produced or processed in or transported through such country from being transported into the United States, and to prevent and punish drug profit laundering in the country, or that (b) the vital national interests of the United States require the provision of such assistance?

3. Drug Act Sec. 2013. (This section applies to the same categories of assistance subject to the restrictions in FAA Sec. 481(h), above.) If recipient country is a "major illicit drug producing country" or "major drug-transit country" (as defined for the purpose of FAA Sec 481(h)), has the President submitted a report to Congress listing such country as one (a) which, as a matter of government policy, encourages or facilitates the production or distribution of illicit drugs; (b) in which any senior official of the government engages in, encourages, or facilitates the production or distribution of illegal drugs; (c) in which any member of a U.S. Government agency has suffered or been threatened with violence inflicted by or with the complicity of any government officer; or (d) which fails to provide reasonable cooperation to lawful activities of U.S. drug enforcement agents, unless the President has provided the required certification to Congress pertaining to U.S. national interests and the drug control and criminal prosecution efforts of that country?

No such report has been submitted to Congress on Peru.

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4.	FAA Sec. 620(c). If assistance is to a government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) the debt is not denied or contested by such government?	No.
5.	FAA Sec. 620(e)(1). If assistance is to a government, has it (including any government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities?	No.
6.	FAA Secs. 620(a), 620(f), 620D; FY 1987 Continuing Resolution Secs. 512, 560. Is recipient country a Communist country? If so, has the President determined that assistance to the country is important to the national interests of the United States? Will assistance be provided to Angola, Cambodia, Cuba, Iraq, Syria, Vietnam, Libya, or South Yemen? Will assistance be provided to Afghanistan without a certification?	No.
7.	FAA Sec. 620(i). Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property?	No.
8.	FAA Sec. 620(l). Has the country failed to enter into an investment guaranty agreement with OPIC?	Yes. However, the GOP is officially discussing signing the agreement. The GOP had two issues with signing it which are now resolved; one with the location of general dispute settlement and the other concerned the Andean Pact. The GOP has made known its willingness to sign it now; however, the USG requires the Belco Co. expropriation matter be resolved first.
9.	FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5. (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made?	No.

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10. FAA Sec. 620(q); FY 1987 Continuing Resolution Sec. 518. (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (b) Has the country been in default for more than o[illegible] year on interest or principal on any U.S. loan under a program for which t[illegible] FY 1987 Continuing Resolution appropriates funds?	(a) No. (b) No.
11. FAA Sec. 620(s). If contemplated assistance is development loan or from Economic Support Fund, has the Administrator taken into account the percent of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? (Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational [illegible]r Budget can be the basis for an affirmative answer during the fi[illegible] year unless signifi[illegible]t changes in circumstances [illegible]r.)	Yes, taken into account by the AID Administrator at time of approval of Agency OYB.
12. FAA Sec. 620([illegible] Has the country severed diplomatic re[illegible]ons with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?	No.
13. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operating Year Budget? (Reference may be made to the Taking into Consideration memo.)	Yes, the payments to the UN are in arrears. [illegible] taken into account by the AID Administrator in determining the AID Operating Year Budget.
14. FAA Sec. 620A. Has the President determined that the recipient country grants sanctuary from prosecution to any individual or group which has committed an act of international terrorism or otherwise supports international terrorism?	No.

15. ISDCA of 1985 Sec. 552(b). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures?	No.
16. FAA Sec. 666(b). Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA?	No.
17. FAA Secs. 669, 670. Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.)	No.
18. FAA Sec. 670. If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device?	No.
19. ISDCA of 1981 Sec. 720. Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and failed to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the Taking into Consideration memo.)	Yes, however [illegible] taken into account in the Administrator's 1986 Taking Into Consideration Memorandum.

20. FY 1987 Continuing Resolution Sec. 528. Has the recipient country been determined by the President to have engaged in a consistent pattern of opposition to the foreign policy of the United States? No.

21. FY 1987 Continuing Resolution Sec. 513. Has the duly elected Head of Government of the country been deposed by military coup or decree? No.

B. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria No.

FAA Sec. 116. Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy?

2. Economic Support Fund Country Criteria No.

FAA Sec. 502B. Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvement in its human rights record that furnishing such assistance is in the U.S. national interest?

5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded from Development Assistance loans; and B(3) applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?	(a) Yes. (b) Yes.

A. GENERAL CRITERIA FOR PROJECT

1. FY 1987 Continuing Resolution Sec. 523; FAA Sec. 634A. Describe how authorization and appropriations committees of Senate and House have been or will be notified concerning the project.	A Congressional Notification for the Project was sent on July 24 , 1987 and expired on August 7 , 1987.
2. FAA Sec. 611(a)(1). Prior to obligation in excess of $500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance, and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?	(a) Yes. (b) Yes.
3. FAA Sec. 611(a)(2). If legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?	No further legislative action by Peru is required.
4. FAA Sec. 611(b); FY 1987 Continuing Resolution Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)	Not applicable.

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?	Not applicable.
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.	The Project is not susceptible to execution as part of a regional or multilateral project.
7. FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.	The Project is not designed to, nor will it, affect any of these areas (a) through (f).
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).	The Project will encourage private U.S. participation in the foreign assistance program by utilizing U.S. technical assistance and procurement of specific commodities.
9. FAA Secs. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.	The GOP will contribute the equivalent of at least US$ 25,015,000 to meet the costs of this Project.
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?	No.

11. FY 1987 Continuing Resolution Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

Not applicable.

12. FY 1987 Continuing Resolution Sec. 558 (as interpreted by conference report). If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities (a) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (b) in support of research that is intended primarily to benefit U.S. producers?

Not applicable.

13. FY 1987 Continuing Resolution Sec. 559. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

No.

14. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (a) stress the importance of conserving and sustainably managing forest resources; (b) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (c) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (d) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (e) help conserve forests which have not yet been degraded, by helping to increase production on lands already cleared or degraded; (f) conserve forested watersheds and rehabilitate those which have been deforested; (g) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (h) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (i) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (j) seek to increase the awareness of

Yes.
Not applicable.
This Project falls under Section 216.2(c) (viii) of A.I.D.'s Environmental Procedures which excludes the requirement of an Initial Environmental Examination or any other environmental documentation for "programs involving nutrition, health care or population and family planning services ...". Thus, items (a) through (k) do not apply.

U.S. government agencies and other donors of the immediate and long-term value of tropical forests; and (k) utilize the resources and abilities of all relevant U.S. government agencies?

15. FAA Sec. 119(g)(4)-(6). Will the assistance (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

Not applicable.

16. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate sysem for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)?

Not applicable.

17. FY 1987 Continuing Resolution Sec. 532. Is disbursement of the assistance conditioned solely on the basis of the policies of any multilateral institution?

No.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Secs. 102(b), 111, 113, 281(a). Describe extent to which activity will (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and

(a) The Project will contribute to the improved health status of the poor, especially women and children, which clearly has long-lasting benefits.
(b) Not applicable.
(c) The Project will involve, utilize and depend on local community involvement to successfully implement some components of this Project.
(d) The Project will contribute to improved women's and children's health status, including reduced

	insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.	unwanted child bearing, which will permit women to more freely and effectively participate in economic activities. (e) Not applicable.
b.	FAA Secs. 103, 103A, 104, 105, 106, 120-21. Does the project fit the criteria for the source of funds (functional account) being used?	Yes.
c.	FAA Sec. 107. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?	The Project stresses appropriate technology for health care in the correct and appropriate use of oral rehydration salts, family planning methods, immunizations and breast-feeding.
d.	FAA Secs. 110, 124(d). Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to whch the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?	Yes. The GOP will provide a counterpart contribution of at least US$25,015,000 which is equal to 57% of Project costs.
e.	FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?	Yes, the Project has been designed and will be monitored specifically to benefit the poor majority in accordance with a new GOP National Health Policy.

f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.	The Project addresses specific GOP health priorities and policies, supports the increased local production of oral rehydration salts, drew upon the expertise of local health experts and authorities in the development of the Project, and will utilize local expertise to implement it.
g. FY 1987 Continuing Resolution Sec. 540. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?	No.
Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?	No.
Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?	No.
h. FY 1987 Continuing Resolution. Is the assistance being made available to any organization or program which has been determined to support or participate in the management of a program of coercive abortion or involuntary sterilization?	No.
If assistance is from the population functional account, are any of the funds to be made available to voluntary family planning projects which do not offer, either directly or through referral to or information about access to, a broad range of family planning methods and services?	No.
i. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	Yes.

j.	FY 1987 Continuing Resolution. How much of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?	Full consideration will be given to small and minority and women-owned businesses for the provision of all goods and services.
k.	FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project (a) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (b) take full account of the environmental impacts of the proposed activities on biological diversity?	Not applicable.
l.	FAA Sec. 118(c)(14). Will assistance be used for (a) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (b) actions which significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas?	(a) No. (b) No.
m.	FAA Sec. 118(c)(15). Will assistance be used for (a) activities which would result in the conversion of forest lands to the rearing of livestock; (b) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undegraded forest lands; (c) the colonization of forest lands; or (d) the construction of dams or other water	(a) No. (b) No. (c) No. (d) No.

control structures which flood relatively undegraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

2. Development Assistance Project Criteria (Loans Only) — Not applicable.

a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

c. FY 1987 Continuing Resolution. If for a loan to a private sector institution from funds made available to carry out the provisions of FAA Sections 103 through 106, will loan be provided, to the maximum extent practicable, at or near the prevailing interest rate paid on Treasury obligations of similar maturity at the time of obligating such funds?

d. FAA Sec. 122(b). Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?

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3. Economic Support Fund Project Criteria

Not applicable.

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

b. FAA Sec. 531(e). Will this assistance be used for military or paramilitary purposes?

c. ISDCA of 1985 Sec. 207. Will ESF funds be used to finance the construction, operation or maintenance of, or the supplying of fuel for, a nuclear facility? If so, has the President certified that such country is a party to the Treaty on the Non-Proliferation of Nuclear Weapons or the Treaty for the Prohibition of Nuclear Weapons in Latin America (the "Treaty of Tlatelolco"), cooperates fully with the IAEA, and pursues nonproliferation policies consistent with those of the United States?

d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

5C(3) - STANDARD ITEM CHECKLIST

Listed below are the statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. PROCUREMENT

1. FAA Sec. 602(a). Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed?	Yes.
2. FAA Sec. 604(a). Will all procurement be from the U.S. except as otherwise determined by the President or under delegation from him?	Yes.
3. FAA Sec. 604(d). If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?	Peru does not discriminate against marine insurance companies.
4. FAA Sec. 604(e); ISDCA of 1980 Sec. 705(a). If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)	Not applicable.
5. FAA Sec. 604(g). Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those	Not applicable.

countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)

6. FAA Sec. 603. Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? — No.

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

8. International Air Transportation Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? — Yes.

9. FY 1987 Continuing Resolution Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? — Yes, all U.S. direct contracts will contain a termination for convenience clause.

10. FY 1987 Continuing Resolution Sec. 524. If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)? — Yes.

B. CONSTRUCTION

1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used?	Not applicable.
2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?	Not applicable.
3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed $100 million (except for productive enterprises in Egypt that were described in the CP), or does assistance have the express approval of Congress?	Not applicable.

C. OTHER RESTRICTIONS

1. FAA Sec. 122(b). If development loan repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter?	This project is wholly grant funded.
FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?	Not applicable.
3. FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries?	Yes.

4. Will arrangements preclude use of financing:

a. FAA Sec. 104(f); FY 1987 Continuing Resolution Secs. 525, 540. (1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization; (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; or (4) to lobby for abortion?	(1) Yes. (2) Yes. (3) Yes. (4) Yes.
b. FAA Sec. 483. To make reimburse-bursements, in the form of cash payments, to persons whose illicit drug crops are eradicated?	Yes.
c. FAA Sec. 620(g). To compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President?	Yes.
d. FAA Sec. 660. To provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs?	Yes.
e. FAA Sec. 662. For CIA activities?	Yes.
f. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained?	Yes.
g. FY 1987 Continuing Resolution Sec. 503. To pay pensions, annuities, retirement pay, or adjusted service compensation for military personnel?	Yes.

h.	FY 1987 Continuing Resolution Sec. 505. To pay U.N. assessments, arrearages or dues?	Yes.
i.	FY 1987 Continuing Resolution Sec. 506. To carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)?	Yes.
j.	FY 1987 Continuing Resolution Sec. 510. To finance the export of nuclear equipment, fuel, or technology?	Yes.
k.	FY 1987 Continuing Resolution Sec. 511. For the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?	Yes.
l.	FY 1986 Continuing Resolution Sec. 516. To be used for publicity or propaganda purposes within U.S. not authorized by Congress?	Yes.

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: From FY 87 to FY 92
Total U.S. Funding: $19 million
Date Prepared: September 1987

Project Title & Number: Child Survival Action Project (527-0285)

Narrative Summary	Objectively Verifiable Ind.	Means of Verification	Important Assumptions
Program or Sector Goal: To improve the health of infants and children in Peru.	Measures of Goal Achievement: 1. Infant mortality rate reduced from 88.2/1000 in 1987 to 72/1000 by 1992. 2. Child (age 1-4) mortality rate reduced from 14/1000 in 1985 to 10/1000 in 1992.	1. Vital statistics. 2. Epidemiological data. 3. Evaluations and surveys. 4. Secondary data sources.	1. GOP commitment to the health sector in general and to the MOH and IPSS in particular continues. 2. Relative national financial and political stability continues. 3. Absence of major natural disasters continues.
Project Purpose: To strengthen the capability of the public health sector to deliver improved child survival health services through an integrated, expanded and sustainable health care system.	Conditions That Will Indicate Purpose Has Been Achieved (EOPS): 1. 80% of diarrheal episodes treated with ORT and appropriate dietary management. 2. A functioning MOH and IPSS service delivery system will be in place that achieves and maintains nationwide immunization coverage of 80% of all children less than five years old for a complete series of polio, measles, diptheria, whooping cough, tetanus and tuberculosis. 3. Wild polio virus will have been eradicated. 4. The number of family planning users served by the MOH and IPSS will have increased by at least 50%. 5. At least one nutritious weaning food will be promoted in different geographic regions of the country. 6. A comprehensive Health Information System (HIS)	1. Evaluations and special surveys by MOH, IPSS, A.I.D. MOH, IPSS, A.I.D. and other health organizations. 2. GOP Budgets for 1988-1992. 3. VEA disease reporting system including CS sentinel surveillance system reports, and laboratory reports. 4. HIS reports. 5. A.I.D. and GOP Project records. 6. Field observations.	1. GOP continues to assign high priority to CS services offered through the MOH and IPSS. 2. MOH and IPSS support for CS interventions continues. 3. MOH support for decentralization continues. 4. Sufficient GOP funds and staff are made available for the program. 5. All inputs from A.I.D, other international donors and GOP are made available on a timely basis. 6. No major natural disasters occur. 7. Terrorist activities do not significantly increase. 8. GOP debt payments are made to USG to remain out of 620Q and Brooke Alexander sanctins.

