PD-ABF-962

UNCLASSIFIED

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

PERU

PROJECT PAPER

PROJECT 2000

AID/LAC/P-841

PROJECT NUMBER: 527-0366

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Amendment Number: ____

DOCUMENT CODE: 3

2. COUNTRY/ENTITY: Peru

3. PROJECT NUMBER: 527-0366

4. BUREAU/OFFICE: LAC — 05

5. PROJECT TITLE (maximum 40 characters): Project 2000

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 09 DD 30 YY 00

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)
A. Initial FY 93 B. Quarter 4 C. Final FY 99

8. COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY 93 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total	5,815	2,100	7,915	19,811	10,189	30,000
(Grant)	(5,815)	(2,100)	(7,915)	(19,811)	(10,189)	(30,000)
(Loan)	(-)	(-)	(-)	( )	( )	( )
Other U.S. 1. PL 480		1,880	1,880		22,000	22,000
Other U.S. 2.						
Host Country		800	800		8,000	8,000
Other Donor(s)						
TOTALS	5,815	4,780	10,595	19,811	40,189	60,000

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. ACTIVITY CODE	C. ACTIVITY CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) CS	HERI					19,500		19,500	
(2) POP	HECS					4,500		4,500	
(3) HE	HEFI					6,000		6,000	
(4)									
TOTALS						30,000		30,000	

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

11. SECONDARY ACTIVITY CODE: HESD HEMH HEDD PNSD

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

A. Code	PBL	PVO	TFE	CS	RUR	CIT	TWN
B. Amount	11,700	11,700	5,595	21,309	16,380	3,510	3,510

13. PROJECT PURPOSE (maximum 480 characters)

To increase the utilization of priority maternal and child health interventions.

14. SCHEDULED EVALUATIONS
Interim MM 09 YY 95 MM 12 YY 97 Final MM 03 YY 00

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

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

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

James Sanford, Controller

17. APPROVED BY
Signature: George A. Wachtenheim
Title: Mission Director
Date Signed: MM 03 DD 09 YY 93

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

AID 1020-4 (9-70)

PROJECT AUTHORIZATION

Name of Country: PERU

Name of Project: **Project 2000**

Number of Project: 527-0366

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize **Project 2000** ("Project") for Peru, involving planned obligations of not to exceed thirty million United States dollars ($30,000,000) in grant funds ("Grant") over a seven-year period from date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the Project. The planned life of the project is eighty-four months from the date of initial obligation.

2. The Project consists of activities to: (1) strengthen the capability of the Ministry of Health (MoH) to deliver child and maternal health services, including perinatal care, family planning, acute respiratory infection control, nutrition, immunizations, and diarrheal disease control; (2) increase the efficiency, accountability and quality of health services; and (3) encourage the sustainability of health services through improved health financing and resource allocation.

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

Source and Origin of Commodities and Nationality of Services

4. Commodities financed by A.I.D. under the Grant shall have their source and origin in the United States or Peru (for local cost financing, HB 1, Supplement B, Chapter 18), except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services financed under the Grant shall have Peru or the United States as their place of nationality, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Grant shall be financed only on flag vessels of the United States, except as A.I.D. may otherwise agree in writing.

Waivers

5. The following waivers to A.I.D. regulations are approved for the Project, under the specific conditions and justifications stipulated in the Project Paper Annex.

(a) The requirement that the host government fully fund international participant travel is hereby waived (Waiver FY 93-007-527-0366), thereby allowing resources authorized under the Project to be applied for these purposes.

BA

(b) The source/origin restriction to Geographic Code 000 (U.S. and host country only) is amplified to Geographic Code 899 (Free World), to allow the purchase of up to $500,000 worth of cold chain equipment from other sources; and the allowable nationality of flag vessels for ocean shipping is amplified to Geographic Code 935, to permit the use of ocean vessels under flag registry of Free World countries, including Perú. Both of these amplifications are contained in Waiver FY 93-009-527-0366.

(c) The requirement for full and open competition in commodity procurement is waived (Waiver FY 93-008-527-0366), to allow cold chain equipment up to a value of $500,000 to be purchased from UNICEF.

