

PROJECT DATA SHEET

1. TRANSACTION CODE 150 40039

A = Add
 C = Change
 D = Delete

Amendment Number One

DOCUMENT CODE

3

COUNTRY/ENTITY PERU
 BUREAU/OFFICE LAC 05

3. PROJECT NUMBER 527-0335
 5. PROJECT TITLE (maximum 40 characters) PVO Family Planning Service Expansion

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)
 MM DD YY
09 30 93

7. ESTIMATED DATE OF OBLIGATION (Under "B." below, enter 1, 2, 3, or 4)
 A. Initial FY 89 B. Quarter 4 C. Final FY 92

8. COSTS (\$000 OR EQUIVALENT \$' =)

A. FUNDING SOURCE	FIRST FY <u>89</u>			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
Approved Total	1,203	1,014.3	2,217.3	8,293	3,507	11,800
(Grant)	(1,203)	(1,014.3)	(2,217.3)	(8,293)	(3,507)	(11,800)
(Loan)	()	()	()	()	()	()
1.						
2.						
Host Country		<u>1/</u>			<u>1/</u>	
Other Donor(s)						
TOTALS	1,203	1,014.3	2,217.3	8,293	3,507	11,800

9. SCHEDULE OF AID FUNDING (\$000)

APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT <u>2/</u>	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
PN	480	440		2,217.3		7,597.5		9,814.8	
HE	530					1,985.2		1,985.2	
TOTALS				2,217.3		9,582.7		11,800	

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

11. SECONDARY PURPOSE CODE 440

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

A. Code	BWW	BU	BR	PVON
B. Amount	8,582.7	6,497.7	2085	8,582.7

13. PROJECT PURPOSE (maximum 480 characters)

To maximize the availability of all family planning methods to women and men who wish to use them by increasing the capacity of the private voluntary sector to deliver long-lasting contraceptive methods while maintaining support for temporary supply methods and natural family planning.

14. SCHEDULED EVALUATIONS

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

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

- 1/ See Annex I Exhibit E, Justification for Waiver of 25% contribution requirement.
- 2/ Based upon an evaluation of PRISMA's performance in Year 1, Mission has determined that PRISMA should continue to implement the remainder of the Project Years 2 thru 4.

Best Available Copy

17. APPROVED BY Craig G. Buck
 Title Mission Director
 Date Signed 08/30/92

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

PROJECT AUTHORIZATION
(Amendment No. 1)

Name of Country: Peru

Name of Project: Private Voluntary Family Planning
Services Expansion

Number of Project: 527-0335

A. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended the Private Voluntary Family Planning Services Expansion Project was authorized on September 22, 1989. That Authorization is hereby amended as follows:

1. The authorized life-of-project funding is increased by \$9,582,698, from \$2,217,302 to be obligated over a one-year period from the date of authorization to \$11,800,000 to be obligated over a 4-year period from the date of authorization.

2. The authorized life of project is extended from September 21, 1990 to September 30, 1993.

3. Paragraph 3b is revised to include a new condition as follows:

"3.b. ii. Prior to undertaking activities for each project year 2 through 4 the Implementing Agency will prepare, and submit to USAID for approval, detailed month-by-month work plans."

Date: _____

8/30/90



Craig G. Buck
Mission Director

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

PERU

PRIVATE VOLUNTARY FAMILY PLANNING SERVICES EXPANSION
PROJECT SUPPLEMENT

(Project No. 527-0335)

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I. BACKGROUND

A. PROJECT PROGRESS TO DATE:

The Private Voluntary Family Planning Services Expansion Project was designed as a four-year project, with initial authorization to be given only for the first year, and further authorization contingent upon the performance of the implementing agency in year one. The project's goal is to enhance the ability of Peruvian families to determine the number and spacing of children they have by increasing the capacity of the private voluntary sector to deliver long-lasting contraceptive methods, while maintaining support for the delivery of temporary supply and natural methods.

Initial authorization for the project came on September 22, 1989. At that time, \$2,217,302 in grant funds were set aside to finance a cooperative agreement with Proyectos en Informatica, Salud, Medicina y Agricultura (PRISMA), the implementing agency for the project. Prisma received the first project funds in November, 1989. In May, 1990 there was an evaluation of the project's first year which found that sufficient progress had been made in fulfilling the PY1 project objectives as stated in the Project Paper, and which recommended that PRISMA continue as the implementing agency.