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Narrative Summary	Objectively Verifiable Ind.	Means of Verification	Important Assumptions
	will be installed and operational nationwide. 7. An Active Epidemiology Surveillance (VEA) system will be in place and up to 35 physicians trained in field epidemiology will have been assigned at the central and departmental levels. 8. Pharmaceuticals, contraceptives and medical supplies will be available at all health facilities through a functioning logistics system. 9. GOP financial resources for supporting the delivery of CS services will have increased such that adequate GOP budgetary support for local operating expenditures (local recurrent costs) associated with these programs will have been provided for five years.		9. Annual certificiation to GOP to remain out of drug sanctions is authorized by USG. 10. An adequate amount of ORS is produced and made available by LUSA in a timely manner. 11. Agreement between MOH and CDC is reached and a Letter of Understanding is signed in a timely manner.

Narrative Summary	Objectively Verifiable Ind.	Means of Verification	Important Assumptions
Outputs:	Magnitude of Outputs:		
A. Outputs in Diarrheal Disease Control (DDC)			
1. Public sector health personnel trained in DDC, including ORT, IV, antibiotics and dietary management of diarrhea (DMD).	1.a. Each year, all graduating physicians and nurses trained in ORT. b. 32,000 training opportunities provided for MOH and IPSS physicians, nurses and other health personnel in DDC. c. 350 MOH and IPSS physicians and nurses clinically trained in DDC.	1. Medical and nursing schools curricula. 2. MOH and IPSS training plans. 3. MOH and IPSS supervision plans. 4. Special surveys, reports and studies by GOP, A.I.D. and other health agencies.	1. Future MOH re-organizations will not seriously disrupt operations. 2. Project training for MOH and IPSS personnel is successful in transferring specific technical and communication skills. 3. Medical and nursing schools adapt curricula to include MOH norms and appropriate course content.
2. ORS available and promoted and used to treat dehydration in public sector health facilities.	2.a. MOH and IPSS logistical system functions effectively such that 100% of all MOH and IPSS hospitals, polyclinics and health centers and posts are appropriately supplied. b. Sufficient ORS available and used appropriately in MOH and IPSS facilities. c. Regular supervisory trips are conducted to all (3,673) MOH and IPSS polyclinics, health centers and posts.	5. Field observations. 6. HIS and VEA system and laboratory reports and other MOH and IPSS reports. 7. Radio and TV spots and printed materials. 8. A.I.D. and GOP Project documents. 9. Project evaluations.	4. LUSA accepts support from AID/W centrally-funded Project Support. 5. The public responds favorably to community education and mass media campaigns.
3. Rehydration Units established as Regional Training Centers for DDC.	3.a. Five Centers established in MOH hospitals, each in a different UDES. b. Two centers established in IPSS hospitals, each in a different DMU.	10. LUSA reports and records.	
4. Oral rehydration units (ORU) established in hospitals, health centers, health posts and in communities during diarrhea season.	4.a. 35 Hospital ORUs b. 75 Health Center ORUs. c. 500 Health Post ORUs. d. 500 Community ORUs (seasonal)		

Narrative Summary	Objectively Verifiable Ind.	Means of Verification	Important Assumptions
5. Home solutions developed and promoted by MOH and IPSS health personnel and through mass media campaigns appropriate to different groups.	5. At least 1 home solution tested in Lima for efficacy and acceptability and promoted in different geographic regions.		
6. Effective community education conducted on ORT, ORS and home solutions by MOH and IPSS personnel and through mass media campaigns appropriate to different groups.	6.a. 80% of mothers with children under 5 years of age know of ORS and its proper administration. b. 80% of mothers of children under 5 years of age use ORT, ORS or home solution correctly during last episode of diarrhea.		
7. Effective community education on prevention of diarrhea conducted by MOH and IPSS personnel and through mass media campaigns appropriate to different groups.	7. 80% of mothers with children under 5 years of age know about and use hygienic habits which prevent diarrhea and teach them to their children.		
8. ORS accessible to families with children.	8. 80% of families with children under 5 years of age can easily acquire ORS either through a MOH or IPSS facility or a pharmacy.		
9. Local production of ORS by LUSA.	9. 5 million packets produced per year by PY 3.		
10. Public sector health personnel trained in breast-feeding.	10.a. Each year, all graduating physicians and nurses are trained in breast-feeding. b. 35,000 training opportunities provided for MOH and IPSS physicians, nurses and other health personnel in breast-feeding.		

Narrative Summary	Objectively Verifiable Ind.	Means of Verification	Important Assumptions
11. Breast-feeding promoted and used in public health sector facilities.	11.a. Modified birthing and post-partum practices which include rooming-in and breast-feeding are promoted and used in 100% of all MOH and IPSS hospitals. b. Regular supervisory trips are conducted to all (146) MOH and IPSS hospitals.		
12. Appropriate traditional or new weaning foods developed from local foods and promoted by MOH and IPSS personnel and through mass media campaigns appropriate to different groups.	12. At least 1 new weaning food promoted in different geographic regions.		
13. Effective community education on breast-feeding conducted by MOH and IPSS personnel and through mass media campaigns appropriate to different groups.	13.a. 80% of mothers with children under 5 years of age know the benefits of breast-feeding. b. 50% of mothers with new-borns breast-feed exclusively for first four months.		
B. <u>Outputs in Nutrition</u> The exact nature of nutrition activities by the MOH to be financed by the Project will be prepared by the MOH and submitted to A.I.D. for approval prior to the disbursement of A.I.D. funds for this purpose. Outputs and objectively verifiable indicators will be developed at that time.	N/A	N/A	N/A

Narrative Summary	Objectively Verifiable Ind.	Means of Verification	Important Assumptions
C. Outputs in Immunizations			
1. Public sector health personnel trained in immunizations work.	1.a. Each year, all graduating physicians and nurses are trained in immunization. b. 29,900 training opportunities provided for MOH and IPSS physicians, nurses and other health personnel in immunizations. c. Regular supervisory visits are conducted to all (3,673) health centers and posts and polyclinics.		
2. Cold chain in place and immunizations available and used in public sector health facilities.	2.a. All needed cold chain equipment is placed in 100% of all MOH and IPSS hospitals, and 50% of polyclinics, health centers and health posts. b. MOH and IPSS logistical system is functioning effectively such that these same health facilities are supplied appropriately. c. Vaccines against polio, measles, diptheria, whooping cough, tetanus and tuberculosis are available and used appropriately in these same facilities. d. 35,000 MOH and IPSS professionals, paraprofessionals, and technicians trained in cold chain maintenance and sterilization techniques. e. Regular supervisory trips are conducted to all (146) MOH and IPSS hospitals and all (3,673) polyclinics, and health centers and health posts.		

Narrative Summary	Objectively Verifiable Ind.	Means of Verification	Important Assumptions
3. Effective community education on immunizations conducted by MOH and IPSS personnel and through mass media campaigns appropriate to different groups.	3.a. 80% of parents with children under 5 years of age are aware of immunizations. b. 80% of all children under age five will participate in a complete series of polio, measles, diptheria, whooping cough, tetanus and tuberculosis.		
4. More WFA will be immunized against tetanus.	4. 80% of WFA in high risk areas will be immunized against tetanus.		
5. Wild polio virus eradicated from Peru by 1990.	5. No reported cases of polio beginning in 1991 (PY 4).		
D. <u>Outputs in Family Planning (FP)</u>			
1. Public sector health personnel trained in FP.	1.a. Each year all graduating physicians and nurses trained in modern FP methods, including orals, condoms, foams, vaginal foaming tablets and IUDs. All ob/gyn physicians also trained in voluntary surgical contraception. b. 33,000 training opportunities provided for MOH and IPSS physicians, nurses and other health personnel in FP (orals , condoms, foams and vaginal foaming tablets), with nurses and physicians also trained in IUDs, and physicians also trained in voluntary surgical contraception.		

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Narrative Summary	Objectively Verifiable Ind.	Means of Verification	Important Assumptions
2. FP services available and promoted in public sector health facilities.	2.a. MOH and IPSS logistical system functions effectively such that 100% of all MOH and IPSS hospitals, polyclinics, and health centers and posts are appropriately supplied. b. All modern FP methods available and used in 100% of all MOH and IPSS hospitals; all methods but voluntary surgical contraception available and used in 100% of all polyclinics and health centers; and all methods but voluntary surgical contraception and IUDs available in 100% of all health posts. c. Regular supervisory trips are conducted to all (3,673) MOH and IPSS polyclinics and health centers and posts.		
3. Effective community education on FP conducted by MOH and IPSS personnel and through mass media campaigns appropriate to different groups.	3.a. 90% of WFA and men know of modern FP methods and where to obtain them. b. The number of MOH and IPSS users increased by at least 50%. c. Total fertility rate decreased from 4.2 children per woman in 1987 to 3.7 by 1991 (PY 4).		
E. <u>Outputs in Acute Respiratory Infection (ARI) Control</u>			
1. Public sector health personnel trained in ARI control, specifically in early detection and treatment of moderate and severe cases of ARI that can benefit from antibiotic treatment.	1.a. Each year, all graduating physicians and nurses trained in ARI control. b. 27,000 training opportunities provided for MOH and IPSS physicians, nurses and other health personnel in ARI control.		

Narrative Summary	Objectively Verifiable Ind.	Means of Verification	Important Assumptions
2. Antibiotics for ARI control available and used in public sector health facilities.	2.a. MOH and IPSS logistical system functions effectively such that 100% of all MOH and IPSS hospitals, polyclinics and health centers are appropriately supplied. b. Antibiotics available and used appropriately in ARI control in these same facilities. c. Regular supervisory trips are conducted to all (720) MOH and IPSS polyclinics and health centers.		
3. Effective community education on ARI control conducted by MOH and IPSS personnel and through mass media campaigns appropriate to different groups.	3.a. At least 50% of mothers with children under 5 years of age recognize early ARI, know how to treat it at home, and correctly do so. b. Number of children under 5 years of age with moderate and severe cases of ARI decreases by at least 50%.		
F. <u>Outputs in Training and Supervision</u>			
1. In-service training in all 5 CS interventions for physicians, nurses, midwives and other health personnel in MOH and IPSS and for administrative and logistics personnel in MOH and IPSS will be improved and expanded.	46,307 training opportunities provided through at least 372 courses to MOH physicians, nurses, midwives, nurse auxiliaries, health promoters, lab techinicians, and administrative and logistics personnel. (Figures differ from sum of Tables 26 and 27 because FETP training is included in Section I.1. of LogFrame.) 18,703 training opportunities provided through 557 courses to IPSS physicians, nurses, midwives, nurse auxiliaries, health promoters, lab technicians, and administrative and logistics personnel.		

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Narrative Summary	Objectively Verifiable Ind.	Means of Verification	Important Assumptions
2. In-country long-term training opportunities are made available in all 5 CS services for MOH and IPSS physicians, nurses, midwives and other health personnel.	16 MOH physicians, nurses, midwives and other health professionals trained; 22 IPSS physicians, nurses, midwives and other health professionals trained.		
3. Short-term and long-term training opportunities are made available outside of Peru for MOH and IPSS physicians, nurses and midwives.	20 MOH physicians, nurses, midwives and other health professionals trained. 11 IPSS physicians, nurses, midwives and other health professionals trained.		
4. Supervision visits are made to MOH UDES, hospitals, health centers, and posts on an increased and regular basis.	7 visits per LOP from Central MOH to each of the 28 UDES. 125 visits per LOP from UDES to each of the 125 hospitals. 8 visits per LOP from hospitals to each of the 689 health centers. 8 visits per LOP from health centers to each of the 2,738 health posts.		
5. An appropriate number of MOH personnel are trained to utilize and monitor the HIS system.	Number to be determined.		
6. An appropriate number of MOH and IPSS personnel are trained to utilize and monitor the VEA system.	30 MOH physicians, and 5 physicians from IPSS and other Peruvian institutions. 252 Computer operations established. 280 Other personnel trained.		

Narrative Summary	Objectively Verifiable Ind.	Means of Verification	Important Assumptions
G. Outputs in MOH Health Communications			
The specific health communications activities to be financed under this Project will be defined in a plan which will be prepared by the MOH and submitted to USAID for approval prior to the disbursement of A.I.D. funds for this purpose. At that time, outputs and objectively verifiable indicators will be determined.			
H. Outputs in MOH Financial and Personnel Management and Logistics			
1. Computerized systems for financial and personnel management and logistics in the MOH will be expanded with hardware and software to connect the UDES and the central level to the same system.	1. All 28 UDES and central level connected to same system.		
2. The logistics system in the MOH and IPSS that houses Project-financed commodities for CS service delivery and food provided by A.I.D. under other Projects for the MOH feeding program will be improved and expanded.	2. All MOH and IPSS warehouse facilities at hospitals or polyclinics will be rehabilitated as needed and new facilities constructed where needed.		

Narrative Summary	Objectively Verifiable Ind.	Means of Verification	Important Assumptions
I. Outputs in Active Epidemiological Surveillance (VEA) Program			
1. A cadre of epidemiologists trained through the CDC Field Epidemiological Training Program (FETP) and posted throughout the MOH and IPSS system.	1.a. 30 MOH physicians trained and one located in each UDES with 2 at the central level. b. 5 physicians from IPSS and other Peruvian institutions trained and each located in a different Departmental Managerial Unit (DMU) or at the central level in their respective organizations.		
2. A national computerized VEA system installed and functioning in the MOH.	2.a. 15 sentinel surveillance sites established. b. An obligatory disease reporting system in place nationwide in the MOH. c. 100% notification of selected diseases, including ARI, diarrheal disease, and immuno-preventable diseases.		
3. National laboratory system is strengthened.	3.a. Personnel from the National Institute of Health Central Laboratory, 5 Regional Referral Laboratories and the remaining 23 UDES Laboratories trained in clinical and epidemiological aspects of disease, procedures for collection and transport of specimens, and special laboratory techniques. b. All laboratories receive, install, utilize and maintain Project-financed equipment and supplies.		