Conditions Precedent

6. By the time of the first disbursement under the Project, Peru will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

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

(b) A statement of the name(s) of the person(s) holding or acting in the office of the Grantee specified in Section 8.2 of the Agreement and of any additional representatives, together with a specimen signature of each person specified in such statement;

(c) An explicit commitment on behalf of the Government of Peru to correct any institutional weaknesses in its financial management. A.I.D. has been analyzing the possibility of financing a technical assistance contract to support the Ministry of Health in the design of an administrative and accounting system compatible with A.I.D. norms and regulations, thus ensuring transparency of accounts and facilitating audit requirements. Under such a contract, key Ministry personnel that handle A.I.D. funds would receive appropriate training. A letter from the Ministry of Health confirming its interest in this type of assistance would constitute such an explicit commitment.

(d) Resolution of an outstanding debt of US$123,600, by receipt of payment of no less than one-third of that amount by September 30, 1993, and a timetable for remaining payments agreed upon.

7. Prior to any award of the Institutional Contract under this grant, Peru will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(a) Resolution of an outstanding Bill of Collection in the amount of US$1,067,047, either through direct payment in US dollars or alternative resolution satisfactory to USAID/Peru. The

immediate first step in this regard would be for the Ministry to designate a working group to attempt to locate any relevant supporting documentation that might still exist, in the hope of reducing the amount that must be paid.

(b) Proof of the establishment by the Government of Peru of an Interagency Advisory Committee on Health Management and Financing, minimally with representation from the Ministry of Health, which shall chair the Committee, the Ministry of Economy and Finance, and representatives of the major donors of A.I.D., the IDB and the IBRD. By way of regularly scheduled meetings, the Committee will provide an ongoing forum and additional source of technical expertise for the Ministry of Health in the areas of health management and financing. The Committee will be specifically tasked by the Ministry of Health to examine prevailing policies in health management and financing, with a view toward suggesting areas where reforms might be contemplated and outlining, for the consideration of the Ministry of Health, options for the design and implementation of reforms that would strengthen management and financing. Verifiable indicators that would constitute proof of the establishment of a viable Committee are:

1) Specifically-named members have been appointed to the Committee by official letter to A.I.D.; and 2) the Committee has held at least two meetings, at which the Minister of Health or his official designee has chaired, and topics for dialogue have been identified, with written minutes for the meetings having been recorded.

Covenants

8. Peru covenants that, except as A.I.D. may otherwise agree in writing, it will:

(a) agree to absorb an increasing share of recurrent costs over the life of the Project: and
(b) agree to continue financing Project activities beyond the life of the Project.

Signature: _____
George A. Wachtenheim
Director
USAID/Perú

Date: _____

Clearances:
HPN:PCohn
PDP:JBoyer
CONT:JSanford
RLA:JBorns E-Mail + fax
RCO:MStevenson E-Mail + fax
A/DD:JBoyer

Volume I

Project Paper

for

Project 2000

(527-0366)

A collaborative effort by the

Ministry of Health
and USAID/Lima

to improve health and nutrition

Lima, Peru
September 1993

1-D

Volume I: **Project Paper for Project 2000**

TABLE OF CONTENTS i

LIST OF TABLES AND FIGURES iii

LIST OF ABBREVIATIONS AND ACRONYMS iv

PROJECT DATA SHEET vii

PROJECT AUTHORIZATION viii

I. PROJECT SUMMARY AND RECOMMENDATIONS 1

A. Recommendations 1
B. Summary Project Description and Financial Plan . . 1
C. Project Design Issues 7

II. BACKGROUND 17

A. Country Setting 17
B. Status of Maternal/Child Health in Peru 18
C. Health Services Availability and Utilization . . . 20
D. Constraints to Improving the Health Status of Women and Children in Peru 21
E. Project Relationship to GoP, A.I.D. and Other Donor Efforts 24

III. PROJECT RATIONALE AND STRATEGY 37

A. Project Rationale 37
B. Project Strategy 38

IV. PROJECT GOAL AND PURPOSE 41

V. PROJECT DESCRIPTION 41

A. Strengthening Child and Maternal Health Services . 41
B. Initiatives for Efficient Management 60
C. Health Care Financing 65
D. End of Project Status 71

VI. FINANCIAL PLAN 74

A. Overall Project Estimated Budget 74
B. Methods of Implementation and Financing 74
C. Host Country Contributions 80
D. Audit Requirements 80
E. Reporting Requirements 82
F. Evaluation Requirements 82
G. Recurrent Costs 82

