

519-0253

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UNCLASSIFIED

DEPARTMENT OF STATE
AGENCY FOR INTERNATIONAL DEVELOPMENT
Washington, D.C. 20523

EL SALVADOR

PROJECT PAPER

HEALTH AND NUTRITION

LAC/DR:80-5

Project Number:519-0253

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT		PROJECT DATA SHEET		1. TRANSACTION CODE <input type="checkbox"/> A = Add <input type="checkbox"/> C = Change <input type="checkbox"/> D = Delete		Amendment Number _____		DOCUMENT CODE 3	
2. COUNTRY/ENTITY EL SALVADOR				3. PROJECT NUMBER 519-0253					
4. BUREAU/OFFICE LA 05				5. PROJECT TITLE (maximum 40 characters) HEALTH AND NUTRITION					
6. PROJECT ASSISTANCE COMPLETION DATE (PACD) MM DD YY 1 2 3 1 8 3				7. ESTIMATED DATE OF OBLIGATION (Under "B." below, enter 1, 2, 3, or 4) A. Initial FY 80 E. Quarter 2 C. Final FY 80					

8. COSTS (\$000 OR EQUIVALENT \$1 = 2.50)						
A. FUNDING SOURCE		FIRST FY 80			LIFE OF PROJECT	
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	65	1,311	1,376	65	1,311	1,376
(Grant)	(65)	(1,311)	(1,376)	(65)	(1,311)	(1,376)
(Loan)	()	()	()	()	()	()
Other U.S.						
1. Host Country		1,781	1,781		1,781	1,781
2. Other Donor(s)						
TOTALS	65	3,092	3,157	65	3,092	3,157

9. SCHEDULE OF AID FUNDING (\$000)									
A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) PH	520	561				1,100		1,100	
(2) FN	320	320				276		276	
(3)									
(4)									
TOTALS						1,376		1,376	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each) 321 563						11. SECONDARY PURPOSE CODE 580	
12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)							
A. Code		DU		NUTR			
B. Amount		600		140			

13. PROJECT PURPOSE (maximum 480 characters)

The purpose of this project is to develop those mechanisms of primary health care, promotion and self help that will lead to an improvement in health and nutritional status for low-income Salvadorans in urban marginal communities (tugurios), and in rural areas.

14. SCHEDULED EVALUATIONS				15. SOURCE/ORIGIN OF GOODS AND SERVICES			
Interim	MM YY	MM YY	Final	MM YY	MM YY		
	6 8 1	6 8 2		1 2 8 3	1 2 8 3	<input checked="" type="checkbox"/> 000 <input checked="" type="checkbox"/> 941 <input checked="" type="checkbox"/> Local <input type="checkbox"/> Other (Specify) _____	

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

17. APPROVED BY	Signature 	18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION	
	Title Charles J. Stockman Director, USAID/El Salvador		

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON D C 20523

ASSISTANT
ADMINISTRATOR

PROJECT AUTHORIZATION

Name of Country: El Salvador
Name of Project: Health and Nutrition
Number of Project: 519-0253

1. Pursuant to Sections 103 and 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Health and Nutrition project for El Salvador (the "Cooperating Country") involving planned obligations of not to exceed One Million Three Hundred Seventy Six Thousand United States Dollars (\$1,376,000) in grant funds over a three 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.

2. The project ("Project") consists of support activities facilitating the extension of health, nutrition and sanitation services to low-income Salvadorians in marginal urban and rural areas.

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

a. Source and Origin of Goods and Services

Goods and services, except for ocean shipping, financed by A.I.D. under the Project shall have their source and origin in the United States and countries that are members of the Central American Common Market, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Project shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States.

b. Conditions Precedent to First Disbursement

Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement, the Cooperating Country shall furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(1) Evidence that a Project Coordinator within the Ministry of Health has been named.

(2) Evidence that a Project Committee within the Ministry of Health has been established and is composed of representatives of the Normative, Administrative and Planning Divisions of the Ministry of Health.

c. Condition Precedent to Disbursement for the Emergency Feeding Support Component

Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement to finance activities under the Emergency Feeding Support component, the Cooperating Country shall furnish to A.I.D., in form and substance satisfactory to A.I.D., an agreement between the Ministry of Health and the Ministry of the Interior which sets forth the intended use of the funds and an illustrative budget.

d. Condition Precedent to Disbursement for the Rural Community Maternal-Child Health and Nutrition Centers Component

Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement to finance activities under the Rural Community Maternal-Child Health and Nutrition Centers component, the Ministry of Health shall obtain from the Directorate of Community Development and the National Center for Agricultural Technology (CENTA) and furnish to A.I.D. a list of the 65 communities in which the field agencies are willing to collaborate for the first year of the Project and the name of the collaborator for the Project.

e. Covenants (Urban Health Component)

(1) The Cooperating Country shall covenant that for each area selected for assistance under the Urban Health Component, it shall cause the Ministry of Health to provide:

- (a) a minimum of ten hours of training in urban health problems and community development for a physician, auxiliary nurse and sanitation inspector;
- (b) one week of training for sanitation workers;
- (c) two weeks of training for urban health promoters;
- (d) continuing education of approximately one day per month for sanitation and urban health workers;
- (e) retraining of all personnel after one year.

(2) The Cooperating Country shall covenant that it shall cause the Ministry of Health:

- (a) to pay all costs, salaries and training for the Ministry of Health teams, including physicians, auxiliary nurses and sanitation inspectors, for the life of the Project;
- (b) to pay at the conclusion of the Project all salary costs of sanitation workers trained and salaried under this component of the Project.

f. Covenants (Rural Community Maternal-Child Health Nutrition Centers Component)

(1) The Cooperating Country shall covenant that it shall cause the Ministry of Health:

(a) to provide to the Regional Health Offices and to A.I.D., in form and substance satisfactory to A.I.D., a statement describing the role of the Rural Health Aid (RHA) and specifying the percentage of time an RHA may allot to the activities under this component;

(b) to agree to accelerate the phase-in of the World Food Program support to the existing Ministry of Health Maternal-Child Health feeding program to ensure that the food needs of the target population are met.

(c) to sign an agreement with each community in which a Maternal-Child Health Center is to be located, setting forth the responsibilities for the transport of P.L. 480 Title II commodities from the Ministry of Health distribution point to the community, their adequate storage and management within the community.



Acting Assistant Administrator
Bureau for Latin America
and the Caribbean

April 16, 1980
Date

Clearances:

GC/LAC:JLKessler:  date 4/14
LAC/CEN:MArnold:  date 4/14
LAC/DR:CPeasley:  date 4/15
LAC/DR:MBrown:  date 4/15

Drafted:GC/LAC:DAAdams:ckg:4/9/80:ext:29183

HEALTH AND NUTRITION GRANT PROJECT COMMITTEE

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I. SUMMARY AND RECOMMENDATIONS

A. Recommendations

It is recommended that a grant be authorized to the Government of El Salvador for \$1,376,000 to support actions under the GOES Emergency Plan to respond to health and nutrition needs of low income Salvadorans.

B. Project Summary

Low-income Salvadorans of both rural and urban areas suffer substantially poorer health and nutrition than those of better means. Although the lack of income is in itself a cause of these problems, closely related factors are a lack of knowledge of how to improve one's own health and nutrition status, of motivation to produce such improvement, and of simple access to services. This grant project, to be implemented as a part of the FY 80 Accelerated Impact Plan, consists of three components designed to support GOES and other donor efforts to develop mechanisms of primary health care, promotion, and self-help that will lead to better health and nutrition in low-income populations. In contrast to a traditional paternalistic tendency in the health sector to attempt "to provide health", the two major components of the project require and are based on heavy community participation, not only as a client of the health system but as its supervisor and a provider of services and assistance.

The project components are:

- (1) Marginal Community Urban Health Care^{1/}
- (2) Rural Community Maternal-Child Health and Nutrition Centers^{1/}
- (3) Emergency Feeding Program Support

1. Marginal Community Urban Health Care

The MOH will collaborate with 150 marginal urban communities to make primary health care available to low income Salvadorans in urban slums throughout the country. The community will provide a

^{1/} For the sake of brevity, these components are referred to henceforth as Urban Health and Community MCH/Nutrition Centers

space for a health clinic and labor to renovate facilities, guidance on selection of community-based workers, and continuing support of the operation. Each clinic will be staffed by an auxiliary nurse, part-time physician, sanitation inspector, an urban health aide and three sanitation workers. The Ministry of Health will support salary and training costs of the auxiliary nurse, physician and sanitation inspector while AID funds will finance technical assistance, training, commodities, and salaries for sanitation workers. Urban health aides will receive a PL 480 Title II food incentive programmed under the Government-to-Government Emergency Food Program. A total of 100,000 persons will receive benefits from the component at an AID cost of \$1,100,000.

2. Rural Community Maternal-Child Health and Nutrition Centers

This component supports development of 300 maternal-child health and nutrition centers in poorer remote areas of the country. Each center will provide a combination of basic health and nutrition care, including supplementary feeding; day care and nursery school training; and mother education, for approximately fifty 2-5 year old children who will attend the center for 6 month cycles. GOES agencies will play a supporting role only for the community-operated centers, providing assistance for initial community organization, training of volunteers, basic health care and transport of supplemental foods. AID funds are programmed for technical assistance, volunteer training, and outfitting of the centers. Volunteers will receive PL 480 Title II food incentives programmed under the Government-to-Government Emergency Food Program. A total of 30,000 children and their mothers will benefit from the activity at an AID cost of \$226,000.

3. Emergency Feeding Support

In support of the feeding element of the MCH/Nutrition Centers, other Ministry of Health feeding programs and the PL 480 Title II supported Emergency Feeding Program, funding is proposed under this Project to increase logistic capability of the Food Support Division of DIDECO, the agency responsible for transport of all externally-donated foods. Funding in the amount of \$50,000 is programmed for vehicle purchase or rent and for local materials and equipment for work and training elements of the PL 480 Title II Emergency Feeding Program.

The weighting of the project, in terms of funding, toward the urban area reflects the overall thrust of the Accelerated Impact Plan and complements the continuing focus of AID and other donor project activities to date on the rural areas. Furthermore, other donor supported activities ^{1/} are in this same period supporting acceleration or improvement of their rural health and nutrition efforts. The rural component of the project, the Community MCH Nutrition Centers, reinforces these other efforts while both major

^{1/} World Food Program, Inter-American Development Bank, UN Development Program.

project components demonstrate new initiatives of the GOES to reach the poorest and involve them in the process.

C. Project Issues

Both the Urban Health and Community MCH Nutrition Center components of this project depend heavily upon the community's ability to organize itself around the proposed activities and to provide continuing support for them. The extent to which political turmoil will interfere with an orderly development of project activities by the communities and the GOES agencies is uncertain. Furthermore such community involvement is closely related to the ability of the GOES agencies to assume supporting roles, effectively encouraging the communities to take the lead in implementation.

This project, the Marginal Community Improvement Project (No. 519-0251), and the Emergency Employment Program (No. 519-0256) as well as the PL 480 Title II supported Emergency Feeding Program are mutually complementary and reinforcing. Close coordination will be necessary, however, both in the GOES and the Mission, to ensure maximum aggregate impact.

II. PROJECT DESCRIPTION

Goal

The goal of this project is to improve the health and nutrition status of low income Salvadorans in marginal urban communities and in rural areas through improved access to health, nutrition and sanitation services.

Purpose

The purpose of this project is to develop those mechanisms of primary health care, promotion and self help that will lead to an improvement in health and nutritional status for low-income Salvadorans in urban marginal communities (tugurios), and in rural areas.

A. Urban Health Component

1. Background

A rapidly increasing percentage of residents in El Salvador's principal cities live in marginal urban areas, referred to in El Salvador as "tugurios". A tugurio is typically a collection of squatter shanties built through invasion of pockets of unused land such as public right-of-way, steep gullies of dry river beds. Homes are constructed of cardboard, mud-and-wattle or other temporary materials. No form of tenure exists; servicing (power, water, sewer drainage) is poor to non-existent. Given the continuing heavy influx of rural residents to these tugurios, and the concomitant overcrowding of residents which places excessive demand on already inadequate water and sanitation capability, health conditions are rapidly worsening. This project assists the Ministry of Health establish a program to bring health and sanitation services to residents of tugurios, beginning with the most serious situations existing in the country. The experience gained through these activities can serve then as the basis for expanding the program at a later date.

2. Detailed Description

In direct response to demands made by residents of various tugurios and in line with longer range health plans to provide accessible health care to the total population, the Ministry of Health has developed a Three-Year Urban Health Strategy ^{1/} designed to extend health services to 260 tugurios located in principal cities throughout the five regions of El Salvador. The program is to be implemented in stages, i.e., 75 tugurios in the first year, 75 in the second year and 110 in the third year.

^{1/} AID's support for the activity is planned at this time for a 2 year period- i.e. to cover 150 tugurios.

The first year effort has already begun with the staffing of ten clinics in San Salvador, and planning is underway for the extension of services to 65 additional tugurios (see listing of Phase I Tugurios, Annex C). The target population of the first 75 tugurios is approximately 50,000 people.

a) Tugurio Health Team

To ensure that the MOH clinics are not merely a passive presence but have the capacity to reach into the communities to address health-related problems and promote improved living and health conditions, the MOH will provide the tugurios with health teams composed of an auxiliary nurse, sanitation inspector, part-time physician, community health promoter and three sanitation workers. The MOH has requested AID assistance in staffing, training of the teams, provision of medicines, medical supplies, sanitation equipment and basic furniture.

In areas or cities where there are many small tugurios, the team, with the exception of the health promoter, will rotate between two or three tugurios. In other cities, such as San Salvador, the team will remain full-time in one tugurio. In all cases the doctor will spend two-to-four hours a day in the community clinic, primarily seeing patients. The auxiliary nurse, sanitation inspector, health promoter, and sanitation workers will, on the other hand, work full eight hour days in designed tugurios, carrying out health education and coordinating with other GOES agencies and community groups to improve health and sanitation conditions. The Ministry will fund salaries, logistical support and training of the doctor, auxiliary nurse, and inspector.

The role of the auxiliary nurse is critical to the success of the team. Her responsibilities include assisting the physician, providing direct patient care in the physician's absence, working with the community health promoter and sanitation workers in health education, promotion and prevention, and functioning in a liaison capacity with the promoter.

The health promoters will work full time in the tugurio in which they live. Their functions will focus on screening, referrals and health and sanitation education. The MOH proposes to reimburse the promoters with an incentive food ration from the PL 480 Title II Emergency Food Program. In this way, the health promoters will be identified as a part of the "community clinic" rather than the official MOH system, an independence which could increase their credibility in the tugurios.

The sanitation workers, in contrast, will be employees of the MOH and will be paid the minimum wage by the MOH. Although they also will come from the tugurios and their scope of work may include a number of tugurios, depending on their size and population, it is anticipated that each team of three sanitation workers will cover two to three tugurios on a rotating basis. As a team, the sanitation workers and sanitation inspectors will provide environmental education to the community in

the disposal of waste and assist in the construction/maintenance of latrines; provide protection of water supplies; and implement community education campaigns and vector-borne disease control.

The urban health promoter is modeled largely after the existing rural health aide program. Health promoters will be provided a uniform and will work with the auxiliary nurse in providing services on a house to house/family to family basis, and in developing effective referral mechanisms. Furthermore, the RHA effort provides additional spin-off to the tugurio health and sanitation project in the form of a set of management information forms, referral cards, patient tracking systems and a methodology for development of curriculum and training of community workers.

Involvement of the community in the selection of the health promoters is regarded as critical by the MOH if the promoters are to gain acceptance and credibility in the community since residents of the tugurios are suspicious of government-sponsored activities, due in large part to previous political actions and unmet promises.

The health team will be technically supported by the local health unit (Unidad de Salud) which will provide part-time services of a graduate nurse, nutritionist and health educator. Services provided by the health team in the community will be both curative and preventive, the latter to include health education, vaccination, environmental health, nutrition, maternal and child health, and family planning.

The ability of the team to carry out the above, however depends on the health promoters and sanitation workers. The fact that a clinic is opened in the tugurio has little to do with the communities' utilization of that facility, especially if it is seen merely as another government program. The outreach effort, largely through home visits, of the health promoter and auxiliary nurse is designed to significantly increase utilization of the health post, improve the health and hygiene of the community, and span the gap between the formal health system (MOH component) and the people in the tugurios.

The health team will establish working relationships with traditional health providers in the community, including traditional midwives. These women, who are not formally trained, assist with the majority of births in the tugurios. Since the midwives are already accepted in the community and have credibility among the population where the community health promoter lives and work, it is important that the promoter gain their confidence and be perceived by them as a facilitator rather than an obstacle to their work. By assisting the midwife, for example in the referral of complicated births or pregnancies to the hospital or to the MCH physician, by arranging immunizations and nutritional supplements for children, by assuring birth and death registrations, and in carrying out health education, the health promoter can gain credibility while

expanding the service capacity of these other promoters. Although this project will provide no direct funding for formal technical training of these personnel, if the appropriate relationship is established, the visiting health teams will be able to provide on-the-job training to them.

Services will be provided out of very basic clinic facilities constructed or developed in the community and equipped with medications and health education materials. Because of the scarcity of land in some of the tugurios, the physical facility may be little more than one room made out of cardboard. In such cases, much of the community teams's activities will focus on home visits and referral services.

b) Training

An initial training program for the physician, sanitation inspector and auxiliary nurse element of the team has been developed for the Ministry of Health by the Faculty of Medicine of the University of El Salvador. The course, which began March 10, focuses on urban problems and community development and organization and is being attended by health team members from El Salvador as well as by representatives from the four other health regions. Attendees will then be responsible for training team members in their region.