Progress has been made in the following areas: PRISMA has designed and developed an integrated logistics/financial/service statistics system, and is in the process of implenting it in the six service agencies; PRISMA has signed subagreements to provide funds to these agencies, has monitored the use of these funds, and has designed and distributed to the PVOs various administrative manuals relevent to financial reporting in the project; an audit firm is continuing its institutional financial and administrative audits of the participating PVOs; PRISMA has worked on a zonification strategy for selected areas in which the participating PVOs were active; external consultants are in the process of doing cost and market studies (to be completed in August 1990).

B. POLITICAL AND SOCIAL CONSTRAINTS TO FAMILY PLANNING IN PERU

1. Economic and Social Indicators:

Peru is undergoing severe instability, fostered by inconsistent economic policies and the destabilizing presence of guerrilla groups. This instability poses difficulty for the successful implementation of any project. Since the mid-1970s, economic development in Peru has stagnated. There was a brief period of real growth in the mid-1980s, stimulated by government demand-side growth policies, but GDP went from a 7.3 percent rise in 1987 to an 8.5 percent decline in 1988, and ? decline in 1989. For the first six months of 1990, hyperinflation has been running at an annualized rate of around 4,000 percent.

Neither the public nor private sectors can deliver sufficient basic goods and social services to ensure a minimal standard of living for a large proportion of the population. Peru is one of only three Latin American countries whose per capita food consumption is less than 90 percent of the Food and Agricultural Organization (FAO) standard; an estimated 38 percent of all children under five are chronically malnourished. And though education for children age 6-14 is available to 84 percent of the population, drop-out rates exceed 50 percent for the first three grades. Housing is insufficient and inadequate. Less than half of the urban population has access to potable water, and only 30 percent of the population has access to electricity.

The GOP's difficulty in accomplishing urban and rural development is exacerbated by rapid population growth. Peru's population of nearly 22 million is largely urban and is concentrated along the coast. The population growth rate is about 2.6 percent, with urban Peru growing twice as fast as rural Peru. If these trends continue, Peru's population will double within 20 years, with over 75 percent of its people living in urban areas.

Rapid population growth has a direct effect on per-capita income; it also strains already weak health and educational systems. Because the population is multiplying so quickly, public facilities must deal with large increases in the number of new clients each year. In particular, rapid population growth affects health systems because obstetrics cases (mainly deliveries, pregnancy problems, and abortion-related complications) account for half of all hospital admissions.

2. Effect on Family Planning Services:

These demographic trends have important implications for the delivery of family planning services. On one hand, since an overwhelming proportion of private voluntary and commercial sector services are delivered in urban areas, the increasingly large portion of the population that is urban will enhance the economies of scale and market opportunities which could further attract private commercial sector involvement. For the same reasons, however, the rural population will suffer an increasing scarcity of family planning resources and services relative to the urban areas; and this scarcity will in turn foster the population and employment pressures which encourage flight to the cities with its resulting socio-political destabilization.

The economic crisis has exacerbated the difficulty in delivering family planning services. The GOP, for example, has restricted imports to an increasing degree, affecting the importation of raw materials used in the local manufacture of oral contraceptives and spermicides, as well as foreign-manufactured family planning devices such as condoms and IUDs. It is feared there might be sporadic shortages of locally-manufactured contraceptives in the future (even more worrisome given the anticipated stimulation of demand), although none exist at present. In this context, the continued supply of donated commodities becomes even more critical, as does the ability of the PVOs to project their future needs and to exercise better control over logistics.

Yet while the economic crisis has put limitations on the easy supply of contraceptives, it promises to increase demand for those same commodities and for family planning services provided by PVOs. Hyperinflation, for example, has eroded purchasing power and real disposable income, and has created more unemployment and underemployment. This decline could have two significant effects on the middle class. First, greater numbers of the middle class could be priced out of the commercial market, thus increasing demand for the low-cost or no-cost services and commodities provided by PVOs even more than is currently projected. Secondly, the PVOs could be able to generate more income by providing these services and commodities to middle-class clients who would already be accustomed to paying for them.

The imperative behind a growing private sector involvement in the delivery of family planning services and commodities, (as foreseen under the PVFP Project), is highlighted by the relatively weak performance of the public sector. In Peru, public sector delivery of these services suffers from both a weak infrastructure and poor government policy. There is a lack of trained medical personnel and staff continuity. Management capabilities are lacking at all levels with weak logistic systems, poor planning, budgeting and programming, and inadequate availability and use of statistics, all resulting in delays in patient processing.