1-6

VII. IMPLEMENTATION ARRANGEMENTS 86

A. Administrative and Monitoring Arrangements 86
B. Implementation Schedule 94

C. Procurement Plan 99
D. Component-Specific Training Plan 100
E. Information, Education and Communications Plan . . 107
F. Monitoring Plan 109

VIII. PROJECT ANALYSES 112

A. Technical Analysis 112
B. Economic Analysis 117
C. Financial Analysis 119
D. Social Soundness Analysis 119
E. Institutional/Administrative Analysis 126
F. Women in Development 133
G. Initial Environmental Examination 133

Volume II: **Annexes to Project 2000 Project Paper**

1. Host Country Request for Assistance
2. Logical Framework
3. Budget
4. Waiver to Fully Fund International Travel Costs for Participant Training
5. Waiver of Requirements regarding Cold Chain Commodity Source/Origin and Nationality of Ocean Transportation Services
6. Waiver of Full and Open Competition for Procurement of Cold Chain Equipment
7. Cable Approving Project 527-0366 New Project Description (NPD)
8. Memo Approving Project 527-0366 Project Implementation Document (PID)
9. Cable Approving a Categorical Exclusion from an Initial Environmental Evaluation for Project 527-0366
10. Congressional and Technical Notifications for Project 527-0366
11. Statutory Checklists: 5 C(1): Country Checklist
    5 C(2): Assistance Checklist
12. Illustrative List of Commodities
13. Suggested Field Studies, Ethnographic Research and Operations Research
14. Contributors to the Project Paper
15. Bibliography

LIST OF TABLES AND FIGURES

Table 1 Summary Financial Plan 6

Table 2 Health Sector Facilities by Type of Facility and Administrative Entity, 1992 22

Table 3 International Cooperation 1993 27

Table 4 Breakdown of Financial Plan 76

Table 5 Projected Obligations and Expenditures of Project Funds by Fiscal Year 77

Table 6 Summary of Total Project Costs by Funding Source and Foreign Exchange and Local Currency Costs 78

Table 7 Methods of Implementation by Type of Assistance and Financing Method 79

Table 8 Projected HCOLC Allocations and Expenditures by Fiscal Year 81

Table 9 Projected MoH In-Kind Contributions by Project Year 81

Table 10 Total GoP Counterpart Contribution by Calendar Year and Funding Source 84

Table 11 Breakdown of GoP US $8 Million In-kind Counterpart Contribution 85

Figure 1 Project Costs by Funding Source: Foreign Exchange and Local Currency Costs 5

Figure 2 Program and Administrative Costs 75

LIST OF ABBREVIATIONS AND ACRONYMS

ADRA-OFASA	Adventist Relief Agency
AIDS	Acquired Immune Deficiency Syndrome
AID/IG	A.I.D.'s Office of the Inspector General
AID/W	A.I.D./Washington
ARI	Acute Respiratory Infections
BHNP	Basic Health and Nutrition Project (of the World Bank)
CARE	Cooperative for American Relief Everywhere
CARITAS	Catholic Relief Services
CBD	Commerce Business Daily
CDC	Centers for Disease Control
CLAP	Latin American Center for Perinatology (Centro Latinoamericano de Perinatología)
COP	Chief-of-Party
CP	Condition Precedent
CS	Child Survival
CSAP	Child Survival Action Program
CY	Calendar Year
DCOP	Deputy Chief of Party
DDC	Diarrheal Disease Control
DIGEMID	General Directorate of Medicines, Inputs and Drugs Dirección de General de Medicamentos, Insumos y Drogas)
DMIM	Decentralized Management Implementation Model
EB	Exclusive Breastfeeding
ENDES	National Demographic and Family Health Survey (Encuesta Nacional Demográfica y de Salud Familiar)
ENNSA	National Nutritional and Health Survey (Encuesta Nacional de Nutrición y Salud)
EPI	Expanded Program of Immunizations
ESAN	School of Business Administration (Escuela Superior de Administración de Negocios)
FP	Family Planning
FSN	Foreign Service National
FX	Foreign Exchange
FY	Fiscal Year
GDP	Gross Domestic Product
GM	Growth Monitoring
GNP	Gross National Product
GoP	Government of Peru
GTZ	German Technical Assistance Agency