Narrative Summary	Objectively Verifiable Ind.	Means of Verification	Important Assumptions
J. Outputs in Health Information Systems (HIS)			
1. Computerized system for health information in the MOH will be expanded with hardware and software to connect the UDES and the central level to the same system.	1. All 28 UDES and central level connected to the same system.		

Narrative Summary	Objectively Verifiable Ind.	Means of Verification	Important Assumptions
Inputs:	**Implementation Target (Type and Quantity):**		
I. A.I.D. A. Short and long-term overseas training. B. Short and long-term in-country training. C. Short and long-term expatriate and national advisory technical assistance. D. Vehicles, medical, lab, audio-visual, office and other equipment, computers, supplies, contraceptives and other commodities. E. Local Operating Expenses F. Project Implementation Management and Support Costs.	I. A.I.D. US$000 - Training 1,880 - T.A. 1,557 - Commodities 10,736 - Implementation Support 2,476 - Audits and Evaluations 630 - Other Costs 397 - Contingencies 1,324 TOTAL 19,000	1. A.I.D., MOH and IPSS Project records and financial documents. 2. Project audits and evaluations.	1. A.I.D. and GOP funding levels are approved and disbursements are made in a timely manner. 2. GOP meets conditions precedent. 3. Appropriate consultants can be recruited to provide required technical assistance. 4. Appropriate overseas training programs are identified. 5. A.I.D., MOH and IPSS assign adequate numbers of qualified staff to manage and facilitate implementation of the Project.
II. GOP A. Short and long-term in-country training. B. Locally procured office equipment and supplies. C. Staff salaries and operating expenses. D. Supervision, monitoring and support costs. E. Vehicle and equipment operating and repair costs. F. Hospital, clinic and lab facilities.	II. GOP US$000 - Training 3,285 - Commodities 3,905 - Staff Salaries and Operating Expenses 14,026 - Monitoring and Support 3,266 - Other 104 - Contingency 429 TOTAL 25,015 For detailed inputs, see financial analysis, implementation schedule, and commodity, TA and training plans in the PP.		

ILLUSTRATIVE LIST OF COMMODITIES

Table 1 provides a breakdown of the provisional allocation of A.I.D. funds for commodities by project year (PY) and Project component or activity for the life of the Project. This Annex summarizes the commodities to be procured during the first two PYs for each Project component or activity. A description of the commodities, estimated quantities, unit and total costs and likely procurement method are included. PY one consists of the final three months of calendar year (CY) 1987 and all of CY 88. Each of the remaining PYs corresponds to a CY. In developing the commodity procurement schedule, USAID staff assumed that: 1) relevant conditions precedent would be met by January 1988 and orders would be placed with A.I.D. Fiscal Year (FY) 1987 funds at that time; 2) FY 1988 A.I.D. funds would be available by no later than June 1988, at which time orders would be placed; and 3) FY 1989 A.I.D. funds would be available by no later than April 1989, at which time orders would be placed.

1. MOH Diarrheal Disease Control (DDC)

Five hospital rehydration units will be established and equipped to serve as Regional Training Centers for DDC, and oral rehydration units at 110 hospitals also will be equipped. A.I.D. will be responsible for the off-shore procurement of all medical and laboratory equipment and supplies while the MOH will procure furniture and other local supplies.

FY 87 (PY 1-A)	$10,000			
	33	Hospital Oral Rehydration Units	10,000	PSA[1/] & MOH
FY 88 (PY 1-B)	$81,000			
	3	Regional Training Centers for DDC	81,000	PSA & MOH
FY 89 (PY 2)	$67,000			
	2	Regional Training Centers for DDC	54,000	PSA & MOH
	43	Hospital Oral Rehydration Units	13,000	PSA & MOH

2. MOH Immunizations

Due to an emergency request by the MOH, USAID will buy-in to an AID/W central grant with PAHO for the purchase of $175,000 worth of disposable syringes and needles within the first three months of the Project. Otherwise, the procurement schedule will be based on the Five-Year Immunization Plan's Memorandum of Understanding.

1/ PSA = Procurement Services Agent.

TABLE 1. Provisional Allocation of A.I.D. Funds for Commodities by Project Year (PY) and Project Component (US$000)

	PROJECT COMPONENT/ACTIVITY	PY 1 a/ CY 87	PY 1 a/ CY 88	PY 2	PY 3	PY 4	PY 5	TOTAL
1.	MOH Diarrheal Disease Control	10	81	67	14	-	-	172
2.	MOH Immunizations	361	194	761	528	380	366	2,590
3.	MOH Family Planning	454	120	690	752	853	149	3,018
4.	MOH Control of Acute RespiRatory Infections	25	38	61	87	-	-	211
5.	MOH Nutrition	-	54	91	44	69	72	330
6.	IPSS Family Planning	9	9	170	373	256	216	1,033
7.	IPSS Child Survival	200	306	18	-	-	-	524
8.	Feild Epidemology Training Program	74	-	28	3	2	4	111
9.	Epidemiological Surveilance	70	269	158	87	85	49	718
10.	Health Information System	204	239	400	10	10	11	874
11.	Transportation	150	240	252	297	-	-	939
12.	Health Communications	-	50	55	55	55	-	215
	Totals	1,557	1,600	2,751	2,250	1,710	867	10,735

a/ Project Year 1 is divided into the last quarter of CY 87 and 12 months of CY 88, which are separated in this Table for procurement planning purposes.

FY 87	$361,000		
(PY 1-A)			
350,000	Disposable Needles and Syringes	175,000	PAHO
1,000	Steam sterlizers or		
2,500	Destructo kits	52,000	PSA
57	Electric-Kerosene Refrigerators	46,000	USAID
52	Stand-up Freezers	58,000	USAID
	Cold Chain Spare Parts	30,000	USAID
FY 88	$194,000		
(PY 1-B)			
400,000	Needles and Syringes	100,000	PSA
46	Electric-Kerosene Refrigerators	38,000	USAID
35	Ice Pack Freezers	37,000	USAID
11	Electric-Gas Refrigerators	8,000	USAID
33	Vaccine Storage Chests	11,000	USAID
FY 89	$761,000		
(PY 2)			
1,892,000	Needles and Syringes	473,000	PSA
130	Electric-Kerosene Refrigerators	115,000	USAID
108	Electric-Gas Refrigerators	76,000	USAID
21	Stand-up Freezers	23,000	USAID
30	Ice Pack Freezers	33,000	USAID
80	Vaccine Storage Chests	41,000	USAID

3. MOH Family Planning

USAID will be responsible for procuring contraceptives, medical instruments and the off-shore equipment for 15 Regional Family Planning Demonstration-Teaching Centers and five Regional Cancer Detection laboratories. The MOH will procure all local commodities for the Regional Centers.

FY 87	$454,000		
(PY 1-A)			
50,000	IUDs	73,000	AID/W
400,000	Cycles of Pills	192,000	AID/W
1,000,000	Condoms	91,000	AID/W
5	Sets of Equipment for FP Demonstration-Teaching Centers	20,000	PSA & MOH
5	Sets of Equipment for Regional Cancer Detection Laboratories	25,000	PSA & MOH
506	IUD Insertion Kits	45,500	PSA
1,500	Vaginal Specula	7,500	PSA
FY 88	$120,000		
(PY 1-B)			
56,000	IUDs	82,000	AID/W
79,000	Cycles of Pills	38,000	AID/W

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FY 89	$690,000		
(PY 2)			
1,080,000	Cycles of Pills	520,000	AID/W
2,900,000	Condoms	135,000	AID/W
1,500	Vaginal Specula	7,500	PSA
50	Minilap Kits	7,500	PSA
5	Sets of Equipment for FP Demonstration-Teaching Centers	20,000	PSA & MOH

4. <u>MOH Control of Acute Respiratory Infections</u>

FY 87	$25,000		
(PY 1-A)			
1,000	Stethoscopes	15,000	PSA
66	Ophthalmoscopes	5,000	PSA
20,000	5cc Syringes and Needles	5,000	PSA
FY 88	$38,000		
(PY 1-B)			
2,000	Stethoscopes	30,000	PSA
32,000	5cc Syringes and Needles	8,000	PSA
FY 89	$61,000		
(PY 2)			
3,000	Stethoscopes	45,000	PSA
120	Ophthalmoscopes	9,000	PSA
28,000	5cc Syringes and Needles	7,000	PSA

5. <u>MOH Nutrition</u>

Commodities to be purchased for the MOH nutrition component will be determined by the operational plan to be prepared by the MOH. For planning purposes, $54,000 has been budgeted in FY 88 and $91,000 in FY 89.

6. <u>IPSS Family Planning</u>

FY 87	$9,000		
(PY 1-A)			
64	IUD Insertion Kits	5,000	PSA
300	Vaginal Specula	1,500	PSA
15	Minilap Kits	2,500	PSA
FY 88	$9,000		
(PY 1-B)			
100	IUD Insertion Kits	7,900	PSA
70	Vaginal Specula	350	PSA
5	Minilap Kits	750	PSA

FY 89 $170,000
(PY 2)

100	IUD Insertion Kits	7,900	PSA
345	Vagional Specula	1,800	PSA
29,000	IUDs	42,300	AID/W
1,000,000	Cycles of Pills	48,000	AID/W
1,500,000	Condoms	70,000	AID/W

7. IPSS Child Survival

FY 87 $200,000
(PY 1-A)

94	Portable Weighing Scales	13,000	PSA
56	Infant Scales	14,500	PSA
125	Electric-Kerosene Refrigerators	102,000	USAID
200	Vaccine Carriers	4,500	PSA
137	Stethoscopes	2,100	PSA
21	Movie Projectors	8,000	PSA
21	Projection Screens	1,800	PSA
16	Mimeograph Machines	23,000	PSA
16	35mm Cameras	4,800	PSA
44	Slide Projectors	13,200	PSA
32	Megaphones	4,800	PSA
83	White Boards	4,500	IPSS
63	Electric Hot Plates	3,800	IPSS

FY 88 $306,000
(PY 1-B)

275	Portable Weighing Scales	38,000	PSA
188	Infant Scales	48,500	PSA
125	Electric-Kerosene Refrigeratos	102,000	USAID
200	Vaccine Carriers	4,500	PSA
137	Stethoscopes	2,000	PSA
32	Video Recorders with TVs	32,000	PSA
258	Video Cassettes	2,000	PSA
16	Mimeograph Machines	23,000	PSA
2	Regional Training Centers for DDC	54,000	PSA&IPSS

FY 89 $18,000
(PY 2)

34	Infant Scales	9,000	PSA
65	Portable Weighing scales	9,000	PSA

8. Field Epidemiology Training Program

FY 87 $74,000
(PY 1-A)

1	80,386 Computer	5,000	PSA
2	PC-XT Computers	2,100	PSA
6	Lap-Top Portable Computers	15,000	PSA

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2	Uninteruptable Power Supply	2,600	PSA
2	Dot Matrix Printers	1,000	PSA
1	Laser Printer	5,000	PSA
1	Tape Backup	1,200	PSA
3	3.5" Internal Disk Drive	750	PSA
1	HP Graphics Plotter	800	PSA
9	Printer Cables	250	PSA
9	Word Software on 3.5" Disks	4,500	PSA
9	DBase III on 3.5" Disks	4,500	PSA
9	Lotus on 3.5" Disks	4,500	PSA
7	Cross-Talk Linkages	700	PSA
6	Bridge Software Cables	600	PSA
1	Desk-Top Publishing Software	500	PSA
	Diskettes, Paper, Ribbons, etc.	1,000	PSA
	Office Furniture	3,00	MOH
2	Kodak Carrousel Slide Projector w/lens	600	PSA
10	Slide Projector Bulbs	300	PSA
10	Slide Projector Trays	100	PSA
1	Pull-Down Screen	200	PSA
2	Stand Alone Screens	200	PSA
2	Overhead Projectors	700	PSA
2	Light Pointers	50	PSA
1	Copy Machine	4,000	PSA
1	35 mm Camera w/ Copy Lens	400	PSA
1	Copy Stand w/ Lights	300	PSA
3	Transformers	300	PSA
3	Voltage Regulators	300	PSA
2	Electric Typewriters	700	PSA
2	Tape Cassette Recorder	200	PSA
1	Video Monitor	500	PSA
1	VHS Video Cassette Recorder	500	PSA
	Epidemiological Reference Library	10,000	PSA
	Office Supplies	1,650	MOH

FY 89 $28,000
(PY 2)

6	Lap-Top Portable Computers	15,000	PSA
6	Printer Cables	168	PSA
6	Word Processor on 3.5" Disk	3,000	PSA
6	DBase III on 3.5" Disk	3,000	PSA
6	Lotus on 3.5" Disk	3,000	PSA
6	Cross-Talk Linkages	600	PSA
6	Bridge Software Cables	600	PSA
	Diskettes, Paper, Ribbons, etc.	1,032	PSA
	Office Supplies	1,600	MOH

9. <u>VEA Laboratories</u>

FY 87 $70,000
(PY 1-A)

Equipment for National Institute of Health (INS) Viral (Polio) Laboratory	70,000	PSA

FY 88 (PY 1-B)	$269,000		
	Equipment for INS Enteropathogen Laboratory	18,000	PSA
	Equipment for INS Respiratory Laboratory	6,000	PSA
	Equipment for INS Tuberculosis Laboratory	24,000	PSA
	Equipment for 5 Regional Referal Laboratories	141,000	PSA
	Equipment for 23 UDES Laboratories	80,000	PSA
FY 89 (PY 2)	$158,000		
	Equipment for 5 Regional Referal Laboratories	100,000	PSA
	Equipment for 23 UDES Laboratories	58,000	PSA

10. <u>Health Information System</u>

FY 87 $204,000
(PY 1-A)

These funds will cover computer equipment and supplies for the computer centers in the initial eight UDES, the central MOH Family Planning office, the MOH central warehouse, the MOH central software design unit, and other computer hardware to upgrade the existing Wang VS computer to accommodate the Epidemiological Surveillance System.