The Ministry of Health is currently developing the two-week training program for urban health promoters, using elements of the curriculum and program developed with AID assistance for the rural health aide program and designed to meet the special needs of working in a tugurio. The training, to be carried out regionally, will be done by members of the health team (doctor, auxiliary nurse and sanitation inspector) bolstered by specialists (health educator, nutritionist, and graduate nurse) from the regional health staff. Beginning with an orientation to the most important health problems in the tugurios and community involvement, the training will focus on areas such as upper respiratory illnesses, gastro-enteritis, immunizations for children under 5, basic sanitation, first aid, family planning promotion. Basic diagnostic skills rather than direct patient treatment will be emphasized so that the community health promoter can refer patients upward when appropriate, e.g. for treatment of parasitic infections, or secure help from other members of the health team, such as for family planning services, diarrhea medication, or removal of an acute sanitation problem. At this level of training, it is neither reasonable nor advisable to have the promoters render treatment. Once health promotion services are being provided effectively by the community health promoter, however, the Ministry will consider adding other components of health service delivery, perhaps even direct patient treatment, to the training. The MOH will provide all promoters with one day a month of continuing health education, periodically to be conducted with that of other team members to increase team coordination and appreciation of complementary roles of team members in addressing tugurio health problems.

Training for the sanitation workers will also be carried out regionally. The proposed five-day course will include an orientation to the project, collection and disposal of trash and garbage, disposal of wastes, elimination of causes of vectors and rodents, an introduction to potable water supply systems and their maintenance, and control of rabies and diarrhea. The principal trainer will be the sanitation inspector who will also be responsible for providing a day per month of continuing education to the workers.

Finally, funds are included for training and salary of an urban health project coordinator who will be responsible for liaison with the MOH and health and sanitation workers, as well as for on-going monitoring and evaluation. He or she will participate in the community health promoter training course. In the event that this person has had only a minimum amount of training or experience in community development, funds have been budgeted for third country training in this area. The coordinator's ability to work closely with the health and sanitation workers and assist them in the community development aspects of their jobs is critical to the success of the program, especially considering limited training of the workers in this area.

c) Importance of Community Participation

Experience in primary health care programs in other countries emphasizes the importance of community participation and involvement in community-level health activities to achieve the understanding, acceptance, and support of the residents for the services that are being provided. In a sense, then, the residents of the tugurios themselves become the primary supervisor of their health workers, with back-up support provided by the MOH teams. All training programs will emphasize the promotion and monitoring of this involvement.

3. Relationship of Project to AID Country Development Strategy and other Agency Urban Health Projects

The decision to begin an urban health program with extension of primary health care to marginal urban areas is based on the following factors:

- a) a rapidly growing poor urban population that does not utilize the formal health system;
- b) a need to extend services to this population group immediately; and
- c) a public institutional structure that is in need of improved management and management information skills in order to control adequately a larger, diversified national health program.

The urban tugurio health program thus must be seen as only one step of a national effort to extend health services (environmental, curative, preventive, nutritional) to the unserved and underserved urban and rural poor. Measures taken under this project should not only extend health services, but should serve as a basis for the development of training programs and a more efficient organization within the Ministry of Health.

In San Miguel, El Salvador's second city, the Inter-American Development Bank is constructing a hospital adjacent to the city's worst/largest tugurio, La Corruncha, which is one of the targeted urban areas for this project. In La Corruncha itself, a building is being renovated with MOH funds which will serve as the local "health post" and a key delivery point in San Miguel. The hospital, once completed, can serve as a major component of the MOH health delivery system. Furthermore IDB is beginning a large scale (\$10 million) third phase of assistance in development and renovation of health spots, units and centers. This planned expansion of infrastructure underlines the need for improvement of management, planning and training areas of the health system, a need addressed in programmed FY 81 AID assistance to the GOES Ministry of Health.

The IBRD is currently planning a second phase of an urban housing project for marginal areas which will include construction of some community health facilities. Experience gained in the present AID supported urban health project should be useful in selecting sites, services and outreach methodology.

4) End of Project Status

By the end of this activity the following accomplishments are expected to be achieved in the target communities:

- a) an administrative and managerial support mechanism in place within the MOH, both to support those workers funded under this project and to assist with its expansion in other tugurios;
- b) administrative procedures and cooperation established with other USAID/MOH/GOES municipal programs;
- c) a curriculum for training urban health and sanitation workers developed;
- d) broad utilization of the health clinics by residents of the tugurios, which would imply an acceptance of the clinics and providers;
- e) an established system for information gathering referrals, and communication established for the tugurio health system;

f) satisfactory working relationships between community health and sanitation workers, and the health clinics (staffed by physicians, nurse auxiliaries, and sanitation inspectors) established to effectively coordinate health education/prevention activities of MOH;

g) community organizations in each (project-related) tugurio established to support the health team. Many of these organizations will even have a Community Board with well-defined responsibilities in the areas of community relations, needs, assessment, etc.;

h) trash and garbage system for disposal/storage and transportation to designated pick-up locations initiated, and coordinated with municipality for regular collection;

i) health education campaigns planned, developed, and implemented in community hygiene, nutrition, and in public health and sanitation.

B. Community Maternal-Child Health/Nutrition Centers 1/

1. Background

El Salvador's nutrition problem is well documented. Population statistics for 1979 for El Salvador show an under-five population of 830,070, 67.7% of whom or 652,735, live in rural areas. An INCAP study made in 1975-76 of nutrition status in El Salvador indicated that nearly 75% of that age group suffered from some degree of malnutrition. Rates of second and third degree malnutrition were found in 22.15% of the group 2/, a level of severity that ranks El Salvador with such countries as Haiti and Bangladesh.

These rates have been confirmed as well by the Ministry of Health's nutritional surveillance system based on children seen in MOH facilities. In 1978, an estimated 40% of the under-five child population visited MOH clinics. Of the 33,545 who came for initial consultations, 21.5% were in second or third degree malnutrition and suffered from serious diarrhea.

The INCAP data further showed that malnutrition was more acute in rural areas, especially in the Northern and coffee and cotton-growing regions of the country where incidence is as high as 76%. It is hypothesized that these high malnutrition rates in the coffee, sugar cane and cotton areas reflect in part the abandonment of young children to inadequate caretakers during the harvest, a practice which combines with poor living conditions among migratory workers to produce an alarming degree of malnutrition.

Nutrition surveillance data reveal highest rates of second and third degree malnutrition among the under-five year olds in June and July; 31.6% and 32.1% in rural areas compared with a national prevalence in those months of 27.7% and 26.6% respectively. Diarrhea, both a cause and effect of malnutrition, is most prevalent in May in the rural areas. Exacerbating the nutrition problem in June and July is the fact that family stocks of corn and beans have run low and unemployment is markedly high. Finally, in rural El Salvador only an estimated 25% of the populace has access to safe water and only 17% has adequate means of waste disposal.

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- 1/ The Centers which are essentially broadened day-care facilities, are known in El Salvador as Centros Rurales de Nutrición. Given the fact that nutrition is only one of their multiple functions, for improved understanding of the activity USAID has chosen the title Community Maternal-Child Health/Nutrition Centers. This reflects as well their focus on a major part of the Maternal-Child Health (MCH) target group, i.e., pre-schoolers and mothers, and the emphasis on health rather than illness.
- 2/ Gomez grades of moderate or first degree malnutrition, under 90% weight for age; serious or second degree, under 75% of body weight; and severe or third degree, under 60%.

Malnutrition acts synergistically with communicable and diarrheal illness to exacerbate malnutrition, and vice-versa, with a direct effect on morbidity and mortality rates, especially among the under-five population which is the most vulnerable to infectious and parasitic disease. Maternal malnutrition contributes further to the likelihood of early infant susceptibility to disease and malnutrition, resulting in low birth weights and increased mortality risk during the first year of life. Moreover, the survivors' future life is affected by the physical and mental mortgage of early malnutrition. As a result nutritional problems are, in El Salvador, as in other developing countries, among the primary causes of morbidity and mortality for this age group.

El Salvador's long-standing nutrition problem is primarily related first, to social and economic inequities that result in an inadequate consumption of food; and second, to health conditions, such as fevers and diarrheas that rob the body of nutrients from what food is consumed. Dr. Juan Alwood Paredes, Food and Nutrition liaison to the Ministry of Planning, estimates that a basic family diet, including fuel for its preparation and a small amount of "gratification food", would cost 684 colones annually per capita (\$274).^{1/} Nonetheless, 40% of the population received less than \$194 in 1977 prices.

The most recent food balance sheet^{2/} in El Salvador shows a higher per capita availability of calories and proteins than was the case for previous years. Since levels of malnutrition have remained about the same over the period, however, it is apparent that increased food ability is not necessarily translated into greater food availability to remote areas and the poor, or into effective utilization of the food that is available.

The Health Sector sees its role in the Nutrition Sector to be that of improving the use of food at individual, family, and community levels, while simultaneously drawing the attention of other sectors to the food and nutrition requirements of the population. In this effort the Ministry of Health recognizes the importance of working on a multi-sectorial basis and the key role of community participation in the search for desirable actions and their application. Yet to date health and nutrition efforts have been unilateral and without a focus on community development. This project represents an initiative by the Ministry of Health to break this pattern in order to meet increasingly serious health and nutrition needs.

2. Relationship to Other Donor and AID Programs

The proposed Community MCH/Nutrition Center component is the smaller element of a two-part strategy of the Ministry of Health under

^{1/} Costos de la Alimentación Básica en El Salvador, 1979.

^{2/} Hoja de Balance Alimentario, 1978 - Suministro Neto Diario Alimentos per capita, Sección de Indicadores Económicos y Sociales, MINPLAN 31/1/80.

the GOES National Emergency Plan to promote education, nutrition and health through directed supplementary feeding to the most vulnerable parts of the population. The centers complement the major part of that strategy a large-scale mother/child feeding program supported by World Food Program and being carried out in the majority of MOH facilities. As a key part of the Emergency Plan, the MOH is strengthening the MOH feeding program, which was until recently completely supported by CARITAS, by accelerating the phase-in of World Food Program support to reach an increased number of beneficiaries with substantially larger rations. Furthermore, to ensure that the MOH feeding system works more effectively than it has in the past, USAID is supporting the construction of storehouses at the health facilities through the Emergency Employment Generation Project. Under a third component of this project, USAID proposes logistic support for the Food Division of DIDECO, the Ministry of the Interior's Community Development Agency that will be responsible for the logistics of food programs for all the aforementioned agencies.

The Community MCH/Nutrition Center activity will be an integral part of the Ministry of Health MCH/Nutrition coverage of children and families. In contrast to the MOH/WFP supported program which focuses on feeding of pregnant and lactating mothers and malnourished children, especially under the age of three, the Community MCH/Nutrition Centers are designed to provide nutrition, health and educative attention to one part of the MCH target group, i.e., the 2-5 year olds for whom a gap in services has existed. 1/ More importantly the Community MCH/ Nutrition Centers are designed to focus the community on nutrition and health needs of their children and the health status of the population.

The centers will be located, at least in the initial phase, in areas to which MOH outreach workers, Rural Health Aides, are assigned. By providing to the RHA's a more concrete base for their promotion efforts the centers will strengthen the work of the RHA's in both nutrition and community development, areas in which a recent MOH evaluation indicated need for improvement. As a liaison from the Center to the Health System, the RHA will visit the centers regularly, serving as a technical consultant and referral agent to the Centers. The Centers will, however, be run by the volunteers and the community.

3. Detailed Description -- Community MCH/Nutrition Centers

Under this component 300 Community MCH/Nutrition Centers are to be established in rural areas of the country over the life of the project. A total of 70 centers are to be initiated in the first year with 100 more in year two and another 130 in the third year. The activity builds on experience with similar centers in Honduras and with a pilot activity of four centers begun in late 1979 in El Salvador with

1/ Health facilities are considered to exist within "reasonable access" to most Salvadorans, meeting needs especially of children under two and pre- and post-natal care of women. Such access is defined by the MOH as one-half hour from all residents. It should be noted, however, that roads and paths are very rough in some areas and impassable in some months. See Social Soundness Analysis for further discussion of access.

UNICEF support. Each Center will offer feeding, primary health care and nursery school activities 1/ designed to stimulate learning for fifty 2-5 year olds who will attend the centers for a six month period. Simultaneously the Centers will provide health and nutrition education and promotion to mothers and other family members. The Centers, to be largely supported by the communities, will provide both a stimulus and a channel for focusing parents and communities on means easily within their access of improving the well-being of their children.

The Centers will serve as well as a focus for other health and development actions that can improve living conditions of the community. The Ministry of Health plans to give priority to installation or improvement of potable water systems in communities in which the Centers are or will be located; and the Regional Development Committees 2/ will explore possibilities of focusing productive enterprise assistance and access road improvement efforts to these areas.

Successful implementation of the activity is dependent on community cooperation. Such support will be promoted initially by the GOES community development organization, DIDECO, working in close coordination with the Ministry of Health. Once funding is obtained, DIDECO personnel will promote the project in communities where a community development program is on-going or planned. 3/ In responsive communities, DIDECO and MOH personnel will then arrange with the community for use of a facility for the center, necessary improvements or renovations to it and assist the community in selection of a staff of 3-5 volunteers to staff and administer the center. They will also arrange for donation of local foods for additional support of the center's feeding program beyond that provided with limited P.L. 480 Title II support. Training of volunteer staff and Center supervisors will be carried out by the MOH in already established regional health training centers according to the schedule included in the Implementation Plan. Volunteers working in the Centers will receive an incentive food-for-work ration provided under the Government to Government Emergency Feeding Program, (see Annex D which provides criteria for selection of communities and children, and ration details).

The Centers will operate initially for a four-hour period 5 days a week, providing to pre-school children both preventive and curative health attentions including immunizations, nutritional surveillance, hygiene and nutrition promotion, treatment of diarrheas and respiratory ills, deparasitization and worm treatment. All of these activities can be carried out by the Center volunteers in consultation with the Rural Health Aide, or by MOH health teams involved in special campaigns such as immunization or nutrition promotion. The Centers will

1/ Technical assistance will be provided to the Ministry to develop a program of psycho-motor stimulation designed to enhance learning and social capabilities of the children and to orient parents, primarily mothers, to improved child care.

2/ Including representatives of the Ministry of Health, DIDECO and the Ministry of Agriculture.

3/ In many communities in which a development program has been launched, a community-based health committee often exists which will facilitate the activity. In others the Community MCH/Nutrition Center idea may provide necessary impetus for formation of such a committee.

also provide an opportunity for education of mothers in recognition of child ailments needing medical attention, and a basis to facilitate referral of such cases into the health system.

The Centers will provide a snack and lunch each day consisting of 40% of the normal caloric requirements for a 2-5 year old and 60% of the protein requirements from a combination of P.L. 480 Title II foods (milk, rice, corn and vegetable oil) and domestically provided foods to the extent available (fruits, vegetables and sugar). Parents, primarily mothers, will participate on a rotating basis in preparation of the foods for the children, a further orientation to improved means of child care. Local support of the food program will be difficult in some areas, especially at certain times of the year. In these areas, a special effort will be made by the MOH, DIDECO and cooperating Ministry of Agriculture extension agents to encourage community action to plant gardens, raise chickens or rabbits, or otherwise develop local resources to meet the needs of the Center. 1/ Rations are planned for two six-month cycles of children per year, or for 100 annually, in each of the centers. The volunteers will be paid in Title II food for half time work in the Center. DIDECO 2/ will receive the food in port, arrange transport and storage for the Title II foods to the health post nearest the Center. Parents and other interested community members will then be responsible for pick up and delivery of the food to the Centers.

Title II foods for 2-5 years old include: 70 grams of corn, 30 grams each of rice and NFD; and 15 grams of oil; or a total of 594 calories and 19 protein grams. The additional sugar, fruits and vegetables expected to be supplied locally would bring values up to over 700 calories and 26 protein grams meeting 50% of caloric requirements for 2-5 years old and 86% of protein requirements. Local value of the Title II food is approximately \$0.12 a day per child (See Annex D).

This grant activity includes provision for the purchase of renovation materials such as roofing tiles that are not available locally to ready the community-provided facilities, as well as simple cooking and eating ware, first aid kits, scales and measuring tapes and boards.

4. End of Project Status

The Centers are designed to stimulate improved nutrition and health care for children in general in the community. Although efforts will be made to include malnutrition (first or second degree) children or those in greatest risk of malnutrition in the program, primary emphasis will be placed on improving the well-being of all children and

1/ Such actions are potentially useful in increasing local resources for supplementary feeding in general in these areas in which such assistance is most needed.

2/ DIDECO has been designated overall responsibility of logistic support of all feeding programs in country.

securing community support toward that end rather than on spotlighting needs of a few. Nonetheless as a result of feeding and health measures as well as mother education an improvement in nutritional status is anticipated in 70% of the malnourished entrants to the Centers. An improvement in health of siblings of these entrants is expected as well from improved child care skills of mothers.

Staff for the Centers, consisting of 1200 volunteers (3-5 per Center), will have been trained by the MOH in 10-day to two week courses emphasizing food handling, health referral indices, first aid and techniques for stimulating the development of post-toddler pre-schoolers and supervision in the 300 centers. The Ministry will carry out refresher training once a year and train replacements as required.

A total of 30,000 children will have participated in center activities for a 6-month period and received rations meeting at least 60% of the protein requirements and 45% of the calorie requirements.

Some of the more successful village units will be used to develop models for community health nutrition planning, following the emergency period, an effort that can benefit and be benefitted by close coordination with GOES office of Nutrition Planning and Coordination, OCOPAN which is also receiving USAID support. 1/

An intensive joint (AID/MOH) evaluation is proposed for the MCH/Nutrition Center Activity to assure that the purpose and capabilities of the experimental activities are regularly assessed and reoriented if necessary. During this process, OCOPAN will be requested to participate and will coordinate community nutrition planning activities in the villages that have been selected.