HCC	Host Country Contribution
HCOLC	Host Country Owned Local Currency
HIS/MIS	Health Information System/Management Information System
HPN	Health, Population and Nutrition Office
I	Immunization
IBRD	International Bank for Reconstruction and Development (World Bank)
ICC	Interagency Coordinating Committee
IC	Institutional Contractor
IDB	Interamerican Development Bank
IEC	Information, Education and Communications
IGV	Value Added Tax
IIN	Nutrition Research Institute
IMR	Infant Mortality Rate
INE	National Institute of Statistics
IPSS	Peruvian Institute of Social Security
IQC	Indefinite Quantity Contract
IUD	Intra-Uterine Device
JICA	Japanese International Cooperating Agency
KAP	Knowledge, Attitudes and Practices
LAC/DR	Bureau for Latin America and the Caribbean/Office of Development Resources
LC	Local Currency
Mat/PH	Maternal Perinatal Health
MCH	Maternal and Child Health
MEF	Ministry of Economy and Finance
MoH	Ministry of Health
NFA	Non-Federal Audit
NCHS	National Center for Health Statistics
NSDD	National Security Decision Directive
ODIT	Office of Democratic Initiatives and Training
OE	Operating Expenses
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
ORU	Oral Rehydration Units
OYB	Operating Year Budget
PACD	Project Assistance Completion Date
PAHO	Pan American Health Organization
PANFAR	Programa de Alimentación y Nutrición para Familias en Alto Riesgo
PD&S	Program Development and Support
PHC	Primary Health Care
PID	Project Identification Document

PIL	Project Implementation Letter
PIMI	Integrated Maternal-Infant Program (Programa Integrado Materno-Infantil)
PIO	Project Implementation Order
PIO/C	Project Implementation Order for Commodities
PL-480	Public Law 480
PP	Project Paper
PRISMA	Projects in Informatics, Health, Medicine and Agriculture
PSA	Procurement Services Agent
PSC	Personal Services Contractor
PVO	Private Voluntary Organization
PY	Project Year
RCO	Regional Contracts Officer
RFP	Request for Proposals
RIG/A/T	Regional Inspector General/Tegucigalpa
SAI	Supreme Audit Agency of the GOP
SHIP	Strengthening Health Institutions Project
SHSP	Strengthening Health Services Program (SHSP) (of the IDB)
SILOMED	Sistema Local de Medicamentos
TB	Tuberculosis
TBA	Traditional Birth Attendant
TCN	Third Country National
TQM	Total Quality Management
UDES	Health Department (Unidad Departamental de Salud)
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Emergency Fund
UNIPAC	UNICEF Packing and Assembly Center
UROC	Unidad de Rehidratación Oral Comunitaria
UROI	Unidad de Rehidratación Oral Institucional
USDH	United States Direct Hire
USG	United States Government
UTES	Health Territories (Unidad Territorial de Salud)
VEA	Active Epidemiological Surveillance (Vigilancia Epidemiológica Activa)
W	Appropriate Weaning
WHO	World Health Organization
ZONADIS	Zone for Integrated Health Development (Zona de Desarrollo Integral de Salud)

I. PROJECT SUMMARY AND RECOMMENDATIONS

A. Recommendations

Funding. USAID/Peru recommends authorization of Project 2000 (No. 527-0366), a $60 million project with the Ministry of Health to improve the health and nutrition status of young children and women of childbearing age. The Project will have a life of seven years with the Project Assistance Completion Date (PACD) set for September 30, 2000.

Waivers. USAID/Peru has approved three waivers for the Project. The first is a waiver of the requirement that the host country finance travel expenses for A.I.D.-funded participants in overseas training. The second is a source/origin waiver for the procurement of cold chain equipment, while the third is a waiver from competitive procurement for the acquisition of that same equipment. The full text and appropriate clearances for the waivers are contained in the annexes to the Project Paper (Volume II).

B. Summary Project Description and Financial Plan

The Ministry of Health (MoH) is officially responsible for providing health services to the majority of Peruvians. Geographic and cultural factors have never made this a simple task. In recent years, however, declining budgets, increasing levels of political turmoil and rapid urbanization have made the task even more difficult. In spite of these odds, the MoH has made significant advances in improving the health of the Peruvian population. The national infant mortality rate has declined from some 88 deaths per 1000 live births in 1987 to approximately 55 in 1991; deaths from immuno-preventable diseases and diarrhea have dropped significantly; polio appears to have been eradicated. Nonetheless, much remains to be done. The level of infant and maternal mortality from preventable causes is still too high. Over 300 women still die for every 100,000 live births, giving Peru one of the highest maternal mortality rates in Latin America. Further, poor nutrition status contributes to and compromises the quality of survivorship. Finally, wide disparities in health conditions continue to exist between geographic areas, between rural, mountainous areas and coastal cities, between the educated and the non-educated, and between upper and lower income groups.