15	PC/ATs	36,000	PSA
13	PC/XTs	9,100	PSA
13	Printers	9,750	PSA
13	UPS	13,000	PSA
11	Modems	2,750	PSA
210	Boxes of Diskettes	3,150	PSA
210	Boxes QD Diskettes	6,300	PSA
55	Tape Cartridges	1,650	PSA
28	Strip Plugs	840	PSA
13	Switches	520	PSA
11	Tape Back-ups	11,000	PSA
28	Network cards	5,880	PSA
1	Wang VS Upgrade	95,300	PSA
	Spare Parts	8,760	PSA

FY 88 $239,000
(PY 1-B)

These funds will cover equipment to establish computer centers in eight additional UDES and to upgrade the equipment in the eight previously installed UDES computer centers and the central level HIS.

27	PC/ATs	64,800	PSA
16	PC/XTs	11,200	PSA
19	Printers	14,250	PSA
16	UPS	16,000	PSA
8	Modems	2,000	PSA
270	Boxes of Diskettes	4,050	PSA
270	Boxes QD Diskettes	8,100	PSA
90	Tape Cartridges	2,700	PSA
52	Strip Plugs	1,560	PSA
16	Switches	640	PSA
8	Tape Back-ups	8,000	PSA
50	Network Cards	10,500	PSA
1	Memory Upgrade 2 to 4 MB	8,500	PSA
1	Disk Controler Upgrade	2,300	PSA
1	Disk Subsystem	25,400	PSA
1	Band Printer	22,000	PSA
1	Tape Subsystem	25,500	PSA
1	Emergency Power Supply	11,500	PSA

FY 89 $400,000
(PY 2)

These funds will be used to purchase equipment to establish computer centers in the remaining twelve UDES and to upgrade previously installed UDES computer centers and the central level MOH units and to purchase spare parts.

11. Transportation

FY 87 $150,000
(PY 1-A)

8	Double cab Pickup Trucks for Regional Coordinators	USAID
1	Double cab Pickup Truck for FETP Advisor	USAID
1	Double cab Pickup Truck for HIS Advisor	USAID

FY 88 $240,000
(PY 1-B)

16	Double cab Pickup Trucks	USAID

FY 89 $252,000
(PY 2)

16	Double cab Pickup Trucks	USAID

12. Health Communications

Commodities to be procured under the MOH Integrated Health Communications component will be determined by the operational plan to be prepared by the MOH. For planning purposes, $50,000 has been budgeted in FY 88 and $55,000 in FY 89.

1. CONSOLIDATED PROJECT BUDGETS BY INPUTS, PROJECT YEARS AND PROJECT COMPONENTS
(IN US $'000)

INPUTS	Project Year 1 AID Fx	Project Year 1 AID LCC	Project Year 1 GOP	Project Year 2 AID Fx	Project Year 2 AID LCC	Project Year 2 GOP	Project Year 3 AID Fx	Project Year 3 AID LCC	Project Year 3 GOP	Project Year 4 AID Fx	Project Year 4 AID LCC	Project Year 4 GOP	Project Year 5 AID Fx	Project Year 5 AID LCC	Project Year 5 GOP	Total AID Fx	Total AID LCC	TOTAL AID	Total GOP
I Training	105	267	573	86	414	639	91	265	618	99	215	574	91	101	592	472	1,262	1,734	2,996
Overseas	105	0	0	86	0	0	91	0	0	99	0	0	91	0	0	472	0	472	0
In Country	0	267	573	0	414	639	0	265	618	0	215	574	0	101	592	0	1,262	1,262	2,998
II Technical Assistance	218	120	0	168	208	0	179	44	0	229	44	0	191	19	0	1,025	427	1,432	0
Expatriate Advisors	218	0	0	168	0	0	179	0	0	229	0	0	191	0	0	1025	0	1225	0
National Advisors	0	120	0	0	208	0	0	44	0	0	44	0	0	19	0	0	427	427	0
	25	0	0	25			0			0			0			50	0	50	0
III Commodities	3,035	112	1,049	2,486	98	939	2,002	85	1,271	1,489	81	281	658	32	202	9,622	406	10,028	3,660
Vehicles	390	0	0	240	0	0	270	0	0	0	0	0	0	0	0	900	0	900	0
Medical,Lab. & Other Equip.	1,239	0	0	566	0	0	391	0	0	269	0	0	283	0	0	2,748	0	2,722	0
Office Equipment	0	39	41	0	20	0	0	4	2	0	0	0	0	0	0	6	54	60	41
Computers	581	0	0	410	0	0	2	0	0	1	0	0	1	0	0	995	0	995	0
Buildings	324	26	1287	492	21	939	377	21	1271	154	21	281	185	21	202	1,528	110	1,638	3,019
Commodities	447	0	0	755	0	0	1,202	0	0	955	0	0	324	0	0	3,683	0	3,683	0
Other	0	55	0	0	57	0	0	60	0	0	60	0	0	11	0	0	244	244	0
	0	0	0	0			0			0			0			0	0	0	0
IV Other Costs	152	417	2,468	150	758	2,737	252	347	3,725	150	377	3,452	252	357	3,685	950	2,246	3,193	15,067
USAID Management Staff	152	50	0	150	50	0	152	50	0	150	50	0	152	50	0	756	252	1,008	0
Evaluations	0	70	0	0	105	0	100	40	0	0	65	0	100	65	0	200	365	565	0
Operating Expenses	0	16	2843	0	15	2237	0	15	2594	0	0	2762	0	0	2984	0	46	46	12,140
Monitoring and Support	0	239	380	0	241	472	0	241	690	0	242	691	0	242	691	0	1,225	1,225	2,932
Other	0	42	29	0	330	26	0	0	21	0	0	9	0	0	10	0	372	372	77
Sub-Total	3,585	916	4,861	2,918	1,462	4,314	2,522	741	5,186	1,867	717	4,257	1,222	589	4,479	12,249	4,345	16,394	22,317
V Contingency	244	64	78	283	102	83	176	52	100	131	50	82	85	35	86	839	303	1,142	429
Total Project Costs	3,752	980	4,159	3,113	1,564	4,397	2,698	792	5,286	2,016	767	4,339	1,307	544	4,565	12,888	4,649	17,536	22,746

TABLE: TOTAL AID PROJECT COSTS BY PROJECT YEAR
(LS6223)

DIARRHEAL DISEASE CONTROL

BUDGET ITEM	Project Year 1 A I D Fx	Project Year 1 A I D LCC	Project Year 1 GOP	Project Year 2 A I D Fx	Project Year 2 A I D LCC	Project Year 2 GOP	Project Year 3 A I D Fx	Project Year 3 A I D LCC	Project Year 3 GOP	Project Year 4 A I D Fx	Project Year 4 A I D LCC	Project Year 4 GOP	Project Year 5 A I D Fx	Project Year 5 A I D LCC	Project Year 5 GOP	Total A I D Fx	Total A I D LCC	TOTAL AID	Total GOP
I Training	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	61	30	284	44	20	213	9	4	283	0	0	0	0	0	0	114	54	169	780
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical & Lab. Equipment	52	0	0	37	0	0	7	0	0	0	0	0	0	0	0	96	0	96	0
Office Equipment	0	30	0	0	20	0	0	4	0	0	0	0	0	0	0	0	54	54	0
Computers	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Medical & Lab. Supplies	7	0	284	5	0	213	2	0	283	0	0	0	0	0	0	14	0	14	768
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	4	0	4	0
IV Other Costs	0	0	82	0	0	80	0	0	80	0	0	80	0	0	79	0	0	0	399
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	82	0	0	80	0	0	80	0	0	80	0	0	79	0	0	0	399
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	61	30	364	44	20	293	9	4	363	0	0	80	0	0	79	114	54	169	1,179
V Contingencies (5%)	6	3	3	4	2	2	1	0	3	0	0	1	0	0	1	10	5	15	9
Total Project Costs	67	33	367	49	22	295	10	4	366	0	0	81	0	0	80	124	59	183	1,188

TABLE: TOTAL AID PROJECT COSTS BY PROJECT YEAR
(US$000)

NUTRITION

BUDGET ITEM	Project Year 1 AID Fx	Project Year 1 AID LCC	Project Year 1 GOP	Project Year 2 AID Fx	Project Year 2 AID LCC	Project Year 2 GOP	Project Year 3 AID Fx	Project Year 3 AID LCC	Project Year 3 GOP	Project Year 4 AID Fx	Project Year 4 AID LCC	Project Year 4 GOP	Project Year 5 AID Fx	Project Year 5 AID LCC	Project Year 5 GOP	Total AID Fx	Total AID LCC	TOTAL AID	Total GOP
I Training	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	39	20	7	40	21	8	39	21	7	39	21	7	39	21	7	196	104	300	36
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical & Lab. Equipment	30	0	0	30	0	0	30	0	0	30	0	0	30	0	0	150	0	150	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical & Lab. Supplies	9	20	7	10	21	8	9	21	7	9	21	7	9	21	7	46	104	150	36
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	39	20	7	40	21	8	39	21	7	39	21	7	39	21	7	196	104	300	36
V Contingencies (5%)	4	2	0	4	2	0	4	2	0	4	2	0	4	2	0	19	9	27	0
Total Project Costs	43	22	7	44	23	8	43	23	7	43	23	7	43	23	7	214	113	327	36

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TABLE: TOTAL AID PROJECT COSTS BY PROJECT YEAR
(LE0202)

IMMUNIZATIONS

BUDGET ITEM	Project Year 1 AID Fx	Project Year 1 AID LCC	Project Year 1 GOP	Project Year 2 AID Fx	Project Year 2 AID LCC	Project Year 2 GOP	Project Year 3 AID Fx	Project Year 3 AID LCC	Project Year 3 GOP	Project Year 4 AID Fx	Project Year 4 AID LCC	Project Year 4 GOP	Project Year 5 AID Fx	Project Year 5 AID LCC	Project Year 5 GOP	Total AID Fx	Total AID LCC	TOTAL AID	Total GOP
I Training	0	0	0	0	50	0	0	0	0	0	0	0	0	0	0	0	50	50	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	50	0	0	0	0	0	0	0	0	0	0	0	50	50	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	555	0	0	725	0	0	460	0	0	330	0	0	305	0	0	2,395	0	2,395	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical & Lab. Equipment	275	0	0	275	0	0	170	0	0	195	0	0	140	0	0	1,063	0	1,063	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical & Lab. Supplies	280	0	0	450	0	0	302	0	0	135	0	0	165	0	0	1,332	0	1,332	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	30	1,645	0	30	1,700	0	0	1,050	0	0	2,020	0	0	2,150	0	60	60	9,345
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	30	0	0	30	0	0	0	0	0	0	0	0	0	0	0	60	60	0
Operating Expenses	0	0	1,645	0	0	1,700	0	0	1,050	0	0	2,020	0	0	2,150	0	0	0	9,345
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	555	30	1,645	725	60	1,700	460	0	1,050	330	0	2,020	305	0	2,150	2,395	110	2,505	9,345
V Contingencies (5%)	50	3	12	65	7	12	43	0	13	30	0	15	28	0	16	216	10	226	68
Total Project Costs	605	33	1,657	790	67	1,712	523	0	1,063	360	0	2,015	333	0	2,166	2,611	120	2,731	9,413

TABLE: TOTAL AID PROJECT COSTS BY PROJECT YEAR
(US$000)

N O H FAMILY PLANNING

SUBJECT ITEM	Project Year 1 AID Fx	Project Year 1 AID LCC	Project Year 1 GOP	Project Year 2 AID Fx	Project Year 2 AID LCC	Project Year 2 GOP	Project Year 3 AID Fx	Project Year 3 AID LCC	Project Year 3 GOP	Project Year 4 AID Fx	Project Year 4 AID LCC	Project Year 4 GOP	Project Year 5 AID Fx	Project Year 5 AID LCC	Project Year 5 GOP	Total AID Fx	Total AID LCC	TOTAL AID	Total GOP
I Training	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	560	6	0	640	0	0	700	0	0	742	0	0	124	0	0	2,774	6	2,780	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical & Lab. Equipment	20	0	0	31	0	0	27	0	0	0	0	0	0	0	0	78	0	78	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical & Lab. Supplies	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	6	0
Contraceptives	540	0	0	609	0	0	673	0	0	742	0	0	124	0	0	2,696	0	2,696	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	48	0	320	46	0	0	48	0	0	50	0	0	49	0	320	300	243
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	46	0	0	46	0	0	48	0	0	50	0	0	49	0	0	0	243
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other (National Survey)	0	0	2	0	320	0	0	0	0	0	0	0	0	0	0	0	320	320	0
Sub-Total	560	6	48	640	320	46	700	0	48	742	0	50	124	0	49	2,774	326	3,080	243
V Contingencies (5%)	51	1	0	58	27	0	63	0	0	67	0	0	11	0	0	250	28	278	2
Total Project Costs	619	7	48	698	327	48	763	0	48	809	0	50	135	0	49	3,024	334	3,358	245

TABLE: TOTAL AID PROJECT COSTS BY PROJECT YEAR
(US$000)

ACUTE RESPIRATORY INFECTIONS

BUDGET ITEM	Project Year 1 AID Fx	Project Year 1 AID LCC	Project Year 1 GOP	Project Year 2 AID Fx	Project Year 2 AID LCC	Project Year 2 GOP	Project Year 3 AID Fx	Project Year 3 AID LCC	Project Year 3 GOP	Project Year 4 AID Fx	Project Year 4 AID LCC	Project Year 4 GOP	Project Year 5 AID Fx	Project Year 5 AID LCC	Project Year 5 GOP	Total AID Fx	Total AID LCC	TOTAL AID	Total GOP
I Training	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	58	0	525	58	0	525	84	0	788	0	0	0	0	0	0	200	0	200	1,838
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical & Lab. Equipment	58	0	0	58	0	0	75	0	0	0	0	0	0	0	0	175	0	175	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical & Lab. Supplies	0	0	525	0	0	525	9	0	788	0	0	0	0	0	0	25	0	25	1,836
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	58	0	525	58	0	525	84	0	788	0	0	0	0	0	0	200	0	200	1,838
V Contingencies (5%)	5	0	4	5	0	4	8	0	6	0	0	0	0	0	0	18	0	18	13
Total Project Costs	63	0	529	63	0	529	92	0	793	0	0	0	0	0	0	218	0	218	1,851