In terms of all needy rural children, ages 2-5, this program will cover nearly 30,000 or 1 in 10. Nutrition data indicate it is younger part of this age group in El Salvador, as well as in most other countries which is often most vulnerable to malnutrition since elder children and infants claim or are given more feeding attention. The Centers will provide food, health attention and direct play activities to this pre-school group in order to enhance their learning capabilities. Although the criterion for community selection is oriented primarily toward community development as opposed to community nutritional status, the priority areas are those of lowest income and highest rates of malnutrition. The Centers will refer the smallest, most vulnerable infants and children, and those suffering from acute malnutrition requiring medical attention to health posts and/or hospitals for care.

1/ Nutrition Improvement Project, a three year grant (1978-1980) to the GOES Ministry of Planning designed to improve multi-sectoral nutrition planning through work of interministerial committees in the areas of nutrition planning (OCOPAN), nutrition education; rationalization of supplementary feeding, and industrialization of tortilla flour.

III. ANALYSES

A. Marginal Community Urban Health

1. Technical
2. Social Soundness
3. Economic

III. ANALYSES

A. Marginal Community Urban Health

1. Technical Analysis

a. Summary Assumptions

The MOH's 1979 evaluation of the Rural Health Aide Project ^{1/} indicated that the program has resulted in greater use of rural health facilities in areas where these workers are posted than in other sites. This is due to the home visits made, resulting in many referrals upward to the next level. Taking the experience of this rural program into consideration, the following assumptions as to technical feasibility of the proposed activity can be made:

- 1) The Government of El Salvador has a demonstrated commitment to the extension of health services by non-physician personnel to low-income residents in rural areas and can use this experience to initiate services to the population in marginal urban communities;
- 2) Although short of trained manpower and resources at all levels, the MOH possesses the basic capabilities and the will to achieve its stated objectives, given added resources in this key program area;
- 3) Staff are available within the MOH system for reassignment to this priority program.
- 4) Considering the scarcity of resources, the use of para-professionals (health and sanitation workers and auxiliary nurses) is the only feasible way of providing accessible services at a reasonable cost;
- 5) The rural health aide program only utilizes health assistants; this program will use urban health promoters, urban sanitation workers and auxiliary nurses. It is expected that they will each be mutually reinforcing of the other, and that together they will have a greater health impact on the population they serve;

^{1/} Under the Rural Health Aide Program, begun in 1975 with AID assistance, more than 300 community-based aides have been trained in promotion and delivery of health, family planning and nutrition services. The aides are sited in remote rural areas of the country.

- 5) By providing needed resources and minimal technical assistance, AID can effectively assist the MOH's initiation of an urban health delivery system for marginal communities.

With these assumptions in mind, and taking into consideration the constraints mentioned at the end of this section, the proposed two-year program of assistance is regarded as technically feasible.

b. Technical Design: Proposed Specific Project Inputs

This section of the report describes the specific project inputs developed in consultation with the MOH. These project inputs fall into two major categories:

- 1) Human Resources
- 2) Logistics, Medical Supplies, and Equipment Support.

Within these major categories, the specific activities and inputs proposed are as follows:

Human Resources

Training of urban health project coordinator
(Salvadoran or 3rd country national)

Technical Assistance of an evaluator on a short-term basis

Support for a two year period for:

Sanitation workers (72)
Urban Health Project Coordinator
Health promoters (150) (through the P.L. 480
Title II Food-for-Work Program)

Logistics, Medical Supplies and Equipment Support

Drugs and vaccines (medications)

Sanitation Equipment (picks, shovels, trash barrels, wheel barrows, insecticide sprays, lime, etc.)

Health and Education Material

Uniforms for 150 community health promoters and 72 sanitation workers.

Furniture, i.e., tables, chairs, etc.

In this section the individual project inputs and activities are described in narrative form. The budgetary listing of these inputs can be found in Section IV Financial Plan; the timing and schedule of project inputs and activities, in Section V, Implementation Plan.

Human Resources Development

This component emphasizes the training and placement of community health promoters and sanitation workers in marginal urban areas where they will provide outreach for the formal MOH health delivery system and increase the capabilities of the MOH to extend services into urban areas now largely without health services.

Technical assistance is proposed for the project to strengthen management and health delivery capacity of the Ministry. Funds have thus been included to contract a full time coordinator for the urban health activity. This person should be college educated, have excellent inter-personal skills, and be willing to visit on a regular basis the tugurios where community health and sanitation staff are working. A sample job description for this individual is included as Annex E.

Furthermore, over the two-year period of this program, 36 work days have been allocated for short-term technical assistance in evaluation. The evaluator's job description is outlined in Section II, Evaluation Plan.

Logistics, Medical Supplies, and Equipment Support

Annex F details the logistics and equipment support proposed to give sanitation workers a minimal level of basic equipment, to provide medical supplies for use of the MOH teams in the clinic facility and for home visits, and to furnish the clinics.

Drugs and Vaccines (Medications)

Annex G provides a list of drugs and vaccines prepared by the MOH to cover the 33 teams during the first year. This list was compiled from a formulary recommended by PAHO.

Sanitation Equipment

The sanitation teams, recruited from the tugurios in which they live, will be provided with simple hand tools and supplies, including picks, shovels, trash containers, wheel barrows, insecticide sprays, lime for pit latrines, etc. The sanitation teams, working in cooperation with the health teams, will sponsor community campaigns in trash collection and removal, protection of water supplies, and health promotion.

Health Education Materials

Simple teaching aids are programmed for both the MOH and the community health and sanitation teams. While some of the inputs will be used in the initial training program, most are designated for the health clinic, for the teams' use in the communities and in continuing education for the health and sanitation workers, e.g. illustrations of vector borne diseases on flannelgraphs, posters showing activities relating to community hygiene, etc.

Uniforms

In the MOH Rural Health Aide program uniforms are supplied. This helps establish a special identify for the aides and probably adds to this person's self-esteem and pride in the work place. Funds are thus programmed to purchase 75 uniforms (such as jackets) for the community health promoters, 75 replacement uniforms as needed, and 75 uniforms at the end of one year for the new health promoters.

c. Technical Feasibility Analysis

A technical analysis of the project leads to a positive conclusion as to its feasibility. Such a conclusion takes into account the constraints discussed below.

The major constraints to goal achievement in the area of human resources include: (a) an insufficient number of trained health workers who are experienced and enthusiastic about working in poor communities (tugurios); and (b) the inadequacy of financial resources available for supporting the technical and salary costs of the community health and sanitation workers.

In response to (b), the provision of financial assistance to pay the salary costs of 72 sanitation workers, provide food reimbursement for 150 health promoters, and salary for one full time coordinator, will enable the MOH to realize its goal for the initial extension of health services into the tugurios. The MOH has already programmed this expansion; AID funding will make it possible.

The degree of success/effectiveness of the project could be hampered by the following broader constraints which will need to be carefully monitored:

1. The difficult political situation in the country has caused increasing problems in the administration of the MOH and its facilities; the emphasis on short-range, high impact programs creates a potential for inadequate planning, organization and control of project implementation.
2. Political constraints have made community action/organization efforts inadequate.
3. Incentives for the auxiliary nurses who will work in the marginal urban areas on full-time basis are potentially inadequate.
4. A lack of coordination exists with current and planned community development efforts and other programs in the tugurios.
5. Health team members are inadequately trained in community development/organization, i.e., how to get the community residents involved.

Several steps are being taken by USAID/ES, in coordination with the MOH, however, to minimize the impact of these constraints and maximize the project's possibilities for success.

1. To compensate for deficiencies in MOH project management and control, support is proposed for an Urban Health Project Coordinator (Salvadoran or 3rd country national) who will provide day-to-day liaison with the MOH teams; the marginal urban community health and sanitation teams; and the MOH.
2. Discussions with MOH have been initiated to address the difficult problem of incentives for auxiliary nurses who

will work in the urban tugurios. The MOH understands the difficulty of their adjustment to this new environment and the importance of avoiding high turnover. The auxiliaries' ability to adapt and work enthusiastically in the community is critical to the program's success. The MOH is considering alternative incentives in addition to a training program designed to facilitate the adjustment. As part of AID's monitoring responsibility the Mission will pay close attention to the effectiveness of the auxiliary nurses in the tugurios. The need for additional incentives will be reevaluated as a part of the first year evaluation.

3. To coordinate inputs of this project with other USAID efforts in urban communities, the teams designing the "Marginal Community Improvement Project" and the "Employment Generation Project" have discussed means of melding the physical infrastructure components of those projects with the human resource and maintenance features of this activity.
4. Through efforts of the Urban Health Project Coordinator and the MOH, in-service training in community development/organization will be provided as needed through the continuing education sessions.

2. Social Soundness Analysis

a. Accessibility vs. Utilization of Health Services

This project will assist the MOH in making primary health care and environmental services more accessible ^{1/} to unserved or underserved marginal urban dwellers living in San Salvador and San Miguel.

More important than mere accessibility, however, is the level of acceptance, and by logical extension, the utilization of the services. The potential beneficiaries often have recently arrived in the city from rural areas and carry with them a host of traditional beliefs and practices related to solving or preventing health problems. Observers report that although there is no strong aversion to modern curative medicine, it tends to be utilized as a solution of last resort. Traditional home remedies are used first. When this fails, advice and/or treatment from neighbors or traditional practitioners (e.g. midwives, urban curanderos, inyeccionistas, etc.) in the community is sought. Finally, the decision to use the hospital or clinic is taken. Although this pattern of utilization is not unusual for both developing and, to some extent, developed countries, it is coupled in El Salvador with suspicion and occasionally

1/ "Accessibility" is thought to have at least 3 parameters (1) short travel time to the source of services; (2) short waits to be attended; and (3) appropriate contact time with the provider.

outright rejection of government-provided health care at the community level particularly for preventative health care such as immunizations. Some observers have noted that marginal urban dwellers have regarded governmentally-directed services at the community level as palliative, politically motivated and at best, poorly executed. All of these criticisms may be true in varying degree.

There is evidence, however, that community-based health workers in El Salvador, with adequate training and sufficient time to gain acceptance in their communities, can modify utilization patterns of accessible MOH facilities and services. A sample survey in 1979 1/ of 719 households, representative of communities and families served by the Rural Health Aide (RHA), showed that these community-based workers had a 60% success rate in convincing families to use preventive services (well-child, pre/post natal, immunizations) available at the nearby health post or health center. Further, there were significant differences in referral success rates between more and less experienced groups of RHA's. Workers with longer work experience were significantly more effective in persuading their client families to use clinic services, both preventive 2/ and curative.

Finally, the 1979 Survey results support the general conclusion that the RHA through their outreach efforts were gaining increasing acceptance and effectiveness in linking rural families with government health services. It is reasonable to expect, therefore, a similar evolution of the degree of acceptance of the urban health workers by tugurio dwellers, increased utilization of available government health services and an improvement in appropriate use of available government health services in terms of (1) level of contact, i.e. hospital, health center or health post; and (2) preventive (e.g., family planning, well-baby, prenatal) as well as curative services.

b. Impact on Women

Estimates in 1976 indicated that 63% of women in urban areas were economically active. This makes it likely that a woman may choose to ignore (or at least delay attention to) her health problems and those of her children if services are not readily accessible, because of the possible loss of income during visits to the clinic or hospital. Delays in seeking attention for health problems were borne out by a survey in 1976 3/ in which health professionals consistently reported that patients, both adults and children, would invariably seek treatment at very advanced stages of the disease or condition.

1/ MOH Evaluation of the Rural Health Aide Program.

2/ It should be underscored that referrals for preventive services are relatively more "difficult" than for curative attention. The decision to take a well child for a check-up is very different than that for a child with a broken limb or a badly infected cut.

3/ "The Social and Cultural Context of Health Delivery in Rural El Salvador: Implications for Programming." Polly Fortier Harrison, El Salvador, 1976 AID Contract No. 519-127.

An estimated 80% of the morbidity in women and children in developing countries is technologically simple to deal with. Auxiliary nurses and health aides can easily and effectively diagnose and treat diarrheas, colds, simple trauma such as cuts and burns, etc. Locating a health clinic in the marginal community, staffed by a full time auxiliary and part-time physician, as well as the outreach activities through home visitation by the health promoter and auxiliary nurse should serve to minimize the economic loss to women that illness represents.

The project may also serve as a source of employment and additional education for women recruited as health promoters. Indeed, the 1979 RHA survey showed that women RHA's were generally more effective than males in getting other women to seek services for themselves and their children.

c. Impact on the Community

Community involvement is an important feature of this project. A survey completed in 1977 concluded that any effort to improve living conditions in urban tugurios will be feasible only if the community perception is that it was their idea and if they have control over the implementation. Establishment of certain of the health clinics responds directly to community requests for such a facility. These communities will be asked to provide a suitable space, perform any required renovation, and establish a committee or board to advise MOH staff on the health post. This board is also expected to be helpful in interpreting to the community the nature and importance of the outreach efforts of the health aide and sanitation workers, as well as in the recruitment and selection of these workers.

In tugurios where residents have not articulated a request for the establishment of health facilities, the process of stimulating community involvement will be more difficult. The MOH, nonetheless, has developed plans to stimulate the necessary community organization to obtain this full community involvement.

3. Economic Feasibility

It is impractical to impute a cost effectiveness value to this investment. Effectiveness can only be attributable to patient satisfaction, provider efficacy, and the institutional strengthening of an outreach capability. All these may be determinable, to some tenuous extent, at the project's conclusion. At this point, the cost is known and the effectiveness of the investment can only be assumed. Social programs such as this cannot be justified in cost terms alone; they are either worth doing on the sheer basis of obvious need, or they should be passed over for some other social opportunity.

Cost effectiveness in this activity results primarily from two factors: (1) the use of inexpensive community health and sanitation workers rather than physicians and nurses to provide health and sanitation services, and (2) "piggybacking" on the existing urban health system that permits elimination of expensive start-up costs, training and support costs.

A "benefit-cost" relationship which is both descriptive and quantifiable in illustrative terms is the more important consideration with regard to this project. It consists of the following:

a. Benefits

1. Extension of health and sanitation services to unserved areas.
2. Community participation/organization.
3. Improved and expanded referral services.
4. Physical presence of health and sanitation workers 24 hours/day in the community.
5. Development of linkages between health worker, mid-wife and formal MOH system.
6. Creation of operational linkages between MOH, municipalities and community development agencies.
7. Development of potential urban outreach capability for MOH.

B. Costs (AID project related costs only)			
	<u>1st. Yr.</u>	<u>2nd Yr.</u> ^{1/}	<u>T O T A L</u>
1. Human resources			
Community health promoter ^{2/}	(PL 480, Title II)		
Sanitation aides ^{3/}	56,160	126,144	\$ 184,304
Project coordinator	<u>10,000</u>	<u>11,200</u>	<u>21,200</u>
Human Resources - Sub-total	66,160	137,344	\$ 203,504
Benefits (30%)	<u>19,848</u>	<u>41,203</u>	<u>61,051</u>
Human Resources - TOTAL	86,008	178,547	\$ 264,552
Project evaluator (2 trips)	5,000	5,600	10,600
2. Medications	400,000	300,000	700,000
3. Sanitation equipment	25,579	29,568	55,147
4. Medical equipment	9,524	10,667	20,191
5. Uniforms-community health promoter (\$28.00 each)	2,100	4,704	6,804
6. Furniture for health clinics	12,750	14,280	17,030
Tables)			
Chairs) 75 clinics (1st. yr.)			
Benches) 75 clinics (2nd yr.)			
7. Health education materials	1,000	2,240	3,240
8. Training: Project Coordinator	3,000	-	3,000
9. Contingency (Training)	<u>5,000</u>	<u>4,436</u>	<u>9,436</u>
T O T A L S	\$549,961	\$550,039	\$1,100,000

1/ In the 2nd year, wages and commodities are increased by 12% for inflation.

2/ 75 the 1st. year/150 the 2nd. year.

3/ 36 the 1st. year/72 the 2nd. year.

Any economic feasibility study done at this time in El Salvador must take into account the difficult financial situation in which the Government of El Salvador finds itself. 1/ Although the MOH budget has increased every year for the past four years, that is unlikely to be the case in the two years of this project. Given the situation, this project has been structured in a way that is economically feasible for the MOH. The Ministry's contribution to this project is significant (\$887,000 in salaries alone) but it largely entails a reallocation of expensive resources (doctors and sanitation inspectors) and the addition of inexpensive resources (health and sanitation workers) in a way that will extend services and maximize the use of the expensive resources. To further minimize the MOH financial burden, the health promoters (150) will be reimbursed with food from the P.L. 480 Title II program thereby limiting the MOH's recurring cost obligation at the end of this project to the sanitation workers.

1/ See Economic Report, dated February 1980, prepared by Clark, Joel, ROCAP.

III ANALYSES (cont.)

B. Community MCH/Nutrition Centers

1. Technical
2. Social Soundness
3. Economic

**C. Administrative Analyses
(Urban Health and Community
MCH/Nutrition Centers)**

B. Community MCH/Nutrition Centers

1. Technical Analysis

The technology to be tested is that of promoting self-help activities, i.e., the Community MCH/Nutrition Centers, by using village residents to increase the utilization of nutrition and health care with only minimal representation from the official health sector. Once effective community support of the center has been achieved, it is anticipated that the Centers can serve as a basis and focus for community planning of activities to improve both health and nutrition.

Since late 1979 the MOH with UNICEF support has been testing receptivity at the village level of a similar approach to the one being proposed in this activity and from which the concept is derived. 1/ In four centers near San Miguel, UNICEF has succeeded in stimulating local cooperation to establish centers where young pre-school children are provided a nutritious snack and where psychological and motor stimulation and development are stressed. The village provides the building and caretakers for the centers which are supervised by home educators, educadores del hogar, from the regional DIDECO. These UNICEF-sponsored centers provide care for 70 children at a time for 15 months. As under the proposed GOES/AID activity, the Ministry of Health is in charge of vaccinations, nutrition surveillance, deworming and tending medical referrals made by the Center through the Rural Health Aide or other field agent assisting the volunteers.