Government policies have further burdened health facilities by increasing the eligible population (e.g. extended IPSS coverage to all housewives, the population in the Andean Trapezoid, and to market cooperative members) without significantly raising health sector budgets. Family planning services share this burden of attending to greater numbers of clients with decreasing budgets and support, and a limited number of adequately-trained medical personnel.

II. AMMENDMENT RATIONALE

USAID believes that Peru's growing family planning needs, the economic crisis and bottlenecks in public sector services can best be addressed by supporting and strengthening the private sector, while encouraging more public/private cooperation. The original project provided for a four-year effort that would, through an implementing agency, help build stronger institutional capacity into six selected private voluntary organizations involved in family planning. The original authorization was for one year to test and evaluate the capabilities of the Implementing Agency and validate the viability of the proposed project approach. Based on the findings of a threshold evaluation carried out in May, 1990, the remaining three years of the project may now be authorized and the Cooperative Agreement with the Implementing Agency extended accordingly.

A. ENHANCED RESEARCH AND EVALUATION:

The original project, however, did not allow for an adequate

means of verifying and quantifying the effects of the project on the health of the population as a whole. As envisioned in the logical framework of the project paper, such verification was to have been achieved using the 1991 National Census, various economic indicators and a later demographic and health survey (DHS). However, no funding was allocated in the initial document for this DHS.

This ammendment calls for a new DHS which would update and improve the quality of information obtained in the 1986 DHS survey. It would be useful not only to measure the efforts of this project, but to follow changes in family planning activities throughout the public and private sectors. For this project the DHS will provide a variety of useful data including: accurate measures of expanded delivery of family planning services in the private and public sector; a more accurate picture of the level of knowledge about contraception in the community; a better measure of the importance of various sources of contraceptives; a look at both the willingness of women to use long-lasting methods, and their fears about such; a base of information for further community-based family planning programs. The DHS will also help ensure that family planning services are delivered within the guidelines of Peruvian law, as directed in the original Project Paper (p.16). The following section discusses these points in detail.

1. Service Delivery Expansion

Family planning activites have been expanded in the private voluntary, commercial and public sectors since the 1986 DHS; a new survey will note progress since the first DHS, and establish baseline data with which to measure the effectiveness of subsequent activities on the level of contraceptive use.

In the private voluntary sector, PVOs have undertaken a more active role in the delivery of family planning services and in IEC activities over the last four years, mainly through the Private Sector Project. They have both expanded their clinic infrastructure and community-based services and improved their program management. PVOs have intensified their personnel training programs, and the curriculum has been tested to find the most effective way of training voluntary community workers to provide information and distribute contraceptives in marginal urban and rural areas. The cost and duplication of services has been reduced as the country has been separated into zones assigned to particular PVOs, and as services have been standardized in Lima and selected provinces.

In the commercial sector, a Social Marketing Program was launched which included a T.V. and radio campaign that has increased both sales of selected contraceptives, and the number of Peruvians turning to the commercial sector for their contraceptive needs.

In the public sector, the Peruvian government approved the National Population Program at the end of 1987, giving it priority over the next three years. IPSS and the MOH have implemented this plan since 1986 with AID support.

2. Level of Contraceptive Knowledge

A new DHS is needed to improve the quality of information currently available about the level of contraceptive knowledge in the community. Current estimates are based upon the 1986 DHS survey which has some gaps in information, and which draws some questionable conclusions. For example, the earlier survey found that 86% of women of reproductive age knew about some contraceptive method. However, later studies (INANDEP, 1988) demonstrate that when asked to describe the proper use of specific methods, only 50% of women of reproductive age could do so. If confirmed, this result could have important implications for the design and implementation of family planning activities.

3. Sources for Obtaining Contraception

The 1986 DHS found that anywhere from 2% to 7% of Peruvians using modern contraceptive methods were being served by the PVO sector. However, other survey responses, as well as the PVOs' own service statistics, suggest that a better distinction could be made in survey data between the PVO, commercial and public sectors as sources for contraception. Better information would make it easier to set appropriate targets for population coverage by these sectors when planning new programs.