TABLE: TOTAL AID PROJECT COSTS BY PROJECT YEAR
(US$000)

I P S S - FAMILY PLANNING

BUDGET ITEM	Project Year 1			Project Year 2			Project Year 3			Project Year 4			Project Year 5			Total			Total
	A I D			A I D			A I D			A I D			A I D			A I D		TOTAL	
	Fx	LCC	GOP	Fx	LCC	GOP	Fx	LCC	GOP	Fx	LCC	GOP	Fx	LCC	GOP	Fx	LCC	AID	GOP
I Training	15	0	28	15	0	28	15	0	28	15	0	28	7	0	28	67	0	67	140
Overseas	15	0	0	15	0	0	15	0	0	15	0	0	7	0	0	67	0	67	0
In Country	0	0	28	0	0	28	0	0	28	0	0	28	0	0	28	0	0	0	140
II Technical Assistance	0	25	0	0	25	0	0	0	0	0	0	0	0	0	0	0	50	50	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	25	0	0	25	0	0	0	0	0	0	0	0	0	0	0	50	50	0
III Commodities	18	0	0	162	0	0	339	0	0	223	0	0	160	0	0	922	0	922	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical & Lab. Equipment	3	0	0	16	0	0	10	0	0	0	0	0	0	0	0	29	0	29	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical & Lab. Supplies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	15	0	0	146	0	0	329	0	0	223	0	0	160	0	0	893	0	893	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	47	0	0	49	0	0	47	0	0	47	0	0	47	0	0	0	237
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	47	0	0	49	0	0	47	0	0	47	0	0	47	0	0	0	237
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	33	25	75	177	25	77	354	0	75	238	0	75	187	0	75	989	50	1,039	377
V Contingencies (5%)	3	2	1	16	2	1	32	0	1	21	0	1	17	0	1	89	5	94	3
Total Project Costs	36	27	76	193	27	78	386	0	76	259	0	76	204	0	76	1,078	55	1,133	380

TABLE: TOTAL AID PROJECT COSTS BY PROJECT YEAR
(USAID)

I P S S - CHILD SURVIVAL

BUDGET ITEM	Project Year 1			Project Year 2			Project Year 3			Project Year 4			Project Year 5			Total			Total
	A I D			A I D			A I D			A I D			A I D			A I D		TOTAL	
	Fx	LCC	GOP	Fx	LCC	GOP	Fx	LCC	GOP	Fx	LCC	GOP	Fx	LCC	GOP	Fx	LCC	AID	GOP
I Training	6	0	68	0	0	72	6	0	70	6	0	68	6	0	63	30	0	30	323
Overseas	6	0	0	6	0	0	6	0	0	6	0	0	6	0	0	30	0	30	0
In Country	0	0	68	0	0	72	0	0	70	0	0	68	0	0	63	0	0	0	323
II Technical Assistance	10	0	0	15	0	0	0	0	0	0	0	0	0	0	0	25	0	25	0
Expatriate Advisors	10	0	0	15	0	0	0	0	0	0	0	0	0	0	0	25	0	25	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	505	0	0	17	0	0	0	0	0	0	0	0	0	0	0	523	0	523	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical & Lab. Equipment	500	0	0	17	0	0	0	0	0	0	0	0	0	0	0	517	0	517	0
Office Equipment	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	0	6	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical & Lab. Supplies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	60	0	0	62	0	0	60	0	0	60	0	0	60	0	0	0	300
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	60	0	0	62	0	0	60	0	0	60	0	0	60	0	0	0	300
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	522	0	128	30	0	130	6	0	130	6	0	128	6	0	123	578	0	578	623
V Contingencies (5%)	47	0	1	3	0	1	1	0	1	1	0	1	1	0	1	52	0	52	5
Total Project Costs	569	0	121	41	0	131	7	0	131	7	0	121	7	0	124	630	0	630	628

ESTIMATED COMPONENT BUDGET BY INPUTS AND PROJECT YEARS
(US$000)

MCH-FIELD EPIDEMIOLOGICAL TRAINING PROGRAM

INPUTS	Project Year 1 AID Fx	Project Year 1 AID LCC	Project Year 1 GOP	Project Year 2 AID Fx	Project Year 2 AID LCC	Project Year 2 GOP	Project Year 3 AID Fx	Project Year 3 AID LCC	Project Year 3 GOP	Project Year 4 AID Fx	Project Year 4 AID LCC	Project Year 4 GOP	Project Year 5 AID Fx	Project Year 5 AID LCC	Project Year 5 GOP	Total AID Fx	Total AID LCC	TOTAL AID	Total GOP
I Training	44	33	0	33	90	0	37	74	0	54	101	0	54	92	0	222	390	612	0
Overseas	44	0	0	33	0	0	37	0	0	54	0	0	54	0	0	222	0	222	0
In Country	0	33	0	0	90	0	0	74	0	0	101	0	0	92	0	0	390	390	0
II Technical Assistance	205	0	0	173	0	0	179	0	0	229	0	0	191	0	0	980	0	980	0
Expatriate Advisors	205	0	0	173	0	0	179	0	0	229	0	0	191	0	0	980	0	980	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	73	1	11	26	1	7	2	1	7	1	1	7	1	2	8	103	6	109	40
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical,Lab.&Other Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Computers	73	0	0	26	0	0	2	0	0	1	0	0	1	0	0	103	0	103	0
Supplies	0	0	6	0	0	7	0	0	7	0	0	7	0	0	8	0	0	0	35
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Services	0	1	0	0	1	0	0	1	0	0	1	0	0	2	0	0	6	6	0
IV Other Costs	0	0	67	0	0	116	0	0	171	0	0	225	0	0	260	0	0	0	859
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	54	0	0	105	0	0	162	0	0	216	0	0	270	0	0	0	810
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other (Services)	0	0	13	0	0	5	0	0	9	0	0	9	0	0	10	0	0	0	49
Sub-Total	325	34	78	232	91	123	218	75	178	234	102	232	246	94	286	1.705	396	1.701	899
V Contingencies (5%)	29	3	1	21	6	1	20	7	1	26	9	2	22	8	2	116	34	154	7
Total Project Costs	354	37	79	253	99	124	238	82	179	310	111	234	268	102	290	1.423	433	1.855	906

TABLE: TOTAL AID PROJECT COSTS BY PROJECT YEAR
(LS63221)

V E A - LABORATORIES

BUDGET ITEM	Project Year 1 AID Fx	Project Year 1 AID LCC	Project Year 1 GOP	Project Year 2 AID Fx	Project Year 2 AID LCC	Project Year 2 GOP	Project Year 3 AID Fx	Project Year 3 AID LCC	Project Year 3 GOP	Project Year 4 AID Fx	Project Year 4 AID LCC	Project Year 4 GOP	Project Year 5 AID Fx	Project Year 5 AID LCC	Project Year 5 GOP	Total AID Fx	Total AID LCC	TOTAL AID	Total GOP
I Training	15	4	0	0	0	0	9	0	0	0	0	0	0	0	0	33	4	37	0
Overseas	15	0	0	0	0	0	9	0	0	0	0	0	0	0	0	33	0	33	0
In Country	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	4	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	339	0	0	158	0	0	79	0	0	74	0	0	41	0	0	683	0	683	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
LOES,Reg. & IHS Refer. Labor	309	0	0	138	0	0	64	0	0	64	0	0	33	0	0	608	0	608	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consumables for IHS Refer. L	30	0	0	20	0	0	15	0	0	10	0	0	8	0	0	83	0	83	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	355	4	0	158	0	0	88	0	0	74	0	0	41	0	0	716	4	720	0
V Contingencies (5%)	32	0	0	14	0	0	8	0	0	7	0	0	4	0	0	65	0	65	0
Total Project Costs	387	4	0	172	0	0	96	0	0	81	0	0	45	0	0	781	4	785	0

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TABLE: ESTIMATED COMPONENT BUDGET BY INPUTS AND PROJECT YEARS
(US$222)

MCH-EPIDEMIOLOGICAL SURVEILLANCE

INPUTS	Project Year 1			Project Year 2			Project Year 3			Project Year 4			Project Year 5			Total			Total
	A I D			A I D			A I D			A I D			A.I D			A I D			
	Fx	LCC	GOP	Fx	LCC	GOP	Fx	LCC	GOP	Fx	LCC	GOP	Fx	LCC	GOP	Fx	LCC	TOTAL AID	GOP
I Training	0	42	0	0	124	0	0	106	0	0	50	0	0	0	0	0	322	322	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	42	0	0	124	0	0	106	0	0	50	0	0	0	0	0	322	322	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical,Lab.&Other Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Supplies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
USAID Management Staff	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	2	0	2	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	2	2	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	2	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	2	2	0	0	0	2	2	0	2	0	0	0	0	0	0	0	0	0	0
Sub-Total	2	42	0	2	124	2	0	106	2	0	50	0	0	0	0	0	322	322	0
V Contingencies 15%	2	4	0	2	11	0	0	10	0	0	5	0	0	0	0	0	29	29	0
Total Project Costs	0	46	2	0	135	0	0	116	0	0	55	0	0	0	0	0	351	351	0

TABLE: TOTAL AID PROJECT COSTS BY PROJECT YEAR
(US$000)

HEALTH INFORMATION SYSTEM

BUDGET ITEM	Project Year 1			Project Year 2			Project Year 3			Project Year 4			Project Year 5			Total			Total
	A I D			A I D			A I D			A I D			A I D			A I D		TOTAL	
	Fx	LCC	GOP	Fx	LCC	GOP	Fx	LCC	GOP	Fx	LCC	GOP	Fx	LCC	GOP	Fx	LCC	AID	GOP
I Training	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	70	0	0	150	0	0	19	0	0	19	0	0	19	0	0	277	277	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	70	0	0	150	0	0	19	0	0	19	0	0	19	0	0	277	277	0
III Commodities	428	5	0	384	6	0	0	9	0	0	9	0	0	9	0	812	39	850	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical & Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Computers	428	0	0	384	0	0	0	0	0	0	0	0	0	0	0	812	0	812	0
Medical & Lab. Supplies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Computer Supplies	0	5	0	0	6	0	0	9	0	0	9	0	0	9	0	0	39	39	0
IV Other Costs	0	59	44	0	64	107	0	16	232	0	23	202	0	0	202	0	158	159	739
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	10	0	0	0	0	0	20	0	0	0	0	0	30	30	0
Operating Expenses	0	16	20	0	16	87	0	16	220	0	0	202	0	0	202	0	45	45	741
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	42	16	0	38	20	0	0	12	0	0	0	0	0	0	0	80	96	48
Sub-Total	428	133	44	364	220	107	0	44	232	0	48	202	0	28	202	812	473	1,285	739
V Contingencies (5%)	39	12	0	35	20	1	0	4	2	0	4	1	0	3	1	73	43	116	6
Total Project Costs	467	145	44	419	240	110	0	48	234	0	52	203	0	31	203	885	516	1,401	795

ANNEX II
Exhibit C (1)
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TABLE: TOTAL AID PROJECT COSTS BY PROJECT YEAR
(US$000)

INTEGRATED TRAINING PROGRAM

BUDGET ITEM	Project Year 1 AID Fx	Project Year 1 AID LCC	Project Year 1 GOP	Project Year 2 AID Fx	Project Year 2 AID LCC	Project Year 2 GOP	Project Year 3 AID Fx	Project Year 3 AID LCC	Project Year 3 GOP	Project Year 4 AID Fx	Project Year 4 AID LCC	Project Year 4 GOP	Project Year 5 AID Fx	Project Year 5 AID LCC	Project Year 5 GOP	Total AID Fx	Total AID LCC	TOTAL AID	Total GOP
I Training	24	188	470	24	150	526	24	85	497	24	64	471	24	9	497	120	496	616	2,451
Overseas	24	0	0	24	0	0	24	0	0	24	0	0	24	0	0	120	0	120	0
In Country	0	188	470	0	150	526	0	85	497	0	64	471	0	9	467	0	496	496	2,451
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	0	0	59	0	0	23	0	0	24	0	0	24	0	0	24	0	0	0	154
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical & Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	36	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	36
Computers	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical & Lab. Supplies	0	0	23	0	0	23	0	0	24	0	0	24	0	0	24	0	0	0	116
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	46	0	0	46	0	0	46	0	0	46	0	0	46	0	0	0	232
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	46	0	0	46	0	0	46	0	0	46	0	0	46	0	0	0	232
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	24	188	575	24	150	595	24	85	567	24	64	541	24	9	557	120	496	616	2,835
V Contingencies (5%)	2	17	4	2	14	4	2	8	4	2	6	4	2	1	4	11	45	56	21
Total Project Costs	26	205	579	26	164	599	26	93	571	26	70	545	26	10	561	131	541	672	2,856

TABLE: TOTAL AID PROJECT COSTS BY PROJECT YEAR
(US$000)

INTEGRATED SUPERVISION PROGRAM

BUDGET ITEM	Project Year 1			Project Year 2			Project Year 3			Project Year 4			Project Year 5			Total			Total
	A I D			A I D			A I D			A I D			A I D			A I D		TOTAL	
	Fx	LCC	GOP	Fx	LCC	GOP	Fx	LCC	GOP	Fx	LCC	GOP	Fx	LCC	GOP	Fx	LCC	AID	GOP
I Training	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical & Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical & Lab. Supplies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	197	0	0	197	0	0	332	0	0	332	0	0	332	0	0	0	1,390
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	197	0	0	197	0	0	332	0	0	332	0	0	332	0	0	0	1,393
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	0	0	197	0	0	197	0	0	332	0	0	332	0	0	332	0	0	0	1,390
V Contingencies (5%)	0	0	1	0	0	1	0	0	2	0	0	2	0	0	2	0	0	0	10
Total Project Costs	0	0	198	0	0	198	0	0	334	0	0	334	0	0	334	0	0	0	1,400

TABLE: TOTAL AID PROJECT COSTS BY PROJECT YEAR
(6560228)