Although the major function of both the UNICEF and the proposed MOH-sponsored Centers is that described above, it is anticipated that the community may want to broaden their role. For example, during the intensive planting or harvest season, in communities where temporary out-migration rates are high, the centers may provide alternative arrangements to taking infants along where they are likely to be neglected and exposed to perilous living conditions. A Center volunteer might be paid to accompany and care for several children, maintaining a better environment than would otherwise be the case. In short, the Center offers a chance for reducing the threat that migratory work carries for infant and child health.

1/ The day care/feeding center idea as initially implemented by the MOH and proposed here resulted originally from visits made by Ministry personnel to similar centers in Honduras. As a result of that visit MOH personnel requested UNICEF help in 1978 in implementing such a program as a beginning effort in stimulating community action in health and nutrition. Given the need to emphasize such participation under the Emergency Plan, the MOH proposed the large scale amplification of the program as a small but key part of the Plan.

As discussed above, the activity focuses on 2-5 year olds, a group often neglected in terms of general child care as well as health and nutrition attention. Nutrition vulnerability is unquestionably as real a threat to 1-2 year olds as to the majority of this group. The objectives of manageability by the community and simplified logistics, however, override the desirability of including younger children who would require more intensive, qualified care and would interfere with activities for the older children.

In the proposed activity, volunteers will generally be women between 14 and 20 years of age, a group likely to be literate, available and interested in such work. Since illiteracy rates are as high as 75% in many of the areas, record-keeping in the Center will have to be adjusted to meet minimal literacy capabilities. The volunteers will organize preparation of food by the mothers, see that the children are fed properly, demonstrate basic hygiene and advise mothers regarding additional food the children should have at home. Volunteers will also give simple medications for routine complaints including treatment of diarrhea and be able to recognize the clinical signs of edema, dehydration and other reason for clinic or hospital referral. Rural Health Aides will advise on such questions when they are present. Health personnel from the nearest MOH facility will initially be in charge of the weighing and measuring of children but will teach both the volunteer and RHA to carry out such nutrition and health monitoring.

The volunteers will receive incentive pay in food. The MOH believes, however, that the volunteer will be motivated as well by the special training she has been selected to receive, a certificate of satisfactory course completion and the prestige she will enjoy because of her function in the community. This assumption is based on MOH experience with other workers such as malaria volunteers and, in one area of the country, health promoters. 1/

Food for this program will be provided under the Emergency P.L. 480 Title II Program on a Government-to-Government basis.

Unloading, storage and reshipment of the food to the health post will be the responsibility of the transportation element of the Food Division of DIDECO.

Technical assistance for developing a methodology for involving rural populations in community development programs that include health and nutrition components is programmed under this activity.

1/ Health promoters trained in a Catholic Relief Services-related program, San Lucas Center, located in the Eastern Region.

In addition, Technical Assistance is planned for community level nutrition planning and for development of media support of educational messages that will be emphasized in the program, i.e., diarrhea prevention and treatment. This latter activity will be coordinated with the National Nutrition Education campaign to be developed under the Nutrition Improvement Project with the Ministry of Planning.

Since the Nutrition Center does not create an administrative burden of salaries for a central government, but depends on communities to reach a point where they can pay the volunteers in food, there are no inherent limits to its expansion which can be expected to be encouraged by any government interested in community action. The crux is whether or not a substantial number of communities respond to the proposed package as a felt need.

In normal circumstances, this type of activity, which represents the first full-scale effort of the Health Ministry in community development, would begin with more pilot work and be developed in smaller initial increments. Given the urgency of reaching into the rural areas as quickly as possible, however, this approach has been assessed as feasible based on reported successes of the similar Centers operated by UNICEF in four communities near San Miguel over the past two months. Informal evaluations by the MOH/MCH and USAID will be made within six months of project initiation to determine quantitative progress in terms of communities responding favorably, number of volunteers trained, etc., with a 12-month evaluation planned to assess progress toward project goals.

2. Social Soundness Analysis

a. The Target Population

In the rural areas some 340,000 households live at subsistence levels or below with an average per capita disposable income of \$130, 20% lower than for urban comparable groups. ^{1/} More than one third are landless; many more cultivate fewer than two hectares of land.

These rural poor comprise about half of the population of El Salvador and constitute more than three quarters of the rural sector. They are surrounded by the conditions of poverty: high rates of malnutrition and morbidity, illiteracy, unemployment, crowded housing, and lacking a safe water supply and adequate means of waste disposal.

^{1/} CDSS

Infant mortality exceeds 100 per thousand, and rural life expectancy is 54 (compared with the national average of 59). Low educational attainment characterizes the rural poor and is more closely related to lack of access than lack of demand. In 1973, only 32% of rural schools offered all grades in primary education, compared with 93% in urban areas. Education is in fact highly valued by the peasantry as evidenced by the observed practice of rural students repeating grades when instruction at the next highest level was not available. ^{1/}

Rural structure is notable for its lack of social integration and community identity. The El Salvador Health Sector Assessment presents a detailed profile of the highly independent target group which is relevant to the project in terms of a key constraint which must be confronted.

"From an early age, the rural Salvadoran learns to be autonomous, selfreliant and industrious.....The family unit is also the basic social and economic unit. Beyond this there is relatively little social, economic, political, or religious structuring.....There is little concern with so-called community affairs; in fact there are few community affairs to be concerned with.

".....(The rural poor family is not, however, loosely structured).....The family is a tightly structured economic operation. Male-female division of labor is well defined and complementary. Every child and adult has specific responsibilities, and everyday work activity proceeds more or less in an orderly and effective way. The mother often is the anchor point of the family; she is responsible, hard working and a symbol of stability and security....

"Four things stand out strongly in the value system of the Salvadoran small farmer. These are the desire for his own piece of land, desire for education, and an all-embracing concern for subsistence security, and an attachment to a rural versus an urban environment."

Capitalizing on this local interest in children and education, this component is aimed at catalyzing community activity by providing a Center to which families may bring small children 2-5 years of age for activities designed to stimulate physical and mental growth. By placing an emphasis on the preparation of children for later education, potential resistance or indifference to a unit providing only health care is more likely to be overcome. Both Harrison and Murray ^{2/}

^{1/} Harrison, 1976

^{2/} Gerald F. Murray, Traditional and Modern Strategies of Health Care Delivery among peasants in El Salvador, 1976.

have observed that the Salvadoran campesino will not look upon preventive health services as a felt need for which they are likely to contribute their time whereas education on the other hand has great drawing power.

Despite the obstacles noted above regarding lack of participation in community efforts, rural inhabitants have in fact departed from this pattern and have joined with others to solve specific economic problems. Community development groups working in the rural areas can point to successful credit and marketing cooperatives and water associations.

To confront the possible resistance to community organization, the Ministry of Health will rely on the entree to rural communities that can be gained by organizations such as DIDECO, ISTA, etc., and to pin the present activity into programs already begun or to promising openings identified by these groups. With the inducements of food and training and equipment for the centers, receptivity should increase and gradually the program may move into areas not previously organized. Very early in the activity, it will be clear whether or not a community will participate thereby minimizing the danger of misplacing resources. At the outset the community must not only express its interest in the activity but is expected to contribute the building and some of the furnishings.

b. Socio-Cultural Feasibility, Spread Effects and Social Impact

The Community MCH/Nutrition Center activity is designed to motivate self-help at the smallest rural unit that will result in improved health and nutritional status. Similar to the design of the Rural Health Aides project, this activity will attempt to bridge the gap that exists between the campesino and the formal government system of health care. In this case the village helpers, the volunteers who receive incentive pay in food, will not be paid adjuncts of the Health system, and thus should be able to retain their identification with the village.

3. Economic Feasibility

World Bank economist Marcelo Selowsky has estimated the social rates of return for nutrition projects to be as high as 20-30% in terms of increased future earnings of children whose mental and physical development were protected through intervention programs. 1/

1/ Selowsky, Marcelo. "An Attempt to Estimate Rates of Return to Investment in Infant Nutrition Programs".

Others note that research is still needed to support the hypothesis that chronic undernutrition leads to reduced productivity. Sahn and Pestronk urge caution in making the assumption that improved nutritional status will lead to improved quality of human resources or, that in the absence of nutritional supplementation, poor nutrition will result in a population whose physical capabilities are diminished and whose productivity is reduced. ^{2/} The goal of this project is stated more modestly, in terms of improved quality of life (better health and nutritional status) rather than in expectations of increased productivity. Thus, calculations of social rates are unnecessary although high rates of return are implicit when one considers the degree of prevalence of malnutrition and morbidity in the target population -- low-income rural El Salvador -- and the high cost of the social, economic and political problems these conditions promote.

i. Cost Effectiveness

The Community MCH/Nutrition Center activity is not narrowly targeted in terms of either age group or health status; i.e., it does not concern itself exclusively with under three-year olds who are in first, second or third degree of malnutrition. The Community MCH/Nutrition Center project purpose is multiple, with heavy emphasis on community development and the development of mechanisms to stimulate self help. Improvement of child health status, especially that of 2-5 year olds, is one of the activities, the focal one. The cost effectiveness of this approach, however, which does not zero in on the younger and more nutritionally vulnerable of that group, compares favorably with more narrowly focused efforts.

Assuming that a Center covers 100 children a year (50 children for six months each) and that the nutritional status is improved or maintained in all of the children, the cost would be \$32 per improved programmed child. If only 77% ^{1/} of the children are in some grade of malnutrition, the cost is \$42 per improved targeted child. Further refinement of the target to exclude those above three years old (estimated at 30% of the malnourished) would bring the cost to \$58.6 per improved targeted child. It is doubtful, however, that practical opportunities are present anywhere to achieve this idealistic targeting. Rehabilitation centers for the seriously and severely malnourished, for example, tend to be filled with chronically malnourished four and five year old who are in and out over several years.

^{1/} INCAP functional classification, 1975-76

This project does give malnutrition priority although a state malnutrition is not an eligibility criterion, and it is anticipated that 90% of the children in these particular areas will be in some degree of malnutrition rather than 77%. Ignoring the losses of age exclusion, this suggests a starting point of \$35.5 per improved targeted child under this project.

Spillover benefits to siblings as a result of mother education, father orientation and other program components will also be assessed and could bring the cost down to \$20 per improved targeted child. Broader efforts to determine long-term community nutrition benefits which might occur as a result of this project would require longer-range study which is not envisaged.

The breakout of actual cost of the Community MCH/Nutrition Centers, divided into capital and recurring costs is shown below as a basis for comparing alternative programs with some of the project components.

CAPITAL	PER CENTER WITH 2-yr. INFLATION
Technical assistance for program development	\$ 130.
Land and Building (15% Incr.)	156.
Equipment	423
Training for volunteers and Supervisors	230.
	\$ 939.
Obviously land and buildings and the equipment are costs that are repeated in each community, but not for subsequent years in the community.	
Recurring (in community)	
Medicines	30. (incl. above)
Evaluation	39.
GOES Administration	10.3
Food, 4 over a year volunteers	886.
100 Children	1,858.
	2,823.3
Cost per child 1st year \$37.62	
Cost per child 2nd year \$28,23	
<u>AVERAGE COST</u>	\$32.9

Establishing the kind of center in El Salvador described above, which would care only for the most nutritionally vulnerable infants/ children under three years of age and in some grade of malnutrition and which would concentrate on their rehabilitation, would require a paid director and probably an assistant. With mothers assisting, an average 20 children could be managed with a maximum of three cycles of children per year. Costs of the Community MCH/Nutrition Center program are compared with these theoretical costs leading to the cost-effectiveness estimate presented below:

	Rehabilitation Center for most Nutritionally Vulnerable under three 100% malnourished; 60 annually	Rural Nutrition Center for 2-5 year olds, of which 77% mal- nourished 100 annually
Training Costs	\$ 500.	\$ 230.
Administration	3,000	886 (vols.) 10.3 (GOES)
Equipment and materials cooking, weighting, etc.	709.	709.
Sub-Total, costs per Center	4,209	1,834.
Sub-Total, cost per Child without food	70.15	18.34
Food per child	25.	18.58
	\$ 95.00	\$ 36.92
Adjustment due to losses in effectiveness caused by less than 100% target- ing of most nutritionally vulnerable (70% for health status & 70% for age group)		75.00
Cost per child	\$ 95.00	\$ 75.00

In the interest of ration coordination, providing family rations through the Community MCH/Nutrition Center was not given lengthy consideration since the World Food Program CRS/CARITAS MCH programs, which cover rural areas throughout the country, limit rations in their MCH programs to mothers and children. It is relevant, although the Community MCH/Nutrition Center project is not merely a feeding program, to compare the Centers with other feeding operations in the country and estimate the programmed and probable costs per child for the foods received.

The Harvard Institute for International Development has made a study 1/ which estimates the food losses to intended beneficiaries that occur in on-site and take-home feeding programs and which are caused by intrafamilial distribution and "substitution" (the consumption of less food at home because of provision of supplementary foods outside the home).

Analyzing data from five countries, HIID noted that in take-home programs for pre-school children, between 45-56% of the food was not consumed by the beneficiaries. The net caloric increase consumed as supplementary food in these take-home programs ranged from 18-54%. The net increase for on-site feeding for pre-schoolers was 47.63%, reflecting a much smaller loss which decreased further when the number of calories in the ration was increased.

In order to use this background for comparison of programs in El Salvador, calculations were made to adjust expected beneficiary consumption according to increases in rations. The CRS, World Food Program and Community MCH/Nutrition Centers then compare as follows:

1/ Draft of SUPPLEMENTARY FEEDING, Mary Ann Anderson, James E. Austin, Joe D. Wray and Marian F. Zeitlin - Nutrition Intervention in Developing Countries, Vol. II HIID January 1979 draft.

COST PER CHILD	TAKE HOME EST. 700 CAL CRS	TAKE HOME EST. 1200 CAL WFP	ON SITE EST. 900 CAL C/MCH/N/C
Non-food costs of the program calcu- lated or estimated	5.	5.	(2 years 9.5 averaged)
Food Costs	10.67	22.	18.58
	\$ 15.67	27.00	28.08
Take home <u>1</u> / % likely to be eaten by bene- ficiary	40%	26%	
On site <u>2</u> <u>2</u> / likely to be substituted		15%	
Adjusted cost per child	19.94	32.72	30.8

In fact when the objectives of programs become as different as are those of the Community MCH/Nutrition Centers from the food distribution programs of CRS and WFP, despite the inclusion of a similar mother education component in these other programs, comparison of costs is difficult. In sum, one concludes that the Community MCH/Nutrition Centers represent a middle of the road approach which is more expensive than a feeding center and less than a rehabilitation or care Center.

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- 1/ Net calorie increase percent of ration consumed as supplement was 18-54% for a take home program depending on the number of calories provided. Smaller losses are provided for the larger ration.
 - 2/ Net Calorie increase as a percent of ration consumed as a supplement is estimated at 63% for 900 calories. This program, however, combines with the WFP take home program in the area and we have therefore assumed (15% loss) as a reasonable estimate.

C. Administrative Analysis (Urban Health and Community MCH/N Centers)

1. GOES

Administrative and organizational analyses of the MOH carried out by Bustamante Associates (under an IDB contract), separately as a part of the Health Sector Assessment in 1978, and by the MOH itself, have noted inefficiencies in organization and procedures. The MOH has made various organizational improvements in the past year and is currently undertaking a major re-organization expected to respond further to organizational inefficiencies. In the meantime, administrative arrangements have been developed by the Ministry in consultation with the Mission, for effective implementation of the project.

Within the MOH, responsibility for field implementation of both major project components is assigned to the Operative Division which shares equal authority with three other Departments under the Director General for Health (see organogram, Annex M). The Operative Division, responsible for field operations in all regions, has substantial experience in implementation of internationally funded projects, including that of the AID-supported Rural Health Aide project. Furthermore, it is the Operative Division that developed the Urban Health component and has coordinated it with the Regional Health Offices. The Community MCH/Nutrition Center activity on the other hand is an initiative developed by the MCH/FP/N Department of the Normative Division of the Ministry, the Division with which USAID has worked most closely over the past several years. The MCH/FP/N Division will be responsible for continued development of program details for this activity and coordination of its implementation with the Operative Division and the Regional Health Offices.

To assure coordinated management of the project components, a single MOH Program Director has been named. Assigned to the Operative Division, he will coordinate closely with the MCH/Normative Division and the Administrative Department, as well as with other GOES entities (particularly DIDECO), and will serve as liaison, both with other departments of the Ministry and with the USAID Project Manager. Furthermore, to strengthen coordination of the various MOH divisions (Human Resources, Operative, Normative, Administrative) involved in implementation of the activities, the MOH has agreed to form a Project Committee, to be chaired by the Program Director, which will meet regularly with the AID Project Manager and the Urban Health Coordinator (see below) to discuss progress and problems.

a. Supervision

(1) Urban Health

Each tugurio health team is supervised by a Regional Health Office. The Regional offices will provide overall technical supervision to the teams in the same manner as they do to health staffs in other health facilities. Within the team, the physician will serve as team chief. The auxiliary nurse and sanitary inspector will provide day to day supervision to the promoters and sanitation workers respectively. Members of the team will meet periodically with the tugurio health committee to provide the committee an opportunity to participate in the supervisory process.

(2) Community MCH/Nutrition Centers

The staffs of MOH Regional ^fFacilities will provide overall supervision and support to the centers, primarily through periodic field visits. Personnel from the nearest MOH health facility, in close collaboration with the Rural Health Aide, will monitor the centers closely to insure the adequacy of logistic support, community and volunteer participation. The communities, functioning through the village health committees, or in the absence of such a committee, the village governing council, have the fundamental responsibility for the selection of volunteers, setting up food transport and storage arrangements, maintaining the facility, and for supervising the volunteers.

b. Logistics

Logistic support to both activities is to be given special priority by the MOH Administration Division. To that end, the MOH is developing special procedures for rapid procurement and storage apart from regular MOH stores for medical supplies for support of the urban health activity.