4. Unmet Demand for Contraception

The 1986 DHS indicated that 64% of women in union do not want more children. For this project's purpose, it is important to establish what portion of these women are potential candidates for longer-term contraceptive methods, and specifically for IUDs or VSC. In other words, what fears and/or concerns do these women have about these methods, and in turn, how many would be willing to use these methods. This information would be useful both to guide the provision of information and counseling services within the public and private sectors, and to examine the appropriateness of the National Population Law regarding VSC as a family planning method.

5. Program Design Needs

The Ministry of Health is designing a community-based family planning program in the rural sector. The new DHS could be used to assess its progress and whatever improvements might be made in its design.

B. UTILIZATION OF IMPLEMENTING AGENCY AS PROVIDER OF CONTRACEPTIVES FOR PUBLIC SECTOR

One important element of USAID's population strategy is to expand and improve the coordination between the public and private sectors. The PVFP Project recognizes the general need for more coordination, and specifically calls for public-private cooperation in the expansion of family planning services to rural areas. During the first year of the project USAID and the public and private sectors have already discussed ways to facilitate cooperation. The establishment of a joint system for importing and distributing contraceptives, for example, has been identified as a development of potential benefit to all sectors.

According to the PVFP Project Paper, the implementing agency (PRISMA) is responsible in PY1 for ordering, storing, distributing and monitoring contraceptive commodities for PVOs taking part in the project. In the public sector, the MOH and IPSS have been responsible for contraceptives through the USAID-supported Child Survival Action Project. However, there is a strong rationale for making PRISMA responsible for contraceptives in the public sector as well, though the possibility is not explicitly mentioned in the Project Paper. The public and private sectors share the same goal: to provide family planning services to all Peruvian couples who wish to limit or space the children they have. Yet bureaucratic and funding constraints often frustrate MOH efforts to deliver contraceptives to Peru's 28 Department Health Units (UDES), and to the IPSS for which it is also responsible. Giving additional training and technical assistance to the MOH might begin to alleviate distributional problems, but the sheer size and inertia of the public sector makes success unlikely.

Both the MOH/IPSS and the PVOs recognize the value of having one experienced entity distribute contraceptive commodities throughout the country, and the private sector is seen as having the resources and flexibility to best handle the logistics and distribution. Such a system, along with a computerized, integrated logistics and service statistics system, would facilitate the timely delivery of contraceptives and help avoid stockouts to the extent possible. Therefore it is proposed that the PVFP Project Implementing Agency assume the responsibility of handling and distributing all contraceptives provided by AID to Peru's National Family Planning Program.

This proposed role for the implementing agency would, of course, extend only to contraceptive distribution within the country; USAID would continue to procure contraceptives by issuing PIO/Cs to access the central AID/W purchasing contract.

III. PROJECT AMENDMENT DESCRIPTION

A. PROJECT GOALS AND OBJECTIVES

This supplement updates the USAID Private Voluntary Family Planning Services Expansion Project Paper No. 527-0335. The goal of this project, which remains unchanged, is to enhance the ability of Peruvian couples to achieve the desired number and spacing of children by increasing the capacity of the six target agencies to deliver long-lasting methods while maintaining support for their delivery of temporary supply and natural methods. This in turn will support GOP efforts to relieve pressure on the country's health, education, and nutrition infrastructures by slowing population growth.

The objectives of the PVFP project are reiterated below. They include:

- * institutional development, which includes enhanced efficiency, greater service delivery capacity, and increased self-sufficiency for the target agencies;
- * increased availability of long-lasting methods, while maintaining support for temporary supply and natural methods;
- * improved access to family planning services in rural areas.

This project supplement details three elements which differ from those included in the original project. They are discussed below.

B. ADDITIONAL ELEMENTS

1. Demographic and Health Survey

Through the AID/W contract with Westinghouse IRD, the Mission will provide approximately \$300,000 in funds to carry out a second DHS survey. As currently projected, preliminary planning for the survey will begin in July, 1990 and the survey itself will start in 1991. It will take at least a year to complete, and an additional two years for the data to be fully analyzed and the results published. This timetable is consistent with the experience of the 1986 DHS survey.