Project 2000 is designed to assist the MoH to continue to improve the quality and efficiency of its primary health care services, particularly those that target the most vulnerable populations -- women and young children. The goal of the Project is to improve the health and nutrition status of young children and women of childbearing age. The purpose of the Project is to increase the use of child and maternal health interventions.

The Project seeks to increase an appropriate use of child and maternal health interventions while, through community-based preventive activities, it decreases the need for curative care, thus contributing to a greater efficiency in facility-based services. The Project also addresses issues of sustainability, maintaining that higher levels of appropriate utilization can be achieved only if services become more available, accessible and acceptable. This higher level of utilization will in turn contribute to sustainability by generating greater income.

In order to achieve its goal and purpose, the Project takes a three pronged approach by: (1) providing support directly to child and maternal health services (2) improving the efficiency of those services through improved management, and (3) supporting the sustainability of those services through improved health financing. The majority of Project activities and funding support the first component, **Strengthening Child Survival and Maternal Health Services,** which provides immediate support to priority health and nutrition programs and is expected to result in a visible reduction in infant, young child and maternal deaths, as well as improvement in nutrition status. The other two components are "enabling" components that contribute to the long-term viability of child and maternal health services and help ensure the future of those services.

The first Project component, **Strengthening Child Survival and Maternal Health Services,** will help expand and improve the quality and coverage of national child survival and maternal health programs in maternal-perinatal health, including family planning, pregnancy and delivery care, acute respiratory infections, with emphasis on pneumonia; infant and young child nutrition; immunizations; and diarrheal diseases. Because existing child survival programs in Peru have successfully appreciably reduced infant deaths due to immuno-preventable and diarrheal diseases, Project 2000 will place the greatest emphasis on programs that target the current major killers -- perinatal complications and acute respiratory diseases, as well as on undernutrition, as a major contributing cause of mortality and serious impediment to child growth and development. This emphasis is an appropriate response to Peru's child survival status in the 1990s. Peru is now poised to make major strides in reducing infant and young child mortality due to these two major killers and in improving the quality of survivorship. To support child survival interventions, this grant will finance long- and short-term technical assistance, short-term clinical training for MoH personnel and community workers, local and nationwide information, education and communications campaigns including baseline research for message development, the strengthening of support systems, and selected medical equipment and commodities.

The second Project component, **Initiatives for Efficient Management,** will assist the MoH in its efforts to decentralize

administration and improve the management of resources and budget levels for child and maternal health programs. The Project will develop pilot activities in decentralized management improvement and "total quality management" that will be geared toward increasing the quality and efficiency with which health care services are delivered. These pilot programs will be reviewed and evaluated for their potential replication. In addition, this component will introduce a cost-based programming and budgeting process into the MoH that will help the MoH rationalize its budget requests and disbursements. Finally, this component will provide short- and long-term training opportunities in health administration. Under this component, the Project will finance long- and short-term technical assistance, both in-country and overseas training, and evaluation/coordination meetings.

The third Project component, **Health Care Financing**, will support MoH efforts to increase resource levels for primary health care through increased mobilization of resources and increased efficiency. Efforts to increase the amount of the public sector budget available for child and maternal health services will primarily revolve around policy dialogue discussions between USAID, the MoH, the Ministry of Economy and Finance and other donors. Such other issues as decentralization, the budget allocation process, budgetary segmentation, cost recovery and possibilities for public/private sector collaboration will also come under this policy dialogue. Efforts to increase the funds available for services will focus on the development of rational user fee and cost recovery systems. This Project component will finance long- and short-term technical assistance, operations research, and targeted policy analysis studies and surveys.

The Project will also finance evaluations and the services of two full-time USAID PSCs to coordinate the Project: a Project Coordinator and a Project Management Specialist. To facilitate Project management and ensure appropriate technical assistance, the Project will be implemented through an Institutional Contractor. That Contractor will rely on overall policy and technical guidance from the MoH and the Agency for International Development. The Contractor will be selected through competitive bidding, via a selection committee comprised of representatives of both the MoH and A.I.D. The Institutional Contractor will provide eight long-term technical advisors; some 100 person-months of technical assistance; training; pilot activities in management; field studies, surveys and operations research; an information, education and communications program; commodities; and overall logistics and support.