With regard to food support for the Community MCH/Nutrition Centers, the Administrative Department will be responsible for co-ordination with DIDECO for the transport of Title II foods from the port, storage in the MOH regional warehouses and then delivery to the health facility nearest the Center according to a distribution schedule established by the Administrative Office. DIDECO's administrative and logistic capacity to carry out this responsibility has been assessed in connection with the PL 480 Title II Emergency Food Program; a third component of this project will provide resources to assure adequate vehicular support for transport of the foodstuffs for the Centers. The respective Regional Office of the MOH will have major responsibility under the activity for ensuring effective inter-agency collaboration and liaison with participating communities. A regional inter-agency committee (MOH, DIDECO, ISTA, etc.) will select communities in which the activity is to be promoted and assist the communities in organizing a selection process for volunteers. The Regional MOH Office will also be responsible for overseeing equipping of the centers, assuring technical liaison with it, and for the regular delivery of foods and medicines. Prior to establishing a center, the ministry will conclude a written agreement with the community detailing arrangements and responsibility for transport of the food from the MOH distribution point to the Center and food storage arrangements in the community.

2. AID

Responsibility for monitoring and backstopping of the project within AID is assigned to the Health, Population and Nutrition Division of USAID. The Project Manager from that Division is backed normally by a Project Committee which consists of the Program Officer, the Controller, and the Mission Economist. However, because the tense political situation has caused reductions in the Mission staff, outside administrative support is needed. For this reason, it is proposed that an Urban Health Coordinator be hired under the project. This person will, on a day-to-day basis, monitor activities of both the MOH teams and the community health and sanitation teams in urban areas. The Urban Health Coordinator will provide the administrative liaison between USAID and the MOH throughout project implementation. Funds for the Coordinator have been included in the Urban Health component.

As discussed earlier, with reference to the Community MCH/Nutrition Centers, technical assistance for community development education and evaluation is programmed within the project. Normal monitoring of this activity will be carried out by a USAID/HPN Salvadoran Program Assistant and by the P.L. 480 Title II Project Manager to be hired by that Division.

Both project components will require close monitoring to assure that logistical and supervisory support are adequate and that efforts to stimulate community involvement are effective. The USAID Project Committee will review on a quarterly basis a report to be made by the Project Manager on progress to date against the implementation plan and make recommendations as to corrective actions required.

In view of AID's interest in low cost health delivery systems, the Mission has assumed that additional technical assistance for both components, especially in the area of evaluation, can be obtained from centrally funded contracts such as those with the American Public Association as well as from Indefinite Quantity Contracts.

IV. FINANCIAL PLAN

A. OVERALL FINANCIAL PLAN (\$000) (all components)

COMPONENT	AID	GOES	COMMUNITY	TOTAL
<u>A. URBAN HEALTH</u>				
1. Project Coordinator	21			21
2. Salaries	244	887		1,131
3. Training	12	9		21
4. Technical Assistant/ Evaluation	11			11
5. Medications	700	500		1,200
6. Equipment	75	4		79
7. Furniture	27			27
8. Health Education Materials	3			3
9. Uniforms	7			7
TOTAL URBAN HEALTH	1,100	1,400	-o-	2,500
<u>B. COMMUNITY MCH/NUTRI- TION CENTERS</u>				
1. Technical Assistance/ Evaluation	51			51
2. Training	69			69
3. Equipment & Materials	86	32	8	126
4. Contingency	11			11
5. GOES Administration		3		3
6. Mass Media Pilot	9			9
7. Community Distribu- tion:				
a. Land & Building			47	47
b. Local Food			243	243
TOTAL COMMUNITY MCH/ NUTRITION CENTERS	226	35	298	559

COMPONENT	AID	GOES	COMMUNITY	TOTAL
C. <u>P.L. 480 TITLE II</u> ^{1/}				
Food	(429)			(429)
Transportation and Storage of Food		(64)		(64)
TOTAL P.L. 480 TITLE II	(429)	(64)		(493)
D. <u>EMERGENCY FEEDING SUPPORT</u>				
1. Transportation	15			15
2. Vehicles	15	15		30
3. Materials, tools, Cement, Piping	15	33		48
4. DIDECO Administra- tion Costs	5			5
TOTAL EMERGENCY FEEDING SUPPORT	50	48		98
TOTAL PROJECT	1,376 ^{2/}	1,483	298	3,157

1/ Non-add - P.L. 480 Title II in support of Community MCH/Nutrition Centers. P.L. 480 Title II Emergency Feeding Program for urban areas is not included here.

2/ Includes \$161,000 originally programmed for addition in FY 80 to Nutrition Improvement Grant.

B. PROJECTED EXPENDITURES BY FISCAL YEAR (AID only)

COMPONENT	FY 80	FY 81	FY 82
<u>A. URBAN HEALTH</u>			
Project Coordinator	11	10	
Salaries	122	122	
Training	6	6	
Technical Assistance/ Evaluation	5	6	
Medications	300	300	
Equipment	50	25	
Furniture	15	12	
Health Education Materials	3	0	
Uniforms	7	0	
SUB-TOTAL	619	482	
<u>B. COMMUNITY MCH/NUTRITION CENTERS</u>			
1. Technical Assistance/ Evaluation	30	21	
2. Training	20	29	20
3. Equipment and Materials	30	30	26
4. Contingency	-	6	-
5. Mass Media Pilot	14	-	-
SUB-TOTAL	94	86	47
<u>C. EMERGENCY FEEDING SUPPORT</u>			
1. Transportation	15		
2. Vehicles	15		
3. Materials	15		
4. DIDECO Administration Costs	5		
SUB-TOTAL	50		
TOTAL PROJECT	763	566	47

C. URBAN HEALTH COMPONENT
 Summary Cost Estimate and Financial Plan
 (U.S. \$000)
 Project Paper

SOURCE	AID		HOST COUNTRY		OTHER	T O T A L
	FX	LC	FX	LC		
<u>AID Grant</u>						
- Project Coordinator		21				21
- Salaries		244				244
- Training		12				12
- Technical Assistance/ Evaluation	11					11
- Medications		700				700
- Equipment		75				75
Other						
- Furniture		27				27
- Health Educ. Materials		3				3
- Uniforms		7				7
						1,100
<u>GOES</u>						
- Salaries				887		887
- Training				9		9
- Medications				500		500
- Supplies				4		4
						1,400
	11	1,089	0	1,400		2,500

URBAN HEALTH COMPONENT
Input/Output Table
(US \$ 000)

COMPONENT INPUTS	COMPONENT OUTPUTS		T O T A L
	FIRST YEAR	SECOND YEAR	
<u>AID</u>			
- Project Coordinator	10	11	21
- Salaries	76	168	244
- Training	8	4	12
- Technical Assistance/ Evaluation	5	6	11
- Medications	400	300	700
- Equipment	35	40	75
Other			
- Furniture	13	14	27
- Health Education Materials	1	2	3
- Uniforms	2	5	7
TOTAL AID	550	550	1,100
<u>GOES</u>			
- Salaries	274	613	887
- Training	4	5	9
- Medications	-0-	500	500
- Supplies	2	2	4
TOTAL GOES	280	1,120	1,400
T O T A L	830	1,670	2,500

D. Community MCH/Nutrition Centers

The Financial Plan for this component has been prepared against the following four time-phased activity outputs:

- (1) 300 Rural Nutrition Centers equipped and operating in all regions of El Salvador.
- (2) 1200 Volunteers trained and participating in Center activities.
- (3) Supplementary Rations provided to 30,000 2-5 years old children for six-month periods.
- (4) 15,000 families participating in center support, utilizing primary health child care services and health and nutrition counsel.

1. Technical Assistance and Commodities

Initial technical assistance for this project is to be obtained from INCAP under AID's Regional Grant to that organization (Job Description attached as Annex I). Other TA needs will be refined by MCH and include a specialist in child development and motivation; community development experts and a education-media specialist in the health and nutrition field. The latter expertise can be funded under the Ministry of Planning Nutrition Improvement Grant.

Equipment and materials for the project, all to be purchased locally, are listed as Annex J.

COMMUNITY MCH/NUTRITION CENTER

PROJECT OUTPUTS (IN \$000 OR EQUIVALENTS) PROJECT PAPER

PROJECT INPUTS	PROJECT OUTPUTS				TOTAL
	#1	#2	#3	#4	
<u>AID GRANT</u>					
Technical Assistance	9.7	9.7		19.5	38.9
Training Costs		68.8			68.8
Other:					
Materials & Equipment	86.3				86.3
Evaluation Cost	2.95	2.95	2.9	2.9	11.8
Contingency	3.55	3.55		4.7	11.8
SUB-TOTAL	102.6	85.	2.9	27.1	217.6
<u>TITLE II</u>			429.0		429.0
<u>COES</u>					
Administration	.775	.775	.775	.775	3.1
Materials & Equipment	32.3				32.3
Transportation & Storage of Title II foods			64.0		64.0
SUB-TOTAL	32.1	775	64.775	.775	99.4
<u>COMMUNITY</u>					
Land & Buildings	23.4			23.4	46.8
Local Food			242.6		242.6
Materials & Equipment	8.4				8.4
SUB-TOTAL	31.8		242.6	23.4	297.8
PROJECT TOTALS	166.5	85.7	739.3	51.3	1043.8

COMMUNITY MCH/NUTRITION CENTER

SUMMARY COST ESTIMATE AND FINANCIAL PLAN IN \$000 OR EQUIVALENTS PROJECT PAPER

	AID		HOST COUNTRY		OTHER TITLE II	TOTAL
	FX	IC	FX	IC		
<u>AID GRANT</u>						
Technical Assistance	38.9					
Training Costs (Per Diem 61.5 Trainer Hours 5.2 Materials .2.1)		68.8				68.8
Other:						
Material & Equipment		86.3				86.3
Evaluation Cost		11.8				11.8
Contingency		11.8				11.8
SUB-TOTAL	38.9	178.7				217.6
<u>GOES</u>						
Administration				3.1		3.1
Other:						
Materials & Equipment				32.3		32.3
Transportation & Storage of Title II food				64.0		64.0
SUB-TOTAL				94.9		94.9
<u>COMMUNITY</u>						
Land & Buildings				46.8		46.8
Local Food				242.6		242.6
Materials & Equipment				8.4		8.4
SUB-TOTAL				297.8		297.8
TITLE II					429	429
PROJECT TOTAL	38.9	178.7		297.8	429	1043.8

V. IMPLEMENTATION PLAN

A. Implementation Arrangements

Implementation and monitoring responsibilities are presented in the Administrative Analysis Section of this document. The Ministry of Health is the counterpart agency for the project with overall implementation assigned to the Operative Division of the Ministry. Implementation of the Emergency Feeding Support Component will be the responsibility of DIDECO, to be carried out under an agreement between the Ministry of Health and the Ministry of Interior developed by USAID (see Section X, Conditions Precedent to Disbursement).

Financial arrangements, to include an advance of \$200,000 to the Ministry of Health and establishment of a revolving fund, will be developed for inclusion in the Project Agreement.

B. Procurement

A listing of the pharmaceuticals and equipment to be purchased under this project is given in Annexes F, G, and J. It is anticipated that a combination of local source and U.S. source/origin procurement will be used for this project. In accordance with HB 1B, Chapter 4C3, approval will be solicited from SER/COM for any local procurement of pharmaceuticals. A detailed list of specifications and all necessary supporting data will be provided for review of the eligibility and appropriateness of specific pharmaceuticals for all pharmaceutical procurement. The need for rapid implementation of the project will dictate the degree of shelf item procurement of medical supplies and other commodities listed in Annex F, the majority of which is expected to be of U.S. or Central American Common Market source/origin.

Standard AID guidelines will be followed for all other procurement actions.

C. Urban Health Implementation Calendar

<u>Dates by which events are to occur:</u>		<u>Description</u>
March 1, 1980	MOH	75 Tugurios selected
March 1, 1980	MOH	Selection of health teams
March 10-15, 1980	MOH	Community Development Training for Regional Team Representatives
March 30, 1980	MOH	Meetings with representatives of the tugurios

<u>Dates by which events are to occur:</u>		<u>Description</u>
April 2, 1980	AID/W	Funds available for project implementation
April 2, 1980	MOH	Procurement process begins
April 2, 1980	AID/ES	Begin recruitment for Project Coordinator
April 10, 1980	AID/MOH	Project Agreement signed
April 10, 1980	AID/ES	PIO/T prepared for AID contract for Project Coordinator
April 10, 1980	MOH	Recruitment begins for 75 health promoters and 36 sanitation workers
April 25, 1980	AID	Project Coordinator hired
April 25, 1980	MOH	Selection of health and sanitation workers
April 28, 1980		Health clinics begin to open
May 5, 1980	MOH	Training Programs for health and sanitation workers
May 12, 1980		Sanitation workers on site
May 19, 1980		Health workers on site
May 19, 1980	AID/ES	Training for Project Coordinator
October 1, 1980		Joint MOH/AID/ES project review meeting
November 1, 1980		First Stage Evaluation
April 2, 1981		Joint MOH/AID project review meeting to develop schedule for 2nd. year activities
April 2, 1981		Selection of 75 additional tugurios and corresponding health teams

<u>Dates by which events are to occur:</u>	<u>Description</u>
April 10, 1981	Meetings with representatives of tugurios
April 15, 1981	Recruitment of 75 health and 36 sanitation workers
April 30, 1981	Selection of health and sanitation workers
May 1, 1981	75 new clinics begin to open
May 4, 1981	Training begins for sanitation and health workers
May 11, 1981	Sanitation workers on site
May 18, 1981	Health promoters on site
May 18, 1981	1-week retraining for initial group of health and sanitation workers
October 1, 1981	2nd. Stage Evaluation
November 30, 1981	Joint MOH/AID project evaluation/ review meeting to determine review meeting to determine status of project and future course of action i.e. is the project to be expanded on the basis of positive results
February 15, 1982	Joint MOH/AID project review meeting
June 1, 1982	End of project review meeting has been held, and report completed on results of project

D, Community MCH/Nutrition Centers Implementation CalendarINITIAL PHASE

IMPLEMENTATION PLAN	Period of Implementation or Dates when action is to have been completed
Preparation of Materials	February 20 - April 15, 1980
Conditions and Covenants agreed by GOES. Funds available	March 20, 1980
PIO/T's prepared for Technical Assistance	March 15, 1980
Visits to Health Regions by Central MOH to present activity	On-going
Prepare TA for food requirements, and arrange for local borrowing of stocks for first tranche (WFP)	March 1, 1980
Purchase equipment and materials for first group of centers	March 20, 1980
Selection of Communities by Regional Committees of MOH, Agriculture, DIDECO	March 1 - 20, 1980
Technical Assistance available to assist with training, procedures and teaching manuals, community development and child development experts	March 10 - April 20, 1980
Training of Docents and Regional Staff	April 1, 1980
Negotiations completed with community regarding locale and furnishings; renovation and village improvements.	April 1 - 15, 1980
Children selected in villages (60) Volunteers selected (240)	April 15, 1980
Volunteers trained; first six groups of 40 each	April 15 - 30, 1980
Supervisors trained (60)	April 15 - 20, 1980
Equipment and Food arrive from Regional Office to community	April 15 - May 15, 1980
Nutrition surveillance data taken on children and siblings	May 1 - 15, 1980
First Centers begin to function Community work begins	May 31, 1980

COMMUNITY MCH/NUTRITION CENTERS - BUILDUP OF PROGRAM

IMPLEMENTATION PLAN

1. CENTERS

	FY 1980		FY 1981				FY 1982	
	3/Qtr	4/Qtr	1/Qtr	2/Qtr	3/Qtr	4/Qtr	1/Qtr.	2/Qtr
New	30	35	35	40	50	50	60	-o-
Cummulative by FY	30	65	35	75	125	175	60	60
Cummulative by Project	30	65	100	140	190	240	300	300

2. NUMBER OF CHILDREN

New	1,500	1,750	1,750	2,000	2,500	2,500	3,000	-o-
Old	-o-	-o-	1,500	1,750	3,250	3,750	5,750	8,750
TOTAL	1,500	1,750	3,250	3,750	5,750	6,250	8,750	8,750
Cummulative by FY	1,500	3,250	3,250	7,000	12,750	19,000	31,000	8,750
Cummulative by Project	1,500	3,250	6,500	10,250	16,000	22,250	31,000	31,000

3. NUMBER OF VOLUNTEERS

New	120	140	140	160	200	200	240	-o-
Cummulative by FY	120	260	140	300	500	700	240	240
Cummulative by Project	120	260	400	560	750	960	1,200	1,200

VI. EVALUATION PLAN

A. Urban Health

The evaluation plan for this project should be simple and the initial stage based primarily on quantitative indicators. The final evaluation would be both quantitative and qualitative. The two evaluations should include the following:

Stage One

After the project has been in effect for six months, an evaluation will be needed for a period of approximately three weeks to:

1. Visit tugurios where MOH teams are in place.
2. Interview:
 - a. Beneficiaries
 - b. Community health workers
 - c. Sanitation workers
 - d. MOH team physicians, nurses, and sanitation inspectors

During the visit and interviews, the evaluator would attempt to determine:

1. The number of health teams in place.
2. The number of community health and sanitation workers trained and in place;
3. Programs implemented other than direct curative services provided by MOH physicians and nurses.
4. Referral mechanisms between clinics in the tugurios, the health posts/centers and hospitals and the forms developed to record them.
5. Adequacy of training programs, both the initial program and the continuing education programs.
6. Linkages developed with community organizations.
7. Extent and adequacy of reporting systems/management information systems.