2. Contraceptive Commodities to Public Sector Facilities

The implementing agency, PRISMA, will enter into an official agreement with the MOH governing the receipt, customs clearance, storage, distribution and monitoring of contraceptive commodities to be used in public sector programs. A.I.D. will continue to purchase and ship contraceptives for the public sector based on requirements determined from the Contraceptive Procurement Tables (CPTs) and the MOH's QUIPUS model. PRISMA will receive the commodities at the port and either it, or a commercial company, will then clear supplies through customs, arrange storage through a commercial warehouse, and effect delivery. Depending on various situations which may exist during the period of the agreement between PRISMA and the MOH, either the UDES will be responsible for collecting commodities from the PRISMA warehouse, or PRISMA will place them directly at the UDES. The exact distribution workplan will be developed jointly with the MOH and approved by AID. In the future, it is envisioned that contraceptive logistics and distribution will be arranged and formalized through subagreements between PRISMA and the MOH regional offices as part of ongoing regionalization.

3. USAID Project Monitoring

The PVFP Project Paper states that the Population Division (now the Health, Population and Nutrition Division) of the Office of Human Resources would have responsibility within USAID for managing the project and that the Chief of the Population Division (the Population Officer) would serve as the Project Manager with responsibility for the administrative approval of all project inputs and for overall project monitoring and coordination. The Project Manager would be assisted by a personal services contract Project Monitor for the first year of the project. Contingent upon USAID's determination, this position could be continued in Years 2 through 4 of the Project.

While the Threshold Evaluation saw a continuing requirement for the Project Monitor position during the remainder of the Project, it viewed that role as not justifying a permanent physical presence at the Implementing Agency offices since the Project Monitor's major functions are USAID related. Therefore, USAID has determined that the PSC Project Monitor position will be discontinued at the end of PY 1 and that for the remainder of the Project the Population Officer, assisted by the Population Specialist in the HPN Division, will assume the Project Monitor duties along with the responsibilities of Project Management.

C. PROJECT PARTICIPANTS

The PVFP Project has involved six PVOs delivering family planning services, as well as the implementing agency, Proyectos en Informatica, Salud, Medicina y Agricultura (PRISMA). Subsequent to the PY1 evaluation, as stipulated in the original Project Paper, PRISMA was retained as implementing agency for the remainder of the project. The six participating PVOs are:

- Asociacion de Trabajo Laico Familiar (ATLF),
- Asociacion de Profesionales para la Promocion de la Salud Materno-Infantil (APROSAMI),
- Centro Nor-Peruano de Capacitacion y Promocion Familiar (GENPROF),
- Instituto Peruano de Paternidad Responsable (INPPARES),
- Promocion de Labores Educativas y Asistenciales en Favor de la Salud (PROFAMILIA), and
- Proyecto Planificacion Familiar (PLANIFAM).

Other Peruvian PVOs may be invited to participate in specific activities, such as training, research, and production of educational materials.

D. END-OF PROJECT STATUS

As stated in the original Project Paper, the overall objectives of the Project are (1) to increase the capacity of selected PVOs to deliver family planning services (institution building); (2) to improve the availability of long-lasting contraceptive methods; (3) to maintain support for temporary supply methods and natural family planning; and (4) to enhance rural family planning coverage through PVO-public sector collaboration.

At the end of the project, September 30, 1993, the following additional outputs will have been achieved in support of the planned end-of-project status as described in the original Project Paper and below.

The DHS will have been carried out, and information for analysis and planning of future projects should be available.

A joint private/public mechanism will have been established to provide contraceptive commodities for Peru under a single, efficient means of distribution and control.

1. Increased Capacity to Deliver Family Planning Services

Institution building is a crucial prerequisite to increasing the availability of cost effective services and information and to providing family planning services to more users. By the end of the project, the participating agencies will have reduced the unit costs of services delivered so that they will be able to increase the number of users served at present donor funding levels or reduce the international donor support required to maintain the current level of users served. This is reflected in indicators presented immediately below.

Improved Administrative Systems. By the end of the project (EOP), all six participating PVOs will have developed and implemented:

- strategic plans,
- annual operational plans and financial objectives, and
- management information systems.

Improved Cost Effectiveness. By EOP, participating PVOs will have improved operational efficiency, reduced costs, and improved cost efficiency. Costs per service delivered will vary by contraceptive method, service delivery outlet, and geographic region. Following the completion of the technical studies in PY 1, numerical targets for use of installed capacity in both full-service clinics and rotating posts will be specified for PY 2, 3, and 4.

- for urban areas: (a) full-service clinics, and
(b) rotating posts; and
- for rural areas: (a) full-service clinics, and
(b) rotating posts.