TRANSPORTATION

BUDGET ITEM	Project Year 1 AID Fx	Project Year 1 AID LCC	Project Year 1 GOP	Project Year 2 AID Fx	Project Year 2 AID LCC	Project Year 2 GOP	Project Year 3 AID Fx	Project Year 3 AID LCC	Project Year 3 GOP	Project Year 4 AID Fx	Project Year 4 AID LCC	Project Year 4 GOP	Project Year 5 AID Fx	Project Year 5 AID LCC	Project Year 5 GOP	Total AID Fx	Total AID LCC	TOTAL AID	Total GOP
I Training	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	392	0	0	240	0	0	270	0	0	0	0	0	0	0	0	922	0	922	0
Vehicles	392	0	0	240	0	0	270	0	0	0	0	0	0	0	0	900	0	900	0
Medical & Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical & Lab. Supplies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	35	0	0	57	0	0	81	0	0	81	0	0	81	0	0	0	335
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	35	0	0	57	0	0	81	0	0	81	0	0	81	0	0	0	335
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	392	0	35	240	0	57	270	0	81	0	0	81	0	0	81	922	0	922	335
V Contingencies (5%)	35	0	0	22	0	0	24	0	1	0	0	1	0	0	1	81	0	81	2
Total Project Costs	425	0	35	262	0	57	294	0	82	0	0	82	0	0	82	981	0	981	337

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TABLE: TOTAL AID PROJECT COSTS BY PROJECT YEAR
(US$000)

HEALTH COMMUNICATIONS

BUDGET ITEM	Project Year 1 AID Fx	Project Year 1 AID LCC	Project Year 1 GOP	Project Year 2 AID Fx	Project Year 2 AID LCC	Project Year 2 GOP	Project Year 3 AID Fx	Project Year 3 AID LCC	Project Year 3 GOP	Project Year 4 AID Fx	Project Year 4 AID LCC	Project Year 4 GOP	Project Year 5 AID Fx	Project Year 5 AID LCC	Project Year 5 GOP	Total AID Fx	Total AID LCC	TOTAL AID	Total GOP
I Training	0	0	15	0	0	15	0	0	15	0	0	15	0	0	14	0	0	0	74
Overseas	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	15	0	0	15	0	0	15	0	0	15	0	0	14	0	0	0	74
II Technical Assistance	0	25	0	0	25	0	0	25	0	0	25	0	0	0	0	0	100	100	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	25	0	0	25	0	0	25	0	0	25	0	0	0	0	0	100	100	0
III Commodities	0	50	162	0	50	162	0	50	162	0	50	163	0	0	163	0	200	200	812
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical & Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical & Lab. Supplies	0	0	162	0	0	162	0	0	162	0	0	163	0	0	163	0	0	0	812
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	50	0	0	50	0	0	50	0	0	50	0	0	0	0	0	200	200	0
IV Other Costs	0	0	62	0	0	63	0	0	63	0	0	63	0	0	63	0	0	0	314
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	62	0	0	63	0	0	63	0	0	63	0	0	63	0	0	0	314
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	0	75	239	0	75	240	0	75	240	0	75	241	0	0	240	0	300	300	1,200
V Contingencies (5%)	0	7	2	0	7	2	0	7	2	0	7	2	0	0	2	0	27	27	9
Total Project Costs	0	82	241	0	82	242	0	82	242	0	82	243	0	0	242	0	327	327	1,209

ESTIMATED COMPONENT BUDGET BY INPUTS AND PROJECT YEARS
[illegible]

W [illegible] - GENERAL PROJECT SUPPORT

INPUTS	Project Year 1 A I D Fx	Project Year 1 A I D LCC	Project Year 1 GOP	Project Year 2 A I D Fx	Project Year 2 A I D LCC	Project Year 2 GOP	Project Year 3 A I D Fx	Project Year 3 A I D LCC	Project Year 3 GOP	Project Year 4 A I D Fx	Project Year 4 A I D LCC	Project Year 4 GOP	Project Year 5 A I D Fx	Project Year 5 A I D LCC	Project Year 5 GOP	Total A I D Fx	Total A I D LCC	TOTAL AID	Total GOP
I Training	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical,Lab. & Other Equip.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Supplies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	152	329	129	150	356	212	250	331	295	150	357	296	250	357	296	950	1,730	2,680	1,228
USAID Management Staff	152	50	0	150	50	0	150	50	0	150	50	0	150	50	0	750	250	1,000	0
Audits & Evaluations	0	42	0	0	65	0	100	40	0	0	65	0	100	65	0	200	275	475	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	239	129	0	241	212	0	241	295	0	242	296	0	242	296	0	1,205	1,205	1,228
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	150	329	129	150	356	212	250	331	295	150	357	296	250	357	296	950	1,730	2,680	1,228
V Contingency	0	15	29	0	16	47	0	15	66	0	16	66	0	24	67	0	86	86	275
Total Project Costs	150	344	159	150	372	259	250	346	361	150	373	362	250	381	363	950	1,816	2,766	1,503

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2. CONSOLIDATED BUDGET OF A.I.D.-FINANCED INPUTS BY PROJECT YEARS AND PROJECT COMPONENTS

(IN US $'000)

INPUTS	PY 1 UNADJUSTED AMOUNT	PY 1 INFLATION ADJUSTED AMOUNT	PY 2 UNADJUSTED AMOUNT	PY 2 INFLATION ADJUSTED AMOUNT	PY 3 UNADJUSTED AMOUNT	PY 3 INFLATION ADJUSTED AMOUNT	PY 4 UNADJUSTED AMOUNT	PY 4 INFLATION ADJUSTED AMOUNT	PY 5 UNADJUSTED AMOUNT	PY 5 INFLATION ADJUSTED AMOUNT	TOTAL UNADJUSTED AMOUNT	TOTAL INFLATION ADJUSTED AMOUNT
I Training	372	372	500	525	356	392	314	361	192	230	1,734	1,880
Overseas	105	105	85	90	91	100	99	114	91	109	472	518
In Country	267	267	414	435	265	292	215	247	101	121	1,262	1,362
II Technical Assistance	336	336	388	407	223	245	273	314	210	252	1,432	1,557
Executive Advisors	210	210	188	197	179	197	229	263	191	229	1,285	1,105
National Advisors	120	120	200	210	44	46	44	51	19	23	427	452
	25		25		0		0		0			
III Commodities	3,147	3,147	2,564	2,713	2,087	2,296	1,490	1,714	722	866	10,030	10,736
Vehicles	350	350	240	252	270	297	0	0	0	0	920	939
Medical,Lab. & Other Equip.	1239	1,239	586	615	391	430	289	332	203	244	2,725	2,860
Office Equipment	36	36	20	21	4	4	0	0	0	0	60	61
Computers	501	501	410	431	2	2	1	1	1	1	915	936
Supplies	360	360	514	540	350	394	175	201	203	244	1,612	1,735
Contraceptives	565	565	755	793	1002	1,102	965	1,110	324	365	3,609	3,933
Other	58	58	59	62	60	66	60	69	11	13	246	268
	0		0		0		0		0			
IV Other Costs	567	567	900	945	597	657	527	606	607	728	3,198	3,523
USAID Management Staff	200	200	200	210	200	220	200	230	200	240	1,000	1,100
Evaluations	70	70	185	110	140	154	85	99	165	199	565	630
Operating Expenses	16	16	16	17	16	19	0	0	0	0	45	50
Monitoring and Support	239	239	241	253	241	265	242	278	242	290	1,205	1,326
Other	42	42	336	355	0	0	0	0	0	0	390	397
Sub-Total	4,424	4,424	4,372	4,591	3,263	3,559	2,604	2,995	1,731	2,077	16,394	17,676
V Contingencies	308	308	305	305	227	227	181	181	121	302	1142	1324
Total Project Costs	4,732	4,732	4,677	4,895	3,490	3,617	2,785	3,176	1,852	2,379	17,536	19,020

AID GRANT BUDGET SUMMARY FOR DIARRHEAL DISEASE CONTROL COMPONENT BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	91	91	64	67	13	14	0	0	0	0	168	173
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Equipment	52	52	37	39	7	8	0	0	0	0	96	99
Office Equipment	38	38	28	21	4	4	0	0	0	0	54	55
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	7	7	5	5	2	2	0	0	0	0	14	14
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	2	2	2	2	0	0	0	0	0	0	4	4
IV Other Costs	0	0	0	0	0	0	0	0	0	0	0	0
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	91	91	64	67	13	14	0	0	0	0	168	173
V Contingencies	0	0	6	6	1	1	0	0	0	0	15	15
Total Project Costs	99	99	70	73	14	15	0	0	0	0	183	188

AID GRANT BUDGET SUMMARY FOR THE NUTRITION COMPONENT BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	FY 1		FY 2		FY 3		FY 4		FY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	59	59	61	64	60	66	60	69	60	72	300	330
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Equipment	30	30	30	32	30	33	30	35	30	36	150	165
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	29	29	31	33	30	33	30	35	30	36	150	165
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	0	0	0	0	0	0	0	0	0	0
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	59	59	61	64	60	65	60	69	60	72	300	330
V Contingencies	5	5	6	6	5	5	5	5	5	5	27	27
Total Project Costs	64	64	67	70	65	71	65	74	65	77	327	357

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training												
Overseas	0	0	50	53	0	0	0	0	0	0	50	53
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	50	53	0	0	0	0	0	0	50	53
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities												
Vehicles	555	555	725	761	480	528	330	360	325	366	2,395	2,590
Medical and Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	275	275	275	289	178	196	195	224	140	168	1,063	1,152
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	280	290	450	473	302	332	135	155	165	198	1,332	1,438
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	6	0	0	0	0
IV Other Costs												
USAID Management Staff	30	30	30	32	0	0	0	0	0	0	60	62
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	30	30	30	32	0	0	0	0	0	0	60	62
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	565	585	685	845	480	528	330	360	385	366	2,585	2,784
V Contingencies	53	53	73	73	43	43	30	30	28	28	226	226
Total Project Costs	638	638	878	918	523	571	360	409	333	394	2,731	2,938

AID GRANT BUDGET SUMMARY FOR THE NGO FAMILY PLANNING COMPONENT BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	574	574	846	672	700	770	742	853	124	149	2,780	3,018
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Equipment	20	20	31	33	27	30	0	0	0	0	78	82
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	6	6	0	0	0	0	0	0	0	0	6	6
Contraceptives	548	548	687	639	673	740	742	853	124	149	2,696	2,938
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	300	315	0	0	0	0	0	0	300	315
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	300	315	0	0	0	0	0	0	300	315
Sub-Total	574	574	940	987	700	770	7[illegible]	853	124	149	3,080	3,333
V Contingencies	52	52	85	85	63	63	67	67	11	11	278	278
Total Project Costs	626	626	1,025	1,072	763	833	809	920	135	160	3,358	3,611

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GRANT BUDGET SUMMARY FOR THE ACUTE RESPIRATORY INFECTIONS COMPONENT BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training												
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance												
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities												
Vehicles	58	58	58	61	84	92	0	0	0	0	0	0
Medical and Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	58	58	58	53	75	83	0	0	0	0	203	211
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	0	0	0	8	9	10	0	0	0	0	175	165
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	25	26
IV Other Costs												
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	58	58	58	61	84	92	0	0	0	0	0	0
V Contingencies	5	5	5	5	8	8	0	0	0	0	0	0
Total Project Costs	63	63	63	66	92	100	0	0	0	0	280	211
											10	18
											218	229

AID GRANT BUDGET SUMMARY FOR IFES-FAMILY [illegible]INING COMPONENT BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION [illegible]USTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	[illegible]USTED [illegible]	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training	15	15	15	16	15	17	15	17	7	8	67	73
Overseas	15	15	15	16	15	17	15	17	7	8	67	73
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	25	25	25	26	0	0	0	0	0	0	50	51
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	25	25	25	26	0	0	0	0	0	0	50	51
III Commodities	18	18	162	178	339	373	223	256	188	216	922	1,033
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Equipment	3	3	16	17	10	11	0	0	0	0	29	31
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	15	15	146	153	329	362	223	256	188	216	893	1,003
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	0	0	0	0	0	0	0	0	0	0
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	58	58	202	212	354	389	238	274	187	224	1,039	1,153
V Contingencies	5	5	10	10	32	32	21	21	17	17	86	86
Total Project Costs	63	63	212	222	386	421	259	295	204	241	1,125	1,243

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AID GRANT BUDGET SUMMARY FOR IPSS-CHILD SURVIVAL COMPONENT BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training	6	6	6	6	6	7	6	7	6	7	30	33
Overseas	6	6	6	6	6	7	6	7	6	7	30	33
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	10	10	15	16	0	0	0	0	0	0	25	26
Expatriate Advisors	10	10	15	16	0	0	0	0	0	0	25	26
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	506	506	17	18	0	0	0	0	0	0	523	524
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Equipment	500	500	17	16	0	0	0	0	0	0	517	518
Office Equipment	6	6	0	0	0	0	0	0	0	0	6	6
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	0	0	0	0	0	0	0	0	0	0
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	522	522	38	40	6	7	6	7	6	7	570	583
V Contingencies	47	47	3	3	1	1	1	1	1	1	52	52
Total Project Costs	569	569	41	43	7	7	7	7	7	8	638	635

A I D - FINANCED INPUTS BY PROJECT YEAR
(IN US $000)
NON-FIELD EPIDEMIOLOGICAL TRAINING PROGRAM

INPUTS	FY 1 UNADJUSTED AMOUNT	FY 1 INFLATION ADJUSTED AMOUNT	FY 2 UNADJUSTED AMOUNT	FY 2 INFLATION ADJUSTED AMOUNT	FY 3 UNADJUSTED AMOUNT	FY 3 INFLATION ADJUSTED AMOUNT	FY 4 UNADJUSTED AMOUNT	FY 4 INFLATION ADJUSTED AMOUNT	FY 5 UNADJUSTED AMOUNT	FY 5 INFLATION ADJUSTED AMOUNT	TOTAL UNADJUSTED AMOUNT	TOTAL INFLATION ADJUSTED AMOUNT
I Training	77	77	123	129	111	122	155	178	146	175	612	682
Overseas	44	44	33	35	37	41	54	62	54	65	222	246
In Country	33	33	90	95	74	81	101	116	92	110	390	435
II Technical Assistance	208	208	173	182	179	197	229	263	191	229	980	1,079
Expatriate Advisors	208	208	173	182	179	197	229	263	191	229	980	1,079
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	74	74	27	26	3	3	2	2	3	4	109	112
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical,Lab.&Other Equipmen	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	73	73	26	27	2	2	1	1	1	1	103	105
Supplies	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	1	1	1	1	1	1	1	2	2	6	7
IV Other Costs	0	0	0	0	0	0	0	0	0	0	0	0
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	359	359	323	339	293	322	386	444	340	408	1,701	1,872
V Contingencies	32	32	29	29	26	26	35	35	31	31	154	154
Total Project Costs	391	391	352	368	319	349	421	479	371	439	1,855	2,026