8. Key constraints impeding program implementation.
9. Number of hours worked and number of patients seen by the doctor, auxiliary nurse and health promoters.
10. Number and type of health education sessions provided community residents.
11. Major health problems encountered in the communities.
12. Health and nutrition status indicators including birth rate, infant mortality rate, and child mortality rate.
13. The progress made on sanitation projects (number initiated, underway and completed) by type of project, i.e., trash pickup, latrine construction, etc.
14. Turnover among health promoters and sanitation workers and the effectiveness of reimbursing with food rather than money.

Stage Two

After the project has been in effect for approximately fifteen months, an evaluator would then complete the project evaluation during a two week period.

This second stage would update figures in stage one and include qualitative recommendations for expansion of the project, if such is warranted. This evaluation would determine:

- a. Extent of project purpose accomplished during project implementation.
- b. Extent of community participation in project implementation.
- c. Capacity (managerial, administrative, technical staff) of the MOH to expand the program.
- d. Possible participation of other donors in an expanded project.
- e. Changes in health and nutrition status indicators one-time.

B. Community MCH/Nutrition Centers Evaluation Plan

All project evaluations will be undertaken jointly by GOES and USAID project personnel. An Evaluation and Review Committee, comprised of representatives from the MCH/FP/Nutrition Division of the Normative Department and the Program Director of the Operative Division in the Ministry of Health, a representative of OCOPAN, a representative of the principal cooperating community development agency (DIDECO), and the USAID Project Manager and Evaluation Officer, will meet after project approval to develop details of the proposed evaluation plan and deadlines.

Since the activities under the project are new to the GOES, interim evaluations of the implementation process will be performed early in the project so that design modifications can be incorporated. An assessment of first steps of the project is scheduled six months after the first centers begin operation. A second interim evaluation is proposed for April 1, 1981; by that date, sufficient feedback should be available to judge appropriateness of operating guidelines, record-keeping and content of materials and volunteers' training. Because constraints of time and conditions may prevent formal evaluations, mechanisms for informal and systematic feedback and analysis of progress and problems are being made a part of the daily record-keeping and reporting requirements.

According to the implementation schedule, the first centers will open the end of May 1980. Therefore, a first collection of baseline nutritional status data is scheduled for May 15. The first impact evaluation, if performed (see discussion below) should be scheduled for August/September of 1981 based on one year of operation in at least 20-30 centers and concluding a final project evaluation in May 1982. The schedule then is as follows:

Interim Evaluation No.	April 1, 1981
Impact Evaluation	August/September 1981
Final Project Evaluation	May 1982

Evaluations will measure progress against indicators at the output and purpose levels shown in the Logical Framework and according to the time frame laid out in the Implementation Plan.

Annex J presents quantitative outputs of the project, with associated sets of illustrative indicators, some of which can be included in the routine Supervisory Reports and/or the periodic reports submitted by the volunteers in the Community MCH/Nutrition Centers. The Evaluation and Review Committee will select for inclusion in the reporting system those qualitative indicators which are:

- (a) most relevant to measuring progress toward outputs and purpose;
- (b) feasible to collect, given the expected variability in educational levels of the volunteers;
- (c) and which do not impose time-consuming efforts, either to collect or to analyze and interpret.

Impact Evaluation of Community MCH/Nutrition Centers

This evaluation, tentatively scheduled for August/September 1981, will be based on three anthropometric measurements of participating children; the first, upon entering the program, again at three months, and finally at six months. Improvements in nutritional status are expected for 70% of the malnourished entrants

and for 50% of the siblings.

It should be noted, however, that the feeding accomplished under this project is supplementary and not inherently sufficient to ensure improvement in nutritional status. Other health services, some of which are outside the scope of this project, in tandem with the feeding, are probably necessary to achieve the desired results. Examples of these services include safe water supply, sanitary disposal of excreta, vaccinations, and timely treatment of diarrhea. Thus, the Committee will carefully review the concept of performing an impact evaluation, taking into consideration the possibility of continuing political turmoil, and its implications on the disruption of normal delivery of health and environmental services, logistic support of the RNC's, etc. Indeed, if the country were to suffer a food crisis due to disruption of normal food production, it may be pointless to look for improvements and maintenance of nutritional status may well become the measure of success.

Annex L presents a formula for calculation of cost-effectiveness of the project if it is determined that an impact evaluation is feasible.

VII. CONDITIONS, COVENANTS, AND NEGOTIATING STATUS

As a result of extensive meetings of USAID staff and consultants with the Ministry of Health and the Ministry of Planning, the original proposals of the Ministry of Health for both major project components have been revised to increase impact and feasibility of implementation. In the interest of rapid initiation of the project, Conditions Precedent to initial Disbursement have been minimized. Covenants in all cases reflect agreements between USAID and the Ministry on essential inputs for the project, all of which have been negotiated.

A. Conditions Precedent to Initial Disbursement

Prior to the first disbursement under the grant or to the issuance by AID of documentation pursuant to which disbursement will be made, the Grantee will, except as the parties may otherwise agree in writing, furnish to AID in form and substance satisfactory to AID.

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

2. Evidence of the naming of Ministry of Health Project Coordinator and of a Project Committee in the Ministry to consist of representatives of the Normative, Operative, Administrative and Planning Divisions of the Ministry.

3. The Ministry will obtain from the principal community development agencies that are cooperating with the MOH in this activity, namely DIDECO and CENTA, a list of communities in which the field agencies are willing to collaborate for the first year of the project and the name of the collaborator for the project.

B. Condition Precedent to Disbursement of Emergency Feeding Support Component

The Ministry of Health agrees to develop an agreement with DIDECO, Ministry of Interior, in coordination with and to be approved by USAID, setting forth uses and an illustrative budget for the component.

C. Covenants

1. Urban Health Component

a. For each tugurio selected for assistance, the MOH agrees to provide:

- (1) a minimum of ten hours of training in urban health problems and community development for a physician, auxiliary nurse and sanitary inspector;
- (2) one week of training for sanitation workers;
- (3) two weeks of training for the urban health promoters;
- (4) continuing education of approximately one day per month, of sanitation and urban health workers;
- (5) retraining of all personnel after one year.

b. The Ministry agrees to assume:

- (1) throughout the life of this project all costs of salaries and training for the MOH teams (physicians, nurse auxiliaries, and sanitation inspectors);
- (2) at conclusion of the project, all salary costs of sanitation workers trained and salaried under this project.

2. Community MCH/Nutrition Centers

a. For each community in which a community mch/nutrition center is to be located, the Ministry will sign a written agreement with the community regarding responsibility for transport of PL 480 Title II commodities from the MOH distribution point to the communities and their adequate storage and management within the communities.

b. As executing agency for the Rural Health Aide Project as well, the MOH will provide to the Regional Health Offices and to

AID a statement describing the role of the RHA in this project and specifying the percentage of time the RHA may allot to the activity.

c. The Ministry of Health agrees to accelerate the phase-in of the World Food Program support to the regular MOH/MCH feeding program to assure food needs of the rest of the MCH target population are met.

VIII. INITIAL ENVIRONMENTAL EXAMINATION

USAID/El Salvador requests LAC/DR proceed with approval of IEE for subject project.

I. BASIC PROJECT DATA

Project Location: The rural and urban (marginal areas of the Republic of El Salvador.

Project Title: Health and Nutrition Project

Funding: FY 1980 Grant \$1,376,000

Life of Project: 3 years

IEE Prepared by: C. R. Gavidia, USAID/El Salvador, General Engineer and Environmental Coordinator

Threshold Decision: Negative environmental decision recommended in part IV.

II. DESCRIPTION OF PROJECT

The proposed project is intended to improve health and nutrition of low-income Salvadorans of both rural and urban marginal areas. Although the lack of income is in itself a cause of these problems, closely related factors are a lack of knowledge of how to improve one's own health and nutrition status, of motivation to produce such improvement, and of simple access to services. This grant project, to be implemented as a part of the FY 80 Accelerated Impact Plan, consists of three components designed to support GOES and other donor efforts to develop mechanisms of primary health care, promotion, and self help that will lead to better health and nutrition in low-income populations. In contrast to a traditional paternalistic tendency in the health sector to attempt "to provide health," the two major components of the project require and are based on heavy community participation, not only as a client of the health system but as its supervisor and a provider of services and assistance.

The project components described herein are:

- (1) extension of primary health care and environmental health services into marginal areas of urban communities (tugurios).
- (2) establishment of Community MCH/Nutrition Centers in selected rural communities throughout the country; and

(3) emergency feeding program support.

1. Urban Health Component

The MOH, in response to demands made by residents of various tugurios for health services will provide health care coverage to 150 urban slums located throughout the country. The community will provide space for a health clinic and manual labor to renovate facilities, guidance on selection of community-based workers, and continuing support of the operation. Each clinic will be staffed by an auxiliary nurse, a part-time physician, a sanitation inspector, an urban health promotor and 3 sanitation workers. AID funds will finance technical assistance, training and commodities as well as salaries for sanitation workers. A total of 100,000 persons will receive benefits from the component at a cost of \$1,100,000.

2. Community MCH/Nutrition Centers

This component supports the development of 300 MCH/Nutrition Centers in poorer remote areas of the country. Each Center will provide supplementary feeding, simple health care services and preschool training for approximately 50 children, 2 to 5 years of age. The community will provide space for the Center, 3 volunteers to operate the facility, and part-time participation by families whose children are receiving services. GOES agencies will play a support role only. The Ministry of Health (MOH) will train the community volunteers; provide periodic health services to the children via the MOH outreach agent, the Rural Health Aide (RHA) and special MOH disease control campaigns, and receive referrals of sick children. The GOES Community Development Agency (DIDECO) will assist communities in the initial process of Center organization and assure, with assistance from an Emergency Feeding Support Component included in this project, the flow of the supplementary foods to the Centers. AID funds will finance training of volunteers and equipment and supplies for initial outfitting of the Centers. A total of 30,000 children and their mothers will receive direct benefits from the project offer a two year period at a total cost for the component of \$226,000.

3. Emergency Feeding Support

In support of the feeding element of the MCH/Nutrition Center, other Ministry of Health feeding programs and the P.L. 480 Title II Marginal Urban Area Emergency Feeding Program, funding is proposed under this Project to increase logistic capability of the Food Support Division of DIDECO, the agency which is responsible for transport of externally donated foods. Funding in the amount of \$50,000 is programmed for vehicle purchase or rent, and for local purchase of materials and equipment for work and training elements of the P.L. 480 Title II Urban Feeding Program.

III. IMPACT IDENTIFICATION AND EVALUATION

<u>Impact Areas and Sub-Areas</u>	<u>Impact Identification and Evaluation</u>
A. Land Use	
1. Changing the character of the land through:	
a. Increasing the population	N
b. Extracting natural resources	N
c. Land clearing	N
d. Changing soil capacity	N
2. Altering natural defenses	N
3. Foreclosing important uses	N
B. Water Quality	
1. Physical state of water	N
2. Chemical and biological states	N
3. Ecological balance	N
C. Atmospheric	
1. Air additives	N
2. Air pollution	N
3. Noise pollution	N
4. Other factors	N
D. Natural Resources	
1. Diversion, altered use of water	N
2. Irreversible, inefficient commitments	N
3. Other factors	N
E. Cultural	
1. Altering physical symbols	N
2. Dilution of cultural traditions	N
3. Other factors	N
F. Socio-Economic	
1. Changes in economic/employment patterns	N
2. Changes in population	N
3. Changes in cultural patterns	N
4. Other factors	N

Impact Areas and Sub-Areas

Impact Identification
and Evaluation

G. Health

- | | |
|---|---|
| 1. Changing a natural environment | N |
| 2. Eliminating an ecosystem element | N |
| 3. Other factors | N |

The general health and nutrition of the people living in marginal urban and rural areas will improve greatly, therefore being a positive action which will improve their natural environment.

IV. ENVIRONMENTAL ACTION RECOMMENDED

It is recommended that a negative determination be given to this project.

The proposed action is not a major action which will have a significant effect on the human environment and is, therefore, an action for which an environmental impact statement or an environmental assessment will not be required.



Charles J. Stockman
USAID Mission Director

Drafted by: CRGavidia:Gen.Eng.and Env.Coord.

Cleared by:DCGibb, HNPO DS
PWAskin, ADOM AWT

IX. DRAFT PROJECT AUTHORIZATION

Name of Country: El Salvador

Name of Project: Health and
Nutrition

Number of Project: 519-0253

1. Pursuant to Sections 103 and 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Health and Nutrition Project for El Salvador involving planned obligations of not to exceed \$1,376,000 in grant funds over a three 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.
2. The project consists of the facilitation of a viable extension of health, nutrition and sanitation services to low-income Salvadorans in marginal urban and rural areas.
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 and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

a. Source and Origin of Goods and Services

Goods and services, except for ocean shipping, financed by A.I.D. under the project shall have their source and origin in the United States and member countries of the Central American Common Market, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the project shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States.

b. Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement, the Cooperating Country shall furnish in form and substance satisfactory to A.I.D., evidence of the naming of a Ministry of Health Project Coordinator and a Project Committee in the Ministry to consist of representatives of

the Normative, Operative, Administrative and Planning Divisions of the Ministry.

c. Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement to finance the Emergency Feeding Support Component, the Cooperating Country shall furnish in form and substance satisfactory to A.I.D., an Agreement between the Ministries of Health and Interior, setting forth the component uses with an illustrative budget.

d. The Cooperating Country shall covenant as follows:

1. Urban Health Component

a) for each slum area selected for assistance, the Ministry of Health (MOH) agrees to provide;

- 1) a minimum of ten hours of training in urban health problems and community development for a physician, auxiliary nurse and sanitary inspector;
- 2) one week of training for sanitation workers;
- 3) two weeks of training for the urban health promoters;
- 4) continuing education of approximately one day per month, of sanitation and urban health workers;
- 5) retraining of all personnel after one year.

b) The Ministry agrees to assume:

- 1) throughout the life of this project all costs salaries and training for the MOH teams (physicians, nurse auxiliaries, and sanitation inspectors:
- 2) at conclusion of the project, assume all salary costs of sanitation workers trained and ~~salaries~~ under this project.

2. Community MCH/Nutrition Centers

a) The MOH will obtain from the principal community development agencies that are cooperating with the MOH, in this activ-

ity, namely, Directorate of Community Development (DIDECO) and National Center for Agricultural Technology (CENTA), a list of communities in which the field agencies are willing to collaborate and a designated collaborator for the project;

b) As executing agency for the Rural Health Aide (RHA) Project as well, the MOH will provide to the Regional Health Offices and to AID a statement describing the role of the RHA in this project and specifying the percentage of time the RHA may allot to the activity.

c) The Ministry of Health agrees to accelerate the phase-in of the World Food Program support to the regular MOH/Maternal Child Health (MCH) feeding program to assure food needs of the rest of the MCH target population are met.

e. The following waivers to A.I.D. regulations are hereby approved: source origin in addition to U.S. shall be in CACM.

<u>Name</u>	<u>Office Symbol</u>	<u>Date</u>	<u>Initials</u>
-------------	----------------------	-------------	-----------------

Clearances:

Signature _____

Office Symbol

ANNEXES

- A. STATUTORY CHECKLIST
- B. REQUEST FOR ASSISTANCE
- C. PROPOSED TUCURIOS SITES, PHASE I
- D. COMMUNITY MATERNAL CHILD HEALTH/NUTRITION CENTERS
- E. PROJECT COORDINATOR, URBAN HEALTH, JOB DESCRIPTION
- F. URBAN HEALTH EQUIPMENT AND SUPPLIES
- G. URBAN HEALTH/PROPOSED MEDICATIONS
- H. ORGANIGRAM OF MINISTRY OF HEALTH
- I. JOB DESCRIPTION/TECHNICAL ASSISTANCE, COMMUNITY MCH/NUTRITION CENTERS
- J. EQUIPMENT AND MATERIALS FOR COMMUNITY MCH/NUTRITION CENTERS
- K. SUGGESTED INDICATORS FOR EVALUATION PLAN, COMMUNITY MCH/NUTRITION CENTERS
- L. SUGGESTED FORMULA FOR CALCULATION OF COST-EFFECTIVENESS OF COMMUNITY MCH/NUTRITION CENTERS

5C(1) - COUNTRY CHECKLIST

Listed below are, first, statutory criteria applicable generally to FAA funds, and then criteria applicable to individual fund sources: Development Assistance and Economic Support Fund.

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

- | | |
|--|--|
| <p>1. <u>FAA Sec. 116.</u> Can it be demonstrated that contemplated assistance will directly benefit the needy? If not, has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights?</p> | <p>Project will benefit the country's needy poor</p> |
| <p>2. <u>FAA Sec. 491.</u> Has it been determined that the government of recipient country has failed to take adequate steps to prevent narcotics drugs and other controlled substances (as defined by the Comprehensive Drug Abuse Prevention and Control Act of 1970) produced or processed, in whole or in part, in such country, or transported through such country, from being sold illegally within the jurisdiction of such country to U.S. Government personnel or their dependents, or from entering the United States unlawfully?</p> | <p>El Salvador takes adequate steps to prevent narcotic traffic.</p> |
| <p>3. <u>FAA Sec. 620(b).</u> If assistance is to a government, has the Secretary of State determined that it is not controlled by the international Communist movement?</p> | <p>Yes.</p> |
| <p>4. <u>FAA Sec. 620(c).</u> If assistance is to 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) debt is not denied or contested by such government?</p> | <p>No, as far as is known.</p> |
| <p>5. <u>FAA Sec. 620(e)(1).</u> If assistance is to a government, has it (including 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?</p> | <p>No.</p> |

6. FAA Sec. 620(a), (20(f); FY 79 App. Act, Sec. 411, 412 and 414. Is recipient country a Communist country? Will assistance be provided to the Socialist Republic of Vietnam, Cambodia, Laos, Cuba, Uganda, Mozambique, or Angola? No.
7. FAA Sec. 620(i). Is recipient country in any way involved in (a) subversion of, or military aggression against, the United States or any country receiving U.S. assistance, or (b) the planning of such subversion or aggression? No.
8. FAA Sec. 620 (j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction, by mob action, of U.S. property? No.
9. FAA Sec. 620(l). If the country has failed to institute the investment guaranty program for the specific risks of expropriation, convertibility or confiscation, has the AID Administrator within the past year considered denying assistance to such government for this reason? El Salvador has instituted the Investment Guaranty Program
10. FAA Sec. 620(o); Fishermen's Protective Act of 1957, as amended, Sec. 5. If country has seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters:
- a. has any deduction required by the Fishermen's Protective Act been made?
 - b. has complete denial of assistance been considered by AID Administrator?
11. FAA Sec. 620; FY 79 App. Act, Sec. 603. (a) Is the government of the recipient country in default for more than 6 months on interest or principal of any AID loan to the country? (b) Is country in default exceeding one year on interest or principal on U.S. loan under program for which App. Act appropriates funds? No.
12. FAA Sec. 620(s). If contemplated assistance is development loan or from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget which is for military expenditures, the amount of foreign exchange spent on military equipment and the Yes. 9.2 percent of the current national budget is assigned for military expenses. Of this amount, \$10,000,000 is to be expended on military equipment. The Goes has not purchased sophisticated weapons.