Enhanced Financial Self-Sufficiency. Financial sustainability will be encouraged by increasing locally generated revenues, principally through cost recovery (fees for services and supplies) and income generation (sales of other services, commodities, local donations, etc.). By EOP, urban CBD programs will be self-sufficient, except for donated commodities. In addition, after the completion of the technical studies in PY 1, numerical self-sufficiency targets will be established for PY 2, 3, and 4 for:

- urban clinics,
- urban rotating posts, and
- rural programs (in non-public sector installations).

2. Availability of Long-Lasting Contraceptive Methods.

Installed Capacity. During PY 1, numerical (percentage) targets will be established for increasing PVO capacity to delivery IUDs and VSC and for increasing the portion of the PVOs' operating budgets dedicated to delivery of long-lasting methods.

Long-Lasting Contraceptive Method Users Served. Following the trends observed between 1987-1988, the number of acceptors of IUDs and VSC served directly by the PVOs will increase by 35 percent per year. The proportion of IUD and VSC acceptors over all acceptors in urban areas will increase by 20 percent per year. These levels take into consideration current Peruvian law and MOH norms which allow VSC only for men and women at high health risk.

3. Increased Rural Coverage.

After-hours family planning clinics will be opened in 30 public sector hospitals and/or health centers, of which 10 will be operated by the MOH or IPSS before the project terminated. Four rural CBD programs will be established. As a result of project activities, rural contraceptive prevalence will increase by 2 percent by year, and modern method use will increase to 75 percent of all contraceptive use.

4. Gender Considerations.

The numbers of women in management and other professional positions will be increased as a result of project activities. To correct historical imbalances, at least 66 percent of new hires in professional/management positions will be women. Participation of women in management training courses will be equal to their representation in the PVOs' work force or 50 percent of all management trainees, whichever is greater.

More men will be recruited as CBD distributors and supervisors. Twenty percent of all new CBD distributors trained will be men. Since the restructuring of urban CBD programs may include reducing the numbers of supervisors, no numerical targets for male supervisors will be stipulated. However, programmatic activities aimed at promoting male methods will be encouraged to recruit male supervisors.

E. FINANCIAL PLAN:

A summary of total project costs by component follows in Table 1.

REVISED (8/90) ANNUAL AND TOTAL PROJECT COSTS
BY PROJECT COMPONENT
(US\$000)

<u>Project Component</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>LOP</u>
A. PROGRAM COSTS	<u>1,754</u>	<u>3,784</u>	<u>2,992</u>	<u>1,781</u>	<u>10,311</u>
1. PVO Instit. Support	<u>667</u>	<u>690</u>	<u>550</u>	<u>456</u>	<u>2,363</u>
- APROSAMI	161	165	165	131	622
- ATLF	45	55	35	30	165
- CENPROF	60	65	45	35	205
- INPPARES	155	145	105	90	495
- PLANIFAM	96	90	85	70	341
(Cuzco)	(65)	(65)	(50)	(40)	(220)
(Puno)	(31)	(25)	(35)	(30)	(121)
- PROFAMILIA	150	170	115	100	535
(Lima)	(95)	(115)	(85)	(70)	(365)
(Huancayo)	(55)	(55)	(30)	(30)	(170)
2. Technical Assistance	<u>60</u>	<u>425</u>	<u>150</u>	<u>125</u>	<u>760</u>
- IEC	0	25	20	10	55
- Training	0	25	35	25	85
- Research	60	350	50	50	210
- Other	0	25	45	40	110
3. Contraceptive Commod.	<u>1,027</u>	<u>2,669</u>	<u>2,292</u>	<u>1,200</u>	<u>7,188</u>
B. ADMINISTRATIVE COSTS	<u>246</u>	<u>208</u>	<u>236</u>	<u>246</u>	<u>936</u>
1. Wages & Benefits	76	87	87	87	337
2. Office Expenses	16	32	23	23	94
3. Vehicle Costs	12	25	6	6	49
4. Local Travel	7	14	20	20	61
5. Evaluation	20	0	40	56	110
6. Audits	45	50	60	60	215
7. USAID monitoring	70	0	0	0	70
C. OVERHEAD	<u>27</u>	<u>30</u>	<u>30</u>	<u>30</u>	<u>117</u>
D. CONTINGENCIES	<u>0</u>	<u>121</u>	<u>170</u>	<u>145</u>	<u>436</u>
TOTAL PROJECT	<u>2,027</u>	<u>4,143</u>	<u>3,428</u>	<u>2,207</u>	<u>11,800</u>

F. Conditions, Covenants and Negotiation Status

The Cooperative Agreement is subject to essential terms, covenants, and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

In addition to the conditions, covenants and negotiating status presented in the original Project Paper, the following condition is also included:

1. Prior to undertaking activities for each Project year 2 through 4, the Implementing Agency will prepare, and submit to USAID for approval, detailed month-by-month work plans.