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AID GRANT BUDGET SUMMARY FOR THE V.E.A. LABORATORIES BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training	20	20	8	8	9	10	0	0	0	0	37	38
Overseas	16	16	8	8	9	10	0	0	0	0	33	34
In Country	4	4	0	0	0	0	0	0	0	0	4	4
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	339	339	150	158	79	87	74	85	41	49	683	718
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Equipment	309	309	138	137	64	70	64	74	33	40	608	629
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	30	30	20	21	15	17	10	12	8	10	83	89
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	0	0	0	0	0	0	0	0	0	0
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	359	359	158	166	88	97	74	85	41	49	720	756
V Contingencies	32	32	14	14	8	8	7	7	4	4	65	65
Total Project Costs	391	391	172	180	96	105	81	92	45	53	785	821

A I D - FINANCED INPUTS BY PROJECT YEAR
(IN US $000)
NGH-EPIDEMIOLOGICAL SURVEILLANCE

INPUTS	PY 1 UNADJUSTED AMOUNT	PY 1 INFLATION ADJUSTED AMOUNT	PY 2 UNADJUSTED AMOUNT	PY 2 INFLATION ADJUSTED AMOUNT	PY 3 UNADJUSTED AMOUNT	PY 3 INFLATION ADJUSTED AMOUNT	PY 4 UNADJUSTED AMOUNT	PY 4 INFLATION ADJUSTED AMOUNT	PY 5 UNADJUSTED AMOUNT	PY 5 INFLATION ADJUSTED AMOUNT	TOTAL UNADJUSTED AMOUNT	TOTAL INFLATION ADJUSTED AMOUNT
I Training	42	42	124	130	106	117	58	58	0	0	322	346
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	42	42	124	130	106	117	58	58	0	0	322	346
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	0	0	0	0	0	0	0	0	0	0	0	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical,Lab.&Other Equipmen	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Supplies	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	0	0	0	0	0	0	0	0	0	0
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	42	42	124	130	106	117	58	58	0	0	322	346
V Contingencies	4	4	11	11	10	10	5	5	0	0	29	29
Total Project Costs	46	46	135	141	116	126	55	62	0	0	351	375

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AID GRANT BUDGET SUMMARY FOR THE HEALTH INFORMATION & EPIDEMIOLOGICAL SURVEILLANCE SYSTEMS BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	70	70	158	158	19	21	19	22	19	23	277	293
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	70	70	158	158	19	21	19	22	19	23	277	293
III Commodities	433	433	392	410	9	10	9	10	9	11	852	874
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	428	428	384	403	0	0	0	0	0	0	812	831
Medical and Lab. Supplies	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	5	5	6	6	9	10	9	10	9	11	38	42
IV Other Costs	58	58	64	67	16	18	20	23	0	0	158	166
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	10	11	0	0	20	23	0	0	30	34
Operating Expenses	16	16	16	17	16	18	0	0	0	0	48	51
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	42	42	38	40	0	0	0	0	0	0	80	82
Sub-Total	561	561	684	634	44	48	48	55	28	34	1,265	1,332
V Contingencies	51	51	55	55	4	4	4	4	3	3	116	116
Total Project Costs	612	612	659	689	48	52	52	60	31	36	1,481	1,448

AID GRANT BUDGET SUMMARY FOR THE INTEGRATED TRAINING PROGRAM BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training	212	212	174	183	189	128	88	181	33	40	616	655
Overseas	24	24	24	25	24	26	24	28	24	29	120	132
In Country	188	189	150	158	85	94	64	74	9	11	496	523
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	0	0	0	0	0	0	0	0	0	0	0	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	0	0	0	0	0	0	0	0	0	0
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	212	212	174	183	189	128	88	181	33	40	616	655
V Contingencies	19	19	16	16	10	10	8	8	3	3	56	56
Total Project Costs	231	231	190	198	119	138	96	189	36	43	672	711

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AID GRANT BUDGET SUMMARY FOR THE TRANSPORTATION COMPONENT BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	390	390	240	252	270	297	0	0	0	0	900	939
Vehicles	390	390	240	252	270	297	0	0	0	0	900	939
Medical and Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	0	0	0	0	0	0	0	0	0	0
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	390	390	240	252	270	297	0	0	0	0	900	939
V Contingencies	35	35	22	22	24	24	0	0	0	0	81	81
Total Project Costs	425	425	262	274	294	321	0	0	0	0	981	1,020

AID GRANT BUDGET SUMMARY FOR THE HEALTH C[illegible]ERATIONS COMPONENT BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION[illegible]JUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	FY 1 UNADJUSTED AMOUNT	FY 1 INFLATION ADJUSTED AMOUNT	[illegible] UNADJUSTED AMOUNT	[illegible]	FY 3 [illegible]TED	FY 3 INFLATION ADJUSTED AMOUNT	FY 4 UNADJUSTED AMOUNT	FY 4 INFLATION ADJUSTED AMOUNT	FY 5 UNADJUSTED AMOUNT	FY 5 INFLATION ADJUSTED AMOUNT	TOTAL UNADJUSTED AMOUNT	TOTAL INFLATION ADJUSTED AMOUNT
I Training	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	25	25	25	25	25	28	25	29	0	0	100	108
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	25	25	25	25	25	28	25	29	0	0	100	108
III Commodities	50	50	50	53	50	55	50	58	0	0	200	215
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	50	50	50	53	50	55	50	58	0	0	200	215
IV Other Costs	0	0	0	0	0	0	0	0	0	0	0	0
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	75	75	75	79	75	83	75	86	0	0	300	323
V Contingencies	7	7	7	7	7	7	7	7	0	0	27	27
Total Project Costs	82	82	82	86	82	89	82	93	0	0	327	358

A I D - FINANCED INPUTS BY PROJECT YEAR
(IN US $000)
N O N - SUPPORT COSTS

INPUTS	PY 1 UNADJUSTED AMOUNT	PY 1 INFLATION ADJUSTED AMOUNT	PY 2 UNADJUSTED AMOUNT	PY 2 INFLATION ADJUSTED AMOUNT	PY 3 UNADJUSTED AMOUNT	PY 3 INFLATION ADJUSTED AMOUNT	PY 4 UNADJUSTED AMOUNT	PY 4 INFLATION ADJUSTED AMOUNT	PY 5 UNADJUSTED AMOUNT	PY 5 INFLATION ADJUSTED AMOUNT	TOTAL UNADJUSTED AMOUNT	TOTAL INFLATION ADJUSTED AMOUNT
I Training	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	0	0	0	0	0	0	0	0	0	0	0	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical, Lab. & Other Equip.	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Supplies	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	479	479	526	531	581	639	587	583	687	728	2,660	2,761
USAID Management Staff	200	200	200	210	200	220	200	230	200	240	1,000	1,100
Evaluations	40	40	65	63	140	154	65	75	165	198	475	535
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	239	239	241	253	241	265	242	278	242	290	1,205	1,326
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	479	479	526	531	581	639	587	583	687	728	2,660	2,761
V Contingency	15	15	16	16	15	15	16	16	24	24	86	86
Total Project Costs	494	494	522	547	596	654	523	599	671	752	2,746	3,847

3. CONSOLIDATED BUDGET OF G.O.P.-FINANCED INPUTS BY PROJECT YEARS AND PROJECT COMPONENTS

(IN US $'000)

INPUTS	PY 1 UNADJUSTED AMOUNT	PY 1 INFLATION ADJUSTED AMOUNT	PY 2 UNADJUSTED AMOUNT	PY 2 INFLATION ADJUSTED AMOUNT	PY 3 UNADJUSTED AMOUNT	PY 3 INFLATION ADJUSTED AMOUNT	PY 4 UNADJUSTED AMOUNT	PY 4 INFLATION ADJUSTED AMOUNT	PY 5 UNADJUSTED AMOUNT	PY 5 INFLATION ADJUSTED AMOUNT	TOTAL UNADJUSTED AMOUNT	TOTAL INFLATION ADJUSTED AMOUNT
I Training	573	573	639	671	610	671	574	660	592	710	2,988	3,285
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	573	573	639	671	610	671	574	660	592	710	2,988	3,285
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
	0		25		0		0		0			
III Commodities	1,048	1,048	938	955	1,271	1,398	281	231	282	242	3,660	3,925
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical, Lab.& Other Equip.	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	41	41	0	0	0	0	0	0	0	0	41	41
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Supplies	1007	1,007	938	955	1271	1,398	281	231	282	242	3,619	3,884
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
	0		0		0		0		0			
IV Other Costs	2,460	2,460	2,737	2,874	3,285	3,636	3,492	4,084	3,665	4,422	15,669	17,396
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	2243	2,243	2,237	2,349	2594	2,853	2782	3,199	2984	3,591	12,640	14,025
Monitoring and Support	388	388	472	496	698	759	691	795	691	829	2,932	3,266
Other	29	29	26	29	21	23	9	10	10	12	97	104
Sub-Total	4,081	4,081	4,314	4,538	5,166	5,705	4,257	4,896	4,479	5,375	22,317	24,586
V Contingency	76	78	83	93	120	130	82	82	86	86	429	429
Total Project Costs	4,157	4,159	4,397	4,613	5,286	5,834	4,339	4,977	4,565	5,461	22,746	25,015

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GCP BUDGET SUMMARY FOR THE DIARRHEA DISEASE CONTROL COMPONENT BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training		0		0		0		0		0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	284	284	213	224	283	311	0	0	0	0	780	819
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	284	284	213	224	283	311	0	0	0	0	780	819
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	80	80	80	84	80	88	80	92	79	95	399	439
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	80	80	80	84	80	88	80	92	79	95	399	439
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	364	364	293	308	363	399	80	92	79	95	1,179	1,258
V Contingencies	3	3	2	2	3	3	1	1	1	1	9	9
Total Project Costs	367	367	295	310	366	402	81	93	80	95	1,188	1,266

ANNEX II
Exhibit C (3)
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GOP BUDGET SUMMARY FOR THE NUTRITION COMPONENT BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	7	7	0	0	7	0	7	0	7	0	36	40
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	7	7	0	0	7	0	7	0	7	0	36	40
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	0	0	0	0	0	0	0	0	0	0
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	7	7	0	0	7	0	7	0	7	0	36	40
V Contingencies	0	0	0	0	0	0	0	0	0	0	0	0
Total Project Costs	7	7	0	0	7	0	7	0	7	0	36	40

COP BUDGET SUMMARY FOR THE IMMUNIZATIONS COMPONENT BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I. Training	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	0	0	0	0	0	0	0	0	0	0	0	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	1,645	1,645	1,700	1,785	1,850	2,035	2,080	2,300	2,150	2,580	9,345	10,345
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	1,645	1,645	1,700	1,785	1,850	2,035	2,080	2,300	2,150	2,580	9,345	10,345
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	1,645	1,645	1,700	1,785	1,850	2,035	2,080	2,300	2,150	2,580	9,345	10,345
V Contingencies	12	12	12	12	13	13	15	15	16	16	68	69
Total Project Costs	1,657	1,657	1,712	1,797	1,863	2,048	2,015	2,315	2,166	2,596	9,413	10,413

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SOP BUDGET SUMMARY FOR THE NON FAMILY PLANNING COMPONENT BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	0	0	0	0	0	0	0	0	0	0	0	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	48	48	48	50	48	53	50	50	49	59	243	268
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	48	48	48	50	48	53	50	50	49	59	243	268
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	48	48	48	50	48	53	50	50	49	59	243	268
V Contingencies	0	0	0	0	0	0	0	0	0	0	2	2
Total Project Costs	48	48	48	51	48	53	50	50	49	59	245	269

GOP BUDGET SUMMARY FOR THE ACUTE RESPIRATORY INFECTIONS COMPONENT BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	525	525	525	551	768	867	0	0	0	0	1,838	1,943
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	525	525	525	551	768	867	0	0	0	0	1,838	1,943
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	0	0	0	0	0	0	0	0	0	0
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	525	525	525	551	768	867	0	0	0	0	1,838	1,943
V Contingencies	4	4	4	4	6	6	0	0	0	0	13	13
Total Project Costs	529	529	529	555	794	873	0	0	0	0	1,851	1,956

GOP BUDGET SUMMARY FOR THE IFSS-FAMILY PLANNING COMPONENT BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training	28	28	28	29	28	31	28	32	28	34	140	154
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	28	28	28	29	28	31	28	32	28	34	140	154
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	0	0	0	0	0	0	0	0	0	0	0	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	47	47	49	51	47	52	47	54	47	56	237	261
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	47	47	49	51	47	52	47	54	47	56	237	261
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	75	75	77	81	75	83	75	86	75	90	377	415
V Contingencies	1	1	1	1	1	1	1	1	1	1	3	3
Total Project Costs	76	76	78	81	76	83	76	87	76	91	380	417

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GSP BUDGET SUMMARY FOR THE IPSS-CHILD SURVIVAL COMPONENT BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		FY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training	68	68	70	74	70	77	68	69	63	76	323	355
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	68	68	70	74	70	77	68	69	63	76	323	355
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	0	0	0	0	0	0	0	0	0	0	0	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	60	60	60	63	60	66	60	69	60	72	300	330
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	60	60	60	63	60	66	60	69	60	72	300	330
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	128	128	130	137	130	143	128	138	123	148	623	685
V Contingencies	1	1	1	1	1	1	1	1	1	1	5	5
Total Project Costs	121	121	131	137	131	144	121	139	124	148	628	690