A.12.

ANNEX A
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amount spent for the purchase of sophisticated weapons systems? (An affirmative answer may refer to the record of the annual "Taking Into Consideration" memo: "Yes, as reported in annual report on implementation of Sec. 620(s)." This report is prepared at time of approval by the Administrator of the Operational Year Budget and can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

13. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have they been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

No.

14. 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 AID Administrator in determining the current AID Operational Year Budget?

From information available to the Mission, El Salvador is meeting its UN obligations.

15. FAA Sec. 620A, FY 79 App Act, Sec. 607. Has the country granted sanctuary from prosecution to any individual or group which has committed an act of international terrorism?

No

16. FAA Sec. 656. Does the country object, on basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. there to carry out economic development program under FAA?

No.

17. FAA Sec. 669, 670. Has the country, after August 3, 1977, delivered or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards? Has it detonated a nuclear device after August 3, 1977, although not a "nuclear-weapon State" under the nonproliferation treaty?

No.

B. FUNDING CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria

a. FAA Sec. 102(h)(4). Have criteria been established and taken into account to assess commitment progress of country in effectively involving the poor in development; on such indexes as: (1) increase in agricultural productivity through small-farm labor intensive agriculture, (2) reduced infant mortality, (3) control of population growth, (4) equality of income distribution, (5) reduction of unemployment, and (6) increased literacy?

El Salvador is committed to involve the poor in the development process by carrying out several projects to address their needs in the agricultural, health, nutrition, housing, employment and other sectors.

B.3.

b. FAA Sec. 104(d)(1). If appropriate, is this development (including Sahel) activity designed to build motivation for smaller families through modification of economic and social conditions supportive of the desire for large families in programs such as education in and out of school, nutrition, disease control, maternal and child health services, agricultural production, rural development, and assistance to urban poor?

Yes.

2. Economic Support Fund Country Criteria

a. FAA Sec. 502B. Has the country engaged in a consistent pattern of gross violations of internationally recognized human rights?

No.

b. FAA Sec. 533(b). Will assistance under the Southern Africa program be provided to Mozambique, Angola, Tanzania, or Zambia? If so, has President determined (and reported to the Congress) that such assistance will further U.S. foreign policy interests?

N/A

c. 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?

N/A

d. FY 79 App. Act, Sec. 113. Will assistance be provided for the purpose of aiding directly 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?

N/A

e. FAA Sec. 620B. Will security supporting assistance be furnished to Argentina after September 30, 1978?

N/A

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5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable generally to projects with FAA funds and project criteria applicable to individual fund sources: Development Assistance (with a subcategory for criteria applicable only to loans); and Economic Support Fund.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE?
HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PRODUCT?

A. GENERAL CRITERIA FOR PROJECT

1. FY 79 App. Act Unnumbered; FAA Sec. 653 (b); Sec. 634A. (a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project; (b) Is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that figure)?
Congressional notification has been processed.
2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,000, will there be (a) engineering, financial, and other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?
Yes.
3. FAA Sec. 611(a)(2). If further 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?
None required.
4. FAA Sec. 611(b); FY 79 App. Act Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per the Principles and Standards for Planning Water and Related Land Resources dated October 25, 1973?
N/A
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all 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?
N/A
6. FAA Sec. 209. Is project susceptible of 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.
No.

7. FAA Sec. 601(a). Information and conclusions whether project 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 will foster development of community organizations.

8. FAA Sec. 601(b). Information and conclusion 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).

U. S. contractors will provide technical assistance.

9. FAA Sec. 612(b); Sec. 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 to meet the cost of contractual and other services.

The host country is providing counterpart contribution to the project in local currency. No U.S. owned foreign currencies are available for utilization in 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. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes.

12. FY 79 App. Act Sec. 608. 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?

No.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(b); 111; 113; 281a. 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, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained

This project is designed to benefit the poor by promoting improvements in health, nutrition and sanitation. Self-help will be encouraged by the heavy participation of rural and urban poor in the project. Women will participate in both Project Implementation and Administration.

B.1.a.

basis, using the 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?

b. FAA Sec. 103, 103A, 104, 105, 106, 107.
is assistance being made available: (include only applicable paragraph which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.)

(1) [103] for agriculture, rural development or nutrition; if so, extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, is full account taken of needs of small farmers;

(2) [104] for population planning under sec. 104(b) or health under sec. 104(c); if so, extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems and other modes of community research.

(3) [105] for education, public administration, or human resources development; if so, extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, or strengthens management capability of institutions enabling the poor to participate in development;

(4) [106] for technical assistance, energy, research, reconstruction, and selected development problems; if so, extent activity is:

(i) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

(ii) to help alleviate energy problems;

(iii) research into, and evaluation of, economic development processes and techniques;

(iv) reconstruction after natural or manmade disaster;

Yes. Local productive activities will be encouraged to supplement foods provided from external sources for the MCH/Nutrition Centers.

Both components emphasize provision of primary health and nutrition care, including promotion for poor residents of urban marginal and rural areas.

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B.1.b.(4).

(v) for special development problem, and to enable proper utilization of earlier U.S. infrastructure, etc., assistance;

(vi) for programs of urban development, especially small labor-intensive enterprises, marketing systems, and financial or other institutions to help urban poor participate in economic and social development.

c. [107] Is appropriate effort placed on use of appropriate technology?

Yes. A counterpart contribution exceeding 25% of total project cost is programmed.

d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or has the latter cost-sharing requirement been waived for a "relatively least-developed" country)?

e. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to the Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"?

NO.

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 and political processes essential to self-government.

By improving living conditions among the poor, the project will contribute directly in the people's ability to participate in governmental and political process

g. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase or productive capacities and self-sustaining economic growth?

Yes.

2. Development Assistance Project Criteria
(Loans Only)

a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan, including reasonableness of repayment prospects.

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete in the U.S. with U.S. enterprise, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan?

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B.

3. Project Criteria Solely for Economic Support Fund

a. FAA Sec. 531(a). Will this assistance support promote economic or political stability? To the extent possible, does it reflect the policy directions of section 102?

b. FAA Sec. 533. Will assistance under this chapter be used for military, or paramilitary activities?

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5C(3) - STANDARD ITEM CHECKLIST

Listed below are 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. <u>FAA Sec. 602</u> . Are there arrangements to permit U.S. small business to participate equitably in the furnishing of goods and services financed? | Yes. Standard procurement regulations, procedures and good commercial practices will be followed under the project. |
| 2. <u>FAA Sec. 604(a)</u> . Will all commodity procurement financed be from the U.S. except as otherwise determined by the President or under delegation from him? | Yes. |
| 3. <u>FAA Sec. 604(d)</u> . If the cooperating country discriminates against U.S. marine insurance companies, will agreement require that marine insurance be placed in the United States on commodities financed? | Yes. |
| 4. <u>FAA Sec. 604(e)</u> . If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? | N/A |
| 5. <u>FAA Sec. 608(a)</u> . Will U.S. Government excess personal property be utilized wherever practicable in lieu of the procurement of new items? | Yes. |
| 6. <u>FAA Sec. 603</u> . (a) Compliance with requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 per centum 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 that such vessels are available at fair and reasonable rates. | Yes. |
| 7. <u>FAA Sec. 621</u> . If technical assistance is financed, will such assistance be furnished to the fullest extent practicable as goods and professional and other services from private enterprise on a contract basis? If the | Yes. |

A.7.

facilities of other Federal agencies will be utilized, are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

8. International Air Transport. Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will provision be made that U.S.-flag carriers will be utilized to the extent such service is available?

Yes.

9. FY 79 App. Act Sec. 105. Does the contract for procurement contain a provision authorizing the termination of such contract for the convenience of the United States?

B. Construction

1. FAA Sec. 601(d). If a capital (e.g., construction) project, are engineering and professional services of U.S. firms and their affiliates to be used to the maximum extent consistent with the national interest?

N/A

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?

N/A

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the United States not exceed \$100 million?

N/A

C. Other Restrictions

1. FAA Sec. 122 (e). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter?

N/A

2. 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?

Yes.

3. FAA Sec. 620(h). Do arrangements preclude promoting or assisting the foreign aid projects or activities of Communist-bloc countries, contrary to the best interests of the United States?

Yes.

4. FAA Sec. 636(i). Is financing not permitted to be used, without waiver, for purchase, long-term lease, or exchange of motor vehicle manufactured outside the United States, or guaranty of such transaction?

Yes.

C.

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5. Will arrangements preclude use of financing:
- a. FAA Sec. 104(f). To pay for performance of abortions or to motivate or coerce persons to practice abortions, to pay for performance of involuntary sterilization, or to coerce or provide financial incentive to any person to undergo sterilization? Yes.
 - b. FAA Sec. 620(g). To compensate owners for expropriated nationalized property? N/A
 - c. FAA Sec. 660. To finance police training or other law enforcement assistance, except for narcotics programs? N/A
 - d. FAA Sec. 662. For CIA activities? N/A
 - e. FY 79 App. Act Sec. 104. To pay pensions, etc., for military personnel? N/A
 - f. FY 79 App. Act Sec. 100. To pay U.N. assessments? N/A
 - g. FY 79 App. Act Sec. 107. To carry out provisions of FAA sections 209(d) and 251(h)? (Transfer of FAA funds to multilateral organizations for lending.) N/A
 - h. FY 79 App. Act Sec. 112. To finance the export of nuclear equipment, fuel, or technology or to train foreign nations in nuclear fields? N/A
 - i. FY 79 App. Act Sec. 601. To be used for publicity on propaganda purposes within United States not authorized by the Congress? N/A

611

7 de marzo de 1980

CORRESPONDENCIA

Proyectos: "Atención de Salud de los Tu-
guriros" y "Centros Rurales de Nutrición".

Sr. Director de la
Agencia para el Desarrollo Internacional
en El Salvador (AID),
Sr. Charles J. Stockman,
Ciudad.

El propósito de ésta es presentar a Ud. la solicitud ofi-
cial de apoyo que la Agencia a su digno cargo prestará a nues-
tros proyectos: "Atención de Salud de los Tuguriros" y "Centros
Rurales de Nutrición".

El primero para el período de dos años y el segundo para
tres años.

De conformidad a los proyectos, hemos elaborado el costo
total de la ayuda que se eleva al monto de \$1.400.000.00, corres-
pondiendo al primer proyecto \$1.100.000.00, al segundo \$.....
250.000.00 y el aporte de \$50.000.00, para apoyar la logística
de los alimentos.

No omitimos manifestarle que de recibirse esta ayuda y de
ser posible la ejecución de los proyectos antes mencionados, las
poblaciones más beneficiadas serán la rural y la urbana margina-
da, las cuales como es de su conocimiento, son las que están en
condiciones de salud más deficiente.

Al agradecer a Ud. su gentil ayuda, le saludo y me suscri-
bo como siempre atento y seguro servidor.


Dr. Rodolfo Girón Flores,
Ministro.

cc: Srta. Dale C. Gibb. ✓

/onf

PROPOSED TUGURIO SITES, PHASE I

TUGURIOS A ATENDER EN PRIMERA ETAPA POR REGION, LOCALIDAD Y ESTABLECIMIENTO RESPONSABLE

REGION OCCIDENTAL

LOCALIDAD	NOMBRE	N° vivienda	Población	Establecimiento Responsable
Santa Ana	Col. La Fuerteza (Pte.)	463	2093	U.S. Santa Ana
	" " " (Sur)	19	84	
	" " Fortaleza	25	170	
	Cas. El Progreso	22	178	
	" Las Cocinas	57	342	
Ahuachapán	Col. Zacamil	108	553	" Ahuachapán
	Ctón. Chancuyo	105	345	
Sonsonate	El Şulupe	12	70	" Sonsonate
	Sensunapán	16	85	
	La Providencia	10	52	
	Ceniza	20	112	
Acajutla	La Fuerteza	586	2945	" Acajutla
	Calle Vieja	159	580	
	Playa Atarraya	440	3380	
Metapán	Brisas del Sur	90	500	C.S. Metapán
	Riveras del Río San José	180	900	
	La IRCA	20	80	
	Las Flores	25	125	
	San José	110	720	
	El Capulín	20	70	
	Pacheco	20	60	
SUB-TOTAL	21	2507	13444	

REGION CENTRAL

LOCALIDAD	NOMBRE	N° vivienda	Población	Establecimiento Responsable
Nueva San Salvador	San Martín de Porres	90	540	
	El Progreso	115	690	
	La Cascajera	125	950	
	Repto. Mpal. Las Delicias	46	276	
	Santa Marta	27	162	
Antiguo Cuscatlán	El Tanque	38	228	
	Fte. Alcaldía Municipal	70	420	
	El Cementerio	20	120	
Nuevo Cuscatlán	San Antonio La Joya	108	648	
Jayaque	Cuesta de Penate	20	120	
SUB-TOTAL	10	659	4154	
REGION METROPOLITANA	El Hoyo	178	921	U.S. San Miguelito
	Santa Rosa Atlacatl	130	562	" Ciudad Delgado
	El Bambú N° 1	50	375	
	Col. San Simón	53	387	
	Santa Luisa	95	702	U.S. Zacamil
	Trinidad	138	934	
	Campamento San Antonio	98	425	" "
	Banco Hipotecario	97	579	
	Santa Lucía	83	525	
	Mesón Col. San Antonio	9	40	
SUB-TOTAL	10	931	5450	

REGION PARA-CENTRAL

LOCALIDAD	NOMBRE	N° vivienda	Población	Establecimiento Responsable
San Vicente	La Caridad	37	188	
	El Socorro	29	115	
	SUB-TOTAL	2	66	303
REGION ORIENTAL				
San Miguel	Col. San Carlos			U.M. Depto. San Miguel
	3 de Mayo	45	285	
	Col. Los Naranjos			
	" Chávez	50	302	
	" San Juan	15	90	
	" El Angel			
	" 3 de Octubre			
	Samorán 1			
	Samorán 2			
	La Ranchería			
	Col. Latio			
	Motel Palmera			
	Col. Dolores			
	" Granillo			
" La Esmeralda				
Entrada Ctón. Samorán				
Fte. Gasolinera Chevron				
La Unión	Sector La Playa	112	966	U.M. La Unión
	Campo Villalta	268	1553	
	Col. Belén			
	Ctón. Huisquil	592	3719	
Jiquilisco	Puerto Avalos	250	1500	U.S. Jiquilisco

Contin. REGION ORIENTAL

LOCALIDAD	NOMBRE	N° vivienda	Población	Establecimiento Responsable
	La Concordia	167	1002	
	Col. Las Flores			
Gotera	Cas. La Cantera	30	153	U.M. Gotera
	Ctón. San José			
Santiago de María	Pirata	122	782	" Santiago de María
Puerto El Triunfo	Tugurió N° 1			U.S. Puerto El Triunfo
Usulután	Col. El Cocal	300	1800	U.M. Usulután
	" Deusem	150	900	
	" Santa Clara	300	1800	
SUB-TOTAL	32	2401	14852*	
TOTAL	75	6564	38203**	

* datos de Región incompletos
** cifra incompleta

COMMUNITY MATERNAL CHILD HEALTH/NUTRITION CENTERS

RATIONS

	DAILY RATION	MONTHLY RATION (22 days)
<u>A. 2-5 years old</u>		
CORN	70 grams	1,540 Kg.
RICE	30 grams	.660 Kg
NON-FAT DRIED MILK	30 grams	.600 Kg.
VEGETABLE OIL	15 grams	.330 Kg.
TOTAL	145 grams	3,190 Kg.
<hr/>		
	DAILY RATION PER/PERSON	MONTHLY RATION 30 DAYS FAMILY OF 5
<u>B. Volunteers</u>		
RICE	200 grams	30.0 Kg.
SOY-FORTIFIED CORNMEAL	100 grams	15.0 Kg.
NON-FAT DRIED MILK	27 grams	4.08 Kg.
VEGETABLE OIL	23 grams	3.49 Kg.
TOTAL	350 grams	52.57 Kg.

COMMUNITY MATERNAL CHILD HEALTH/NUTRITION CENTERS 1/

Criteria for site selection will be:

1. The communities are already participating in development activities or have indicated receptivity for developing programs. Improvements that would make a site most favorable for establishing a Center would be proximity to potable water and the existence of cooperative or solidarity groups.
2. The communities have highest rates of malnutrition.
3. Rural Health Aides or other field agents from institutions that are participating in the program are working in the area and give direct support to the program.
4. The people in the community are particularly receptive.

The selection of the communities will be the responsibility of Regional Committees on which there are representatives of the Ministries of Health, Interior and Agriculture, ISTA and INSAFACOOB.

Criteria for selection of children to participate in Center activities

They must come from the community and be between the age of two and five.