JUSTIFICATION OF NONCOMPETITIVE AWARD

According to Handbook 13, Chapter 2, para 2B3, Competition is not required for:

Assistance awards for which one recipient is considered to have exclusive or predominant capability, based on experience, specialized facilities or technical competence, or based on an existing relationship with the cooperating country or beneficiaries.

A noncompetitive award of an extension to the Cooperative Agreement with PRISMA is justified on the grounds of predominant capability, based on special circumstances surrounding Peru and the private voluntary family planning sector in Peru.

1. Need for a 123 (e)

Due to debt arrearages, Peru determination most likely will continue under Section 620(q) and Brooke-Alexander Amendment sanctions for the remainder of Fiscal Year (FY) 1990. Therefore, the Mission has requested and received the A.I.D. Administrator's determination, under Section 123(e) of the FAA, that obligations to PRISMA for this project are in the national interest. As a PVO registered with A.I.D. funding for population related activities (Milpo Mining Project, the Risk Project, and Niñor Journal), PRISMA is eligible to receive A.I.D. funding under a Section 123(e) determination.

2. Project success will be enhanced if implemented by a non-family planning PVO.

The Mission determined that it would be in the best interest of the project that it be implemented by a Peruvian PVO that was not a family planning service delivery organization, so as not to be seen as a competitor by the family planning PVOs that would be the direct beneficiaries of the project.

3. Technical competence of PRISMA.

The project design team made a careful search of potential candidates, which needed to satisfy the following criteria:

- previous experience with USAID/Peru Mission disbursement and reporting requirements;
- strong background and experience in a related development field; and
- previous collaborative relationship with the public sector.

Three potential candidates were identified: Vecinos Peru, APROPO, and PRISMA. PRISMA was chosen as the strongest of the three, for its administrative/managerial capabilities, its linkages with the Ministry of Health both centrally and at the departmental level throughout the country, its experience in working with Mission reporting requirements, and its experience in primary health care and P.L. 480 food distribution.

James Dunlap
Regional Contracting Officer

Date

Clearance: HPN:JBurdick for: CPM
HR:CMantione CPM
PROG:CKassebaum CPM CW
CONT:PKramer CPM
DD:BKennedy CPM
D:CBuck CPM

JUSTIFICATION FOR WAIVER
OF 25 PERCENT CONTRIBUTION REQUIREMENT

It is the policy of A.I.D. that a 25 percent contribution to total life-of-project costs from non-A.I.D. sources is required for operational program grants (OPG's) and operational program cooperative agreements (OPCA's) to PVOs. Although it is not mandated by legislation, A.I.D. has administratively determined to establish this requirement. This non-A.I.D. contribution may include cash and in-kind contributions from PVOs, local collaborators and other non-governmental donors as well as from host governments, other governments and international organizations.

This is not the typical PVO project in which A.I.D. receives a proposal from the PVO requesting A.I.D.'s assistance in carrying out one of their programs. Rather, in this case A.I.D. has approached PRISMA and requested it to be the coordinating organization for funding assistance to six local PVOs which at this time lack the administration and financial maturity required to control and monitor A.I.D. project funds. In addition, a major purpose of this four-year effort is to assist these six participating PVOs in acquiring the skills required to undertake income-generating activities, specifically, to increase local in-kind and cash donations and to undertake profit-making activities. These efforts are not expected to begin to bear fruit until near the end of the project; hence neither they nor PRISMA can reasonably be expected to make any significant contributions prior to the end of this project.

For these reasons it is inappropriate to require PRISMA to act as coordinating organization for this A.I.D. project and at the same time expect them to match A.I.D.'s contribution on a 1 to 3 basis in order to comply with A.I.D.'s 23 percent requirement. The same is true for the six local PVOs which are totally dependent on donor support and which we want to make more efficient and cost conscious during this project in order for them to move toward self-sufficiency. (Additionally, it should be noted that as sub-grantees under this project the PVOs are not required to contribute to the total life-of-project costs from non-A.I.D. sources.)