The Institutional Contractor's in-country team will consist of a Chief of Party, a Deputy Chief of Party, a child and maternal health specialist, a health economist, a health training specialist and three subregional advisors. The firm will have the central role of responding to the MoH and A.I.D. in carrying

out all Project technical, training, administrative and implementation responsibilities under the contract. Each in-country team member will be responsible to specific MoH counterparts. Contractor responsibilities include establishing a Project office, Project monitoring and reporting, subcontracting, coordinating training, and procuring commodities. The MoH and A.I.D. will have strong representation in the selection committees for all subcontracting.

At the end of the Project, a greater proportion of children will survive infancy; the quality of that survivorship will be enhanced in the first years of life, which are so critical to long-term health and nutrition; a greater proportion of women will achieve their reproductive intentions in the number and timing of the children they bear, without recourse to abortion; they will also bear them more safely, thus contributing to their own health as well as that of infants; and the GoP will be better able to continue these improvements without over-reliance on donor funding.

Given that both the International Bank for Reconstruction and Development (IBRD or World Bank) and the Interamerican Development Bank (IDB) are in the process of negotiating large health sector loans with Peru, close coordination with these two organizations will be important for assuring that programs complement and reinforce each other. The IBRD focus will also be on maternal-child health and nutrition, emphasizing preventative care and nutrition in four specific regions of Peru. The IDB project centers on strengthening MoH administrative and operational systems and features a large component of policy studies that will inform policy dialogue. Thus, it is important that USAID, the World Bank and the IDB coordinate their policy dialogue programs regarding budget reform issues. Under the Project, an Interagency Committee will accordingly be set up for this purpose.

Overall estimated Project costs (Figure 1) are US $60 million, of which US $30 million will be provided through a grant from A.I.D. The equivalent of US $22 million is expected to be provided from PL480 Title III funds as part of the GOP counterpart contribution. The GOP will also provide the equivalent of US $8 million in budgetary support for personnel and operating costs to implement the Project. USAID will directly contract the services of an Institutional Contractor to implement the Project, a PSC and the evaluations. Grant funds for supervision, seminars, and selected studies will be directly administered by the MoH. A Summary Financial Plan is provided in Table 1. The life-of-project (LOP) is seven years.

A focus on sustainability is pervasive throughout the Project, and much of the impetus for this focus derives directly from initiatives and plans of the GoP. The decentralization thrust,

Figure 1

PROJECT COSTS BY FUNDING SOURCE: FOREIGN EXCHANGE (FX) AND LOCAL CURRENCY (LC) COSTS (US DOLLARS)