Their parents must agree to bring the child to the Center and be willing to take part in the program.

The children must not have complicated malnutrition or other conditions warranting medical care.

If the number of eligible children exceeds the Center's capacity, priority will be given to those with visible signs of malnutrition.

Children will be allowed to stay beyond the six month cycle if they are found to be in second or third degree malnutrition based on weight for age or under weight for height criteria. Furthermore, they may be readmitted if they have had to interrupt their stay for a valid reason such as illness or temporary migration due to parent's place of work.

The Centers will be open from 8-12 Monday through Friday; it may be desirable and possible to keep them open until 3 p.m.

1/ Translation of Ministry of Health Rural Nutrition Center Proposal.

Principal Activities of Centers

1. Providing health care, preventive and curative, and checking nutritional status of children; measurements will be taken at least at the beginning, in the middle and at the end of the six months cycle and will be taken by the superior of personnel from nearby health establishment and eventually by the community personnel (volunteers and mothers). Curative tasks will include giving early treatment for diarrhea, stomach aches, worms, cuts and bruises. Vaccinations will be checked and given as needed by health personnel.
2. Individual and group games that promote social, psychological and other development and enhance learning ability will be an important daily activity.
3. Each day in the Center and children will receive a refreshment and lunch that cover at least 45% of calorie requirements and 61% of protein requirements for this age group. (Title II ingredients will include for each child per day, 30 grams of milk, 30 grams of rice, 60 grams of cornmeal and 15 grams of oil; local foods will include vegetables and fruit and sugar with increasing contributions to the other diet components).
4. Mothers will be educated through their participation, on a rotating basis, in the center, through reinforcement of center activities and promotion provided by the rural health aides; and through project-related activities such as CENTA's mothers clubs, lectures from promotoras from DIDECO, etc.

Organization of the Center, Supervision Levels

Opening a Center will involve the following steps, to be undertaken by coordinated efforts of institutions and programs in the area.

1. Inventory of the human and material resources in the community; survey of under five children, young women between 14 and 20 years of age to serve as volunteers, site possibilities.
2. Determine the extent of community development activity, either undertaken or planned.
3. Put in the necessary resources; the infrastructure (locale, potable water, latrines as feasible); personnel (train volunteers, supervisors and designate responsible support personnel); install equipment and materials.

Volunteers to Operate the Center

The volunteers must be from the community, be able to read and write, be between 14-20 years of age, want to work as a "volunteer" and improve their community, and be willing to take part in the training program.

The volunteers will take care of the children in the Center and will organize the participation of the mothers. They will receive incentive pay in the form of Title II food, which is worth \$20 for a month of half-time work.

Supervision of Centers

Where a Rural Health Aide is working in the same vicinity, he/she will supervise the health aspects of the work during his/her normal round of visits. The RHA will tend to the needed referral cases and see that vaccinations are given.

RHA supervisors as well as the Regional Health Office will provide back-up supervision to the Centers. Promotores and Educadores del Hogar from DIDECO will guide the child development activities.

Other Support

All organizations working in the area will lend support to the community units according to availability, including professional medical care, sanitation inspectors, water engineers.

PROJECT COORDINATOR

URBAN HEALTH

Job Description

- a. Act as the liaison officer between the MOH team and the community health and sanitation teams;
- b. Visits the tugurio teams on a regular basis to provide in-service support, and management information to MOH and USAID;
- c. Arrange coordination of MOH programs with other USAID funded project which are being designed to serve tugurio residents (for example, the USAID funded Marginal Community Upgrading Project; the Emergency Employment Program; and the Food-for-Work Program).

The first two programs have planned inputs (sewer pipe, water, latrine construction, etc.) and infrastructure components which should be coordinated with this program. The incumbent will be responsible for assuring coordination at least at the level of site selection so as to match that infrastructure investment with the human resource functions of this project.

- d. Keep USAID and the MOH updated on number of MOH teams and urban health and sanitation teams on-site, the nature of their patient encounters, constraints to effective project implementation, etc.
- e. Participate in intra-ministerial coordinating committee.

URBAN HEALTH EQUIPMENT AND SUPPLIESFurniture:

Wooden chair
 Wooden couch
 File cabinet
 Wooden table
 First aid box

Medical Equipment and Supplies

Gloves #7
 Gloves #7-1/2
 Thermometer (oral)
 Thermometer (rectal)
 Syringe 10 cc
 Syringe 5 cc
 Syringe (disposable) 3 cc with needle 11 or 23 x 1-1/2
 Hypodermic needle #18 x 1-1/2
 " " 20 x 1-1/2
 " " 22 x 1-1/2
 Rochester forceps
 Auxiliary forceps
 Tray with cover
 Kidney tray
 Graduate cup 100 cc
 " " 50 cc
 First-aid case for auxiliary nurses
 Tongue depressor
 Surgical gauze
 Soap (liquid with hexachloropheno)

 Sheets and towels

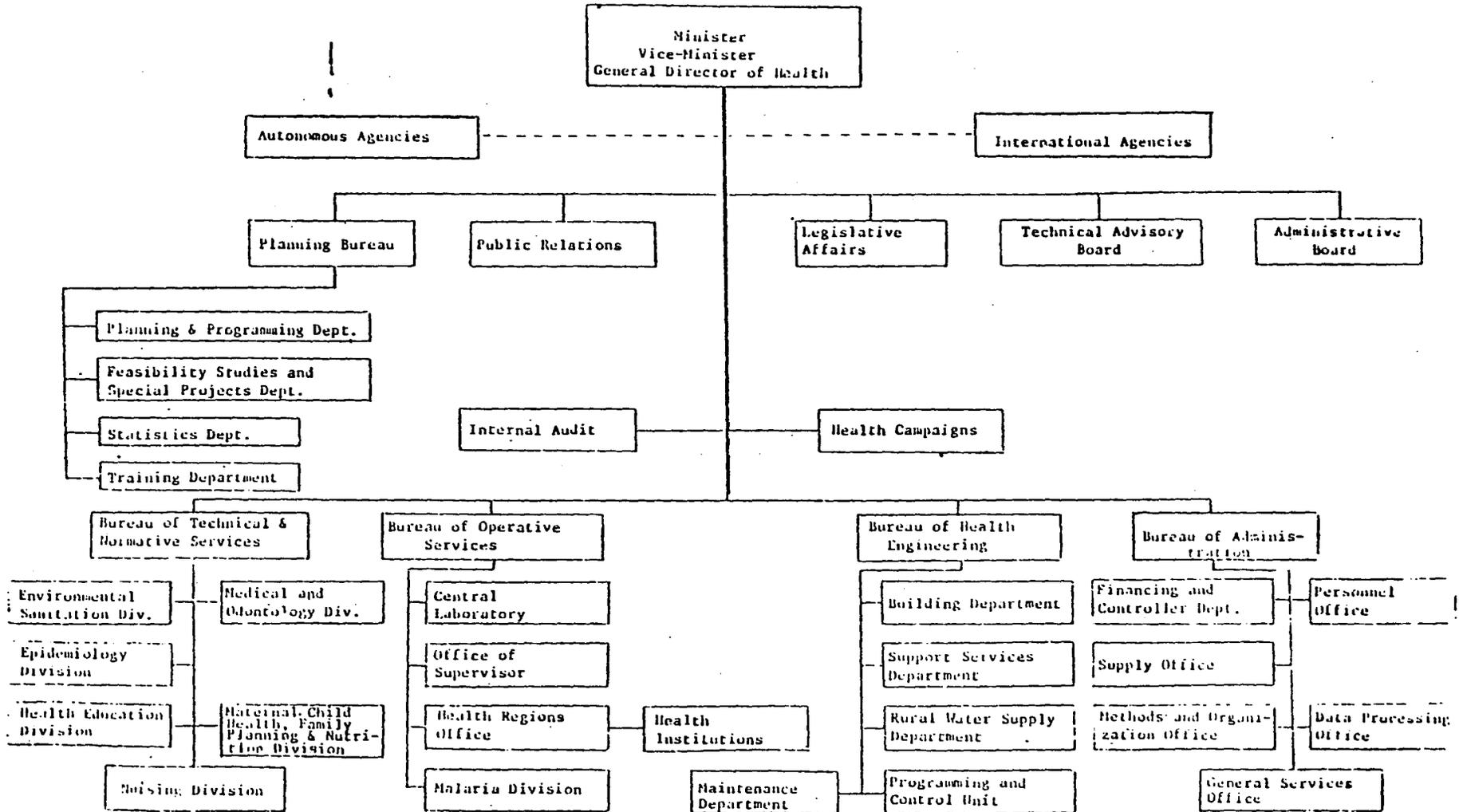
Sanitation Equipment

Wheel barrows
 Picks
 Shovels
 Brooms
 Insecticide bombs
 Larvicides
 Insecticide
 Boots
 Gloves
 Trash containers

URBAN HEALTH PROPOSED MEDICATIONS

DESCRIPCION	Unidad Medida
Ampicilina cap. 250 mgr.	cto.
" jbe. 125 mgrs. x 5 ml.	fco. 60 cc.
Eritromicina comp. 250 mgrs.	cto.
" jbe. 125 mgrs. x 5 ml.	fco. 60 cc.
Pennicilina G Procaínica Potásica 4,000,000 UI vial	fco.
Acido Acetil Salicílico 0.10 gr.	cto.
" " " 0.50 "	"
Multivitaminas jbe.	lit.
" tab.	cto.
Sulfato Ferroso jbe. (gotas)	lit.
" " tab.	cto.
Expectorante Simple jbe.	lit.
Kaolín, Pectina, Nitrofurazona Sulfaguanid Susp.	"
Dimenhidrinato 50 mgr. tab.	cto.
Clorfeniramina Maleato 4 mgr. tab.	"
" " 4 mgr. x 5 ml. jbe.	lit.
Nitrofurazona unguento	Kg.
Calamina loción	lit.
Benzoato de Bencilo Susp. Bals.	"
Belladona y Fenobarbital	"
Hidrox. de Al Gel	"
Diazepán 5 mgr. tab.	cto.
Mebendazole tab.	"
Suero Oral 25 grs.	sobre
Unguento Cloroanfenicol aplicap.	cto.
Fungicida Tintura	lit.
Mercurio Cromo	"
Alcohol desnaturalizado 90%	"
Agua destilada amp. de 10 cc.	c/u

ORGANIZATIONAL CHART OF THE MINISTRY OF PUBLIC HEALTH AND SOCIAL ASSISTANCE



ANNEX I

JOB DESCRIPTION/TECHNICAL ASSISTANCE

Community MCH/Nutrition Centers

The contractor will assist the MCH Division of the Ministry of Health in preparation of operational guidelines, a record-keeping system and course content of the training for the Community MCH/Nutrition Centers activity.

Working with MCH, the contractor will prepare draft manuals for center operation (in addition to criteria already developed regarding the selection of centers and the selection of children for admission), which will include information about the foods to be utilized.

The contractor will meet with the members of the Project's Evaluation and Review Committee to learn their ideas on which of the suggested quantitative and qualitative indicators should be monitored. The contractor will develop draft formats for record keeping at the Regional Health and volunteer level with the MCH and Operative Divisions. Examples of details to be included are:

- a system for noting attendance of children and mothers in the Center.
- a system for recording food use that will permit later calculation of proteins and calories consumed by each child daily.

The contractor will advise the MCH on course content of training for the docentes, supervisors and volunteers and discuss alternatives. Included will be information about food handling, use, storage, etc.

The contractor will discuss Title II food requirements with the temporarily assigned consultant in USAID.

The contractor will visit Regional Offices of MOH and Health posts, and through discussions plus observations at canton level determine the feasibility of the guidelines and format designed. (at least two weeks).

The contractor will discuss necessary alterations in the material and make final drafts together with the MCH.

TIME: 2 months
SUGGESTED SOURCE: INCAP/AID Supported Grant
Leonel Gallardo

EQUIPMENT AND MATERIALS FOR COMMUNITY MCH/NUTRITION CENTERS

Furniture:

- 5 benches
- 5 strawmats
- 5 sacks of jute or other material
- 1 small table
- 1 individual bench

Utensils:

- 1 urn of clay or handened aluminum with 10-liter capacity
- 1 large frying pan of clay or aluminum, 16 to 18" diameter
- 1 rice cooker of 3 lbs. capacity
- 2 large ladles of wood, gourd or other material
- 1 medium sized kitchen knife
- 1 large and 1 small crate
- 50 plastic plates
- 50 plastic glasses, cups of 8 oz.
- 50 metal teaspoons, 5 cc.

Educational/Recreational Material:

- 2 wooden cube games
- 2 perforated cylinder games
- 5 balls
- 15 official-sized reams of paper
- 3 large rolls of scotch tape or gummed paper
- 2 games of perforated wooden balls
- 10 pairs of blunt scissor

Materials available in the community including:

ears of corn, small gourd containers, empty threadspools, small boxes, used juice tins and other discarded materials.
Posters, placards, newspaper and magazine pictures.

First Aid Kit:

Wooden box with a key lock or padlock

Medicines: 500 aspirins for children
1/4 gallon of Neodonal
1 gallon of antidiarrhetic in syrup base
200 ml. of merthiolate
200 ml. of alcohol
25 envelopes of gauze
40 - 1 oz. envelopes of cotton
1 - large roll of adhesive plasters

Equipment for Nutrition Surveillance

- 1 hanging scales, with 60 lb. capacity
- 1 metric tape
- 1 wooden height measuring board

Weight-for-Age Growth Charts (INCAP)

SUGGESTED INDICATORS FOR EVALUATION PLAN, COMMUNITY MCH/NUTRITION CENTERS

QUANTITATIVE OUTPUTS	QUALITATIVE INDICATORS
<p>1. Number of Centers Operating</p>	<p>1.1. Community Development organization (s) working in the canton, caserio?</p> <p>1.2. Rural Health Aide lives in cantón, caserio, in nearby municipio?</p> <p>1.3. Pre-program effort on part of the community. Land and buildings provided. Adequacy? Renovations Made? Materials supplied by community. Access roads; improved water supply; improved sanitation system.</p> <p>1.4. Total number of families; under five and 14-20 year old single females.</p>
<p>2. Number of Volunteers trained.</p>	<p>2.1. Number of volunteers working in center? Hours scheduled? Attendance record.</p> <p>2.2. Child dropouts. Recorded reasons? Amount of time^{for} psychomotor activity? Amount of time^{for} preparing food? Amount of time^{for} record-keeping? Other time utilization?</p> <p>2.3. Number of referrals made to local clinic. Accuracy of referrals?</p> <p>2.4. Medications dispensed in Center? Complaints treated?</p> <p>2.5. Hygiene and cleanliness practiced in Center? Storage of food, preparation; water source?</p>
<p>3. Number of rations delivered to children and volunteers.</p>	<p>3.1. Number of children fed in the center?</p> <p>3.2. Amount of food delivered, percentage of adequacy, calories and proteins.</p> <p>3.3. Promptness of food delivery to centers? Storage adequacy? Do families receive other food? What and how much children eat at home, according to mothers?</p>

QUANTITATIVE OUTPUTS	QUALITATIVE INDICATORS
	<p>3.4. Acceptability of foods given. Kind? Quantity appropriately used and prepared? Menus.</p> <p>3.5. Local food - amount provided? From source?</p>
<p>4. Number of families participating</p>	<p>4.1. Number of families providing food? Land for Center Garden? Other aid to functioning of Center?</p> <p>4.2. Punctuality of bringing children? Reasons for not bringing children?</p> <p>4.3. Number of mothers attending clubs when clubs are available?</p> <p>4.4. Number of fathers attending <u>comités comunales</u>.</p> <p>4.5. Projects undertaken in the community for environmental improvement since the center began operating? Number of families participating?</p> <p>4.6. Number of meetings of Health Committee. Number of attendees.</p> <p>4.7. Mother's cooperation with preparation of food. Number each day? How many mothers or siblings of Center children?</p>

ANNEX L

SUGGESTED FORMULA FOR CALCULATION OF COST-EFFECTIVENESS OF COMMUNITY MCH/NUTRITION CENTERS

If the Committee decides that an impact evaluation is feasible and given that the anthropometric data will be collected in any case, the cost effectiveness formula described below can be used. The Unit-Measure of Cost Effectiveness (UMCE), based on weight-for-age change, equals the total cost of program operation (i.e., No. of children in the program X \$31.67/child/for 6 months) divided by the sum of children gaining and maintaining, less the number of children who lost weight.

- N (+) net number of children in health nutrition status or improved nutrition status.
- N (-) net number of children whose status has deteriorated.
- N (-) → (+) net number of those whose nutritional status has improved.
- N (+) → (+) net number of children who have maintained nutritional status.
- N (+) → (-) net number of children who have deteriorated.

$$\text{Thus: UMCE} = \frac{\text{COST OF THE PROGRAM OPERATION}}{N \text{ (+) } \rightarrow \text{ (+) } + N \text{ (-) } \rightarrow \text{ (+) } - (N \text{ (+) } \rightarrow \text{ (-) })$$

A refinement of the UMCE formula above, which now measures overall program cost-effectiveness, is to include only children entering the program with 2nd and 3rd degree malnutrition in the numerator and denominator. This has the effect of focusing the analysis on the children most in need of supplementary feeding and may show an improved cost-effectiveness ratio due to the expectation that a greater proportion of the more malnourished will show improvements, than the entire population of children participating (i.e., the denominator of the revised UMCE will become relatively larger).

NOTE: If data processing is contemplated for the UMCE calculation, the Committee should ensure that a unique number be assigned to each child entering the program. This can be accomplished easily by assigning blocks of numbers to each Community MCH/Nutrition Center as it is established, i.e.,

001-250 to C/MCH/N/C No. 1
 251-500 to " No. 2, etc.

The first child registered in the Community MCH/Nutrition Center No. 1 is given number 1; the first child in Community MCH/Nutrition Center No. 2, number 251; and so on.