GOP-FINANCED INPUTS BY PROJECT YEARS

NON-FIELD EPIDEMIOLOGICAL TRAINING PROGRAM

INPUTS	PY 1 UNADJUSTED AMOUNT	PY 1 INFLATION ADJUSTED AMOUNT	PY 2 UNADJUSTED AMOUNT	PY 2 INFLATION ADJUSTED AMOUNT	PY 3 UNADJUSTED AMOUNT	PY 3 INFLATION ADJUSTED AMOUNT	PY 4 UNADJUSTED AMOUNT	PY 4 INFLATION ADJUSTED AMOUNT	PY 5 UNADJUSTED AMOUNT	PY 5 INFLATION ADJUSTED AMOUNT	TOTAL UNADJUSTED AMOUNT	TOTAL INFLATION ADJUSTED AMOUNT
I Training	0	0	0	0	0	0	0	0	0	0	0	
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	11	11	7	7	7	8	7	8	8	10	40	44
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical, Lab.& Other Equip.	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	5	5	0	0	0	0	0	0	0	0	5	5
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Supplies	6	6	7	7	7	8	7	8	8	10	35	39
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	67	67	116	122	171	188	225	259	280	336	859	972
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
New Epidemiolog. Positions	54	54	103	113	162	178	216	248	270	324	810	918
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other (Services)	13	13	0	0	9	10	9	10	10	12	49	54
Sub-Total	78	78	123	129	178	196	232	267	269	346	899	1,015
V Contingencies	1	1	1	1	1	1	2	2	2	2	7	7
Total Project Costs	79	79	124	130	179	197	234	268	290	348	906	1,022

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GCP BUDGET SUMMARY FOR THE VEA LABORATORIES - PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	0	0	0	0	0	0	0	0	0	0	0	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Field Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Office [illegible]	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	0	0	0	0	0	0	0	0	0	0
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	0	0	0	0	0	0	0	0	0	0	0	0
V Contingencies	0	0	0	0	0	0	0	0	0	0	0	0
Total Project Costs	0	0	0	0	0	0	0	0	0	0	0	0

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GOP-FINANCED INPUTS BY PROJECT YEARS

MOH EPIDEMIOLOGICAL SURVEILLANCE COMPONENT

INPUTS	PY 1 UNADJUSTED AMOUNT	PY 1 INFLATION ADJUSTED AMOUNT	PY 2 UNADJUSTED AMOUNT	PY 2 INFLATION ADJUSTED AMOUNT	PY 3 UNADJUSTED AMOUNT	PY 3 INFLATION ADJUSTED AMOUNT	PY 4 UNADJUSTED AMOUNT	PY 4 INFLATION ADJUSTED AMOUNT	PY 5 UNADJUSTED AMOUNT	PY 5 INFLATION ADJUSTED AMOUNT	TOTAL UNADJUSTED AMOUNT	TOTAL INFLATION ADJUSTED AMOUNT
I Training	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	0	0	0	0	0	0	0	0	0	0	0	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical, Lab.& Other Equip.	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Supplies	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	0	0	0	0	0	0	0	0	0	0	0	0
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	0	0	0	0	0	0	0	0	0	0	0	0
V Contingencies	0	0	0	0	0	0	0	0	0	0	0	0
Total Project Costs	0	0	0	0	0	0	0	0	0	0	0	0

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GOP BUDGET SUMMARY FOR THE HEALTH INFORMATION & EPIDEMIOLOGICAL SURVEILLANCE SYSTEMS BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	0	0	0	0	0	0	0	0	0	0	0	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	44	44	189	114	232	255	282	232	282	242	789	888
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	28	28	69	93	220	242	282	232	282	242	741	838
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	16	16	20	21	12	13	0	0	0	0	48	50
Sub-Total	44	44	189	114	232	255	282	232	282	242	789	888
V Contingencies	0	0	1	1	2	2	1	1	1	1	6	6
Total Project Costs	44	44	118	115	234	257	283	234	283	244	795	894

GOP BUDGET SUMMARY FOR THE INTEGRATED TRAINING COMPONENT BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training	470	470	526	552	497	547	471	542	487	584	2,451	2,695
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	470	470	526	552	497	547	471	542	487	584	2,451	2,695
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	59	59	23	24	24	26	24	28	24	29	154	166
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	36	36	0	0	0	0	0	0	0	0	36	36
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	23	23	23	24	24	26	24	28	24	29	118	130
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	46	46	46	48	46	51	46	53	46	55	230	253
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	46	46	46	48	46	51	46	53	46	55	230	253
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	575	575	595	625	567	624	541	622	557	668	2,835	3,114
V Contingencies	4	4	4	4	4	4	4	4	4	4	21	21
Total Project Costs	579	579	599	629	571	628	545	626	561	672	2,856	3,135

GOP BUDGET SUMMARY FOR THE SUPERVISION CONTROL BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	0	0	0	0	0	0	0	0	0	0	0	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	197	197	197	207	332	365	332	382	332	398	1,390	1,549
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	197	197	197	207	332	365	332	382	332	398	1,390	1,549
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	197	197	197	207	332	365	332	382	332	398	1,390	1,549
V Contingencies	1	1	1	1	2	2	2	2	2	2	10	10
Total Project Costs	198	198	198	208	334	368	334	384	334	401	1,400	1,559

GOP BUDGET SUMMARY FOR THE TRANSPORTATION ENDOWMENT BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	0	0	0	0	0	0	0	0	0	0	0	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	35	35	57	60	81	89	81	93	81	97	335	374
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	35	35	57	60	81	89	81	93	81	97	335	374
Monitoring and Support	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	35	35	57	60	81	89	81	93	81	97	335	374
V Contingencies	0	0	0	0	1	1	1	1	1	1	2	2
Total Project Costs	35	35	57	60	82	90	82	94	82	98	337	377

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[illegible] FOR THE HEALTH COMMUNICATIONS COMPONENT BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

CATEGORIES	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training	15	15	15	16	15	17	15	17	14	17	74	81
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	15	15	15	16	15	17	15	17	14	17	74	81
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	162	162	162	178	162	178	163	187	163	196	812	893
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Lab. Supplies	162	162	162	178	162	178	163	187	163	196	812	893
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	62	62	63	66	63	69	63	72	63	76	314	346
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	62	62	63	66	63	69	63	72	63	76	314	346
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	239	239	240	252	240	264	241	277	240	289	1,200	1,320
V Contingencies	2	2	2	2	2	2	2	2	2	2	9	9
Total Project Costs	241	241	242	254	242	266	243	279	242	290	1,209	1,329

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EDP BUDGET SUMMARY FOR THE SUPPORT COSTS COMPONENT BY PROJECT YEARS

BASE COST ESTIMATE AND PROJECTED INFLATION ADJUSTED EXPENDITURES BY PROJECT YEARS

INPUTS	PY 1		PY 2		PY 3		PY 4		PY 5		TOTAL	
	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT	UNADJUSTED AMOUNT	INFLATION ADJUSTED AMOUNT
I Training	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0	0	0
In Country	0	0	0	0	0	0	0	0	0	0	0	0
II Technical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Expatriate Advisors	0	0	0	0	0	0	0	0	0	0	0	0
National Advisors	0	0	0	0	0	0	0	0	0	0	0	0
III Commodities	0	0	0	0	0	0	0	0	0	0	0	0
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
Medical, Lab.& Other Equip.	0	0	0	0	0	0	0	0	0	0	0	0
Office Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Computers	0	0	0	0	0	0	0	0	0	0	0	0
Supplies	0	0	0	0	0	0	0	0	0	0	0	0
Contraceptives	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
IV Other Costs	129	129	212	223	295	325	296	348	296	355	1,228	1,372
USAID Management Staff	0	0	0	0	0	0	0	0	0	0	0	0
Evaluations	0	0	0	0	0	0	0	0	0	0	0	0
Operating Expenses	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring and Support	129	129	212	223	295	325	296	348	296	355	1,228	1,372
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	129	129	212	223	295	325	296	348	296	355	1,228	1,372
V Contingency	29	29	47	47	66	66	66	66	67	67	275	275
Total Project Costs	158	158	259	270	361	391	362	406	363	422	1,503	1,647

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MINISTERIO DE RELACIONES EXTERIORES

Nº RE (CTF): 7-9-F/33

Lima, 29 de setiembre de 1987.

Señor Representante:

Tengo el agrado de dirigirme a usted a fin de solicitarle, a titulo de cooperación técnica internacional, el apoyo de esa Agencia respecto al proyecto "Acción para la Sobrevivencia Infantil", que ejecutará el Ministerio de Salud.

Al respecto, se acompaña a la presente Nota la documentación en donde se detalla la solicitud en referencia.

Al agradecer anticipadamente la atención que se sirva dispensar a la presente, hago propicia la oportunidad para reiterar a usted las seguridades de mi distinguida consideración.

GUILLERMO GERDAU O'CONNOR
EMBAJADOR
Director de Cooperación Técnica y Financiera Internacional

Al Señor Representante de la
Agencia para el Desarrollo Internacional (AID)

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AGENCY FOR INTERNATIONAL DEVELOPMENT
ADVICE OF PROGRAM CHANGE

Date:

Country	: Peru
Project Title	: Child Survival Action
Project Number	: 527-0285
FY 1987 CP Reference	: LAC Annex III, p. 385
Appropriation Category	: Health & Child Survival Fund
Life-of-Project Funding	: $19,000,000 (G)
Intended FY 1987 Obligation	: $ 3,500,000 (G) (Child Survival Fund) : $ 100,000 (G) 'ealth)

This is to advise that A.I.D. intends to obligate $3,600,000 in FY 1987 grant funds in Peru for the Child Survival Action project. This will be the first year of funding.

The purpose of the project is to expand and improve delivery of child survival (CS) services through a more comprehensive and sustainable health care system.

Annex: Activity Data Sheet

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AGENCY FOR INTE
ACTIVITY DATA SHEET

CP 81-05 (4 85)

PROGRAM: Peru

TITLE: Child Survival Action Project	FUNDING SOURCE: Health and Child Survival Fund	PROPOSED OBLIGATION (in thousands of dollars): FY 87 3,600	LIFE OF PROJECT (Aggr.) 19,000
NUMBER 527-0785 GRANT [X] LOAN [ ] NEW [X] CONTINUING [ ]	PRIOR REFERENCE: LAC Annex III, p. 385	INITIAL OBLIGATION FY 87 / ESTIMATED FINAL OBLIGATION FY 91	ESTIMATED COMPLETION DATE OF PROJECT FY 92

PURPOSE: To expand and improve Child Survival (CS) services delivery through a comprehensive and sustainable health care system.

BACKGROUND: As Peru faces the most severe economic, political and social crisis in its modern history, the most pressing need in the health sector is to continue moving away from an expensive hospital-based system toward preventive strategies and primary health care services for the neediest groups -- residents of rural and marginal urban areas, children under five, women of childbearing age, and people living in the sierra and jungle where health facilities are nonexistent or severely deficient.

Peru's child health status ranks among the lowest in Latin America. The infant mortality rate in 1985 was 95 per 1000 live births compared to an average of 63 per 1000 for all Latin America. Respiratory problems are the leading cause of illness in Peruvian children. Diarrhea is the greatest cause of death in children under age 1 and morbidity in children 2 to 5 years. Peru has among the highest incidence rates in Latin America for six major preventable illnesses--polio, tetanus, diptheria, pertussis, measles and tuberculosis. Over 50 percent of rural households and many urban households have children classified as malnourished or at risk of becoming malnourished. The current population growth rate (2.56 percent) is slowly dropping but remains one of the most serious impediments to development in Peru.

Over the past four years USAID projects have supported initiatives to develop preventive strategies, strengthen the delivery of primary health care services such as immunization and oral rehydration therapy in rural and poor urban areas and develop country-wide information and improved financial management systems. USAID also supported the establishment of a family planning program in the social security institute (IPSS).

PROJECT DESCRIPTION: The project will expand delivery of essential child survival services. These services include: diarrheal disease control through expanded and more effective use of oral rehydration therapy; immunization of infants and children for polio, tetanus, diptheria, pertussis, measles and tuberculosis; child spacing; and improved nutrition through growth monitoring, promotion of breast-feeding and nutrition education activities. The Government of Peru (GOP) and USAID funding will finance: (a) development of up-to-date norms and guidelines for each child survival intervention; (b) key equipment and supplies at the appropriate levels of service delivery; (c) effective supervision and in-service training at all levels of service delivery; (d) health communications support to develop and disseminate mass media messages and strengthen community participation; (e) operational research studies to improve service delivery; and (f) gathering and analysis of data from the health information and epidemiological surveillance systems to manage project inputs and monitor impact.

RELATIONSHIP TO COUNTRY STRATEGY AND CS INITIATIVE: This project responds to the Mission's strategy of: (a) increasing the efficiency and expanding the coverage of social services delivery (b) effectively delivering key CS interventions: control of diarrhea disease, immunizations, child spacing and nutrition.

BENEFICIARIES: The primary beneficiaries will be the mothers and children of families living in rural communities and in marginal urban settlements who are not served or who are underserved at the present. These two population groups, estimated at 58 percent of the population of Peru, make up the target group to be covered.

HOST COUNTRY AND OTHER DONORS: The counterparts for this project are the Ministry of Health and the IPSS. Other major donors in the health sector include: the German Technical Cooperation Agency, the Inter-American Development Bank (IDB), the United Nations Childrens Fund, and the Pan American Health Organization.

MAJOR OUTPUTS	ALL YEARS:
CS services institutionalized	70% of services funded by GOP
CS services delivered:	
- immunizations	3,250,000 children vaccinated
- diarrheal disease control	15 million children under 5 treated with ORT
- family planning	650,000 new acceptors.
Decentralized system functioning to support the planning, delivery and monitoring of Child Survival services	28 departments - MOH 32 departments - IPSS

A.I.D. Financed Inputs	LOP ($000)
Training	1,200
Technical Assistance	1,217
Commodities	10,783
Other Costs	5,800
	19,000

ANNEX I
Exhibit D
Page 2 of 2

U.S. FINANCING (in thousands of dollars)	Obligations	Expenditures	Unliquidated
Through September 30,			
Estimated Fiscal Year 1987 Through September 30, 1988			

PRINCIPAL CONTRACTORS OR AGENCIES: To be Determined

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