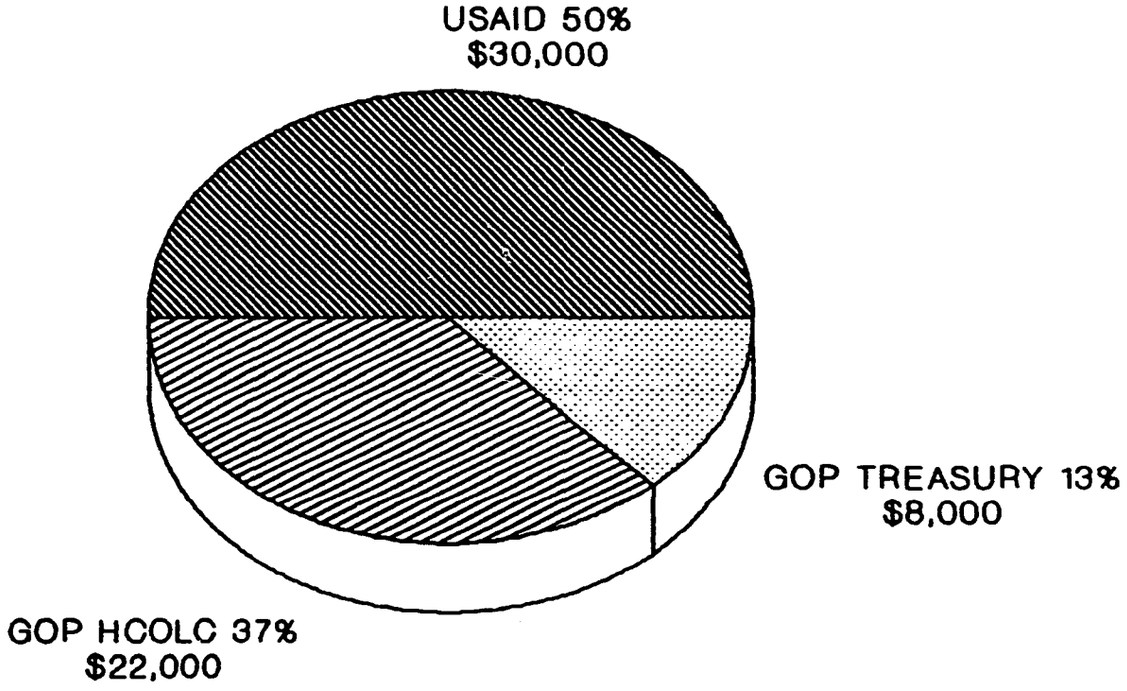

Table 1
SUMMARY FINANCIAL PLAN

(U.S. $'000)

ITEMS	A.I.D. GRANT[1]	GOP		GRAND TOTAL
		ECOLC	BUDGET SUPORT	
Program Costs				
Strengthening Child Survival and Maternal Health Programs	14,071	15,693	0	29,764
Inititive for Efficient Management	3,080	378	0	3,458
Health Care Financing	760	0	0	760
Project Administration Support	10,204	210	0	10,414
Technical Assistance - Demand Study	325	0	0	325
Total Program Costs	28,440	16,281	0	44,721
Administrative Costs				
USAID Management Support	1,170	0	0	1,170
Evaluations	300	350	0	650
Financial Reviews	90	0	0	90
Operating Costs-MoH	0	5,369	8,000	13,369
Total Administrative Costs	1,560	5,719	8,000	15,279
TOTAL PROJECT COSTS	30,000	22,000	8,000	60,000

[1] Subject to availability of funds to A.I.D. and to mutual agreement of the Parties to proceed.

for example, follows GoP plans to increase both resource flow and accountability in the interior. Reallocation of health personnel is a key element of these plans. The health care financing elements, moreover, are consonant with MoH concerns about the budget-making process within the GoP. The MoH is very keen to address these issues with MEF. Similarly, the MoH is interested in devising a cost recovery scheme that is just, financially sound and not disproportionately prejudicial to the poor, who may have no other alternative source of health care. All of this speaks to the GoP commitment to the Project.

Further, the large host-country counterpart contribution that is involved bespeaks GoP commitment, as does the design of the financing of recurrent costs, which the GoP will assume incrementally over the life of the Project. These costs are for pharmaceuticals, training, salaries and supervision, among other items. Thus, at the end of Project, the GoP should offer child and maternal health services that are better managed at a local level and better financed through both core budgetary support and cost recovery, so that these services can continue to be provided despite diminished donor support. Finally, GoP participation in the Interagency Advisory Committee that is a condition precedent to the Project Agreement will provide an ongoing mechanism to ensure and strengthen GoP commitment.

C. Project Design Issues

1. USAID/Peru Staffing Levels

Successful Project implementation will require the full-time assistance of two staff members working within the USAID Mission and funded through the Project -- a technical Project Coordinator and a Project Management Specialist. The Project Coordinator will be the front-line HPN staff person responsible for technical supervision of the Project. That person will liaise between the Ministry of Health, the HPN Office Chiefs and the Institutional Contractor to ensure implementation of Project activities, both in quantifiable outputs and in quality, providing technical input where required. The PSC will monitor the preparation of the periodic reports of the MoH counterparts and the IC, as well as help identify needs for technical assistance and prepare scopes of work for that assistance. The coordinator will track field activities, including research, training and IEC.

The Project Management Specialist will have a strong knowledge of A.I.D. procedures and policies. That person will ensure that all Project documentation adheres to A.I.D. norms, regulations and needs. Procurement will be a major component of this scope of work, with the management specialist responsible for preparing PIO/Ts, PIO/Cs and related documents. That person will also be responsible for collection and presentation of data for the

A.I.D./W Child Survival Data System. Further, the specialist will help make arrangements for consultants who are to provide technical assistance, as well as perform general management liaison among A.I.D., the MoH and the IC.

2. Expatriate Personnel Restrictions

Due to the security situation in Peru, the U.S. Government has limited the number of U.S.-sponsored non-Peruvians allowed in the country at any one time.[1] In addition, travel to "emergency zones" throughout the country is restricted. It is unknown how long these restrictions will be in place. Given some improvements in the security situation over the past year, the Mission is optimistic that some of the restrictions may be lifted. It is unlikely, however, that any modifications will take place before an Ambassador is confirmed and assigned to Peru.

Personnel restrictions seriously constrain the implementation of projects in Peru by limiting access to international experts. The recommendation for the make-up of the technical assistance team proposed in this PP calls for a minimum of two foreign experts; this is what HPN believes is optimal for successful implementation of Project 2000. HPN recommends that the Chief-of-Party and Deputy Chief-of-Party be international experts for the following reasons:

- An underlying goal of this Project is to achieve policy dialogue and eventual policy change in the areas of decentralized, efficient management and health financing, including cost-based budgeting, priority-based programming, cost recovery and possible private contracting of some services. Foreign experts are often better able to exert influence among policy makers than Peruvian experts, because the formers' careers and personal lives are not permanently tied to the local bureaucratic and political system.

- The Deputy Chief-of-Party will have primary responsibility for administering a large and complex institutional contract. This person will be responsible for project personnel systems, logistics systems, procurement systems, administration of subcontracts, financial and management systems and project reporting. The HPN Office believes that an expatriate familiar with both these systems and A.I.D. regulations is required to carry out the demanding and critical functions of this position.

Should USG foreign personnel restrictions make it impossible to

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[1] 1992 National Security Decision Directive No. 38 (NSDD-38).

bring at least two international experts into Peru to work on the Project, an alternative implementation mechanism may have to be found. The following three possible "fallback" positions are suggested:

Fallback Position #1

Assumption: The U.S. Institutional Contractor is able to bring only one international expert into Peru. All remaining long-term positions must be filled by Peruvians or by U.S. or third country nationals already living in Peru.

Implications: It is likely that the IC would fill the Chief-of-Party position with the one allowed international expert. The Deputy position would then be filled by a local hire, who might not have much experience with USG/A.I.D. regulations and contracting procedures. As such, the IC would probably directly contract a Procurement Services Agent (PSA) to take over all procurement under the Project. While this assures that the procurement would be done, the IC would still have to prepare the procurement lists to give to the PSA. A less desirable alternative would be to eliminate the procurement of all pharmaceuticals. This would have negative effects, since lack of access to the correct antibiotics or oral rehydration salts would decrease the use of services at the peripheral level, diminishing the impact of the Project on health and nutrition.

(2) The activities described in the second Project component, **Interventions for Efficient Management,** would be scaled down. Specifically, the pilot activities, which are very management intensive, would be postponed until the Mission is comfortable that the IC has the technical and administrative capability to implement them. In-service training and specific course training would similarly be scaled down, while training out-of-country would not be affected.

(3) One of the Regional Advisor positions to be hired by the IC would be eliminated. While this would slow Project implementation and reduce the impact of the Project, it would reduce the administrative burden on the COP and DCOP.

(4) The Mission could buy into a centrally-managed contract to implement the IEC program. This would relieve the IC of significant subcontracting and management responsibility.

(5) The Mission's Training Office could implement the long-term training proposed under the Project. While this would minimize the subcontracting responsibility of the IC, it would significantly increase the workload of ODIT and the Controller's office.

Fallback Position #2

Assumption: The U.S. Institutional Contractor is not able to bring even one international expert into the country at the time that the contact is negotiated and awarded. All project positions, at least in the short-term, must be filled by Peruvians or by U.S. or third-country nationals already living in Peru.

Implications: If all positions have to be filled by local hires, the Request for Proposals must be explicit in this regard. As has been done in other recent procurements, then, organizations bidding on the Project would be encouraged to present a slate of candidates that draws on local hire of staff who, regardless of nationality, are already residing in Peru. Though this scenario might present some challenges in recruitment and Project management, it has the advantage of promoting sustainability, in that the Project key personnel would likely be people with a long-term commitment to health and nutrition in Peru.

With no U.S. hires on staff in the early phases of the Project it would be vital to hire some personnel experienced with A.I.D. procedures and systems. This might be at a lower level than the Chief-of-Party and Deputy-Chief-of-Party, but would be essential in promoting a mutual understanding of the administrative and technical requirements of the Project.

The other implications listed under the Fallback Position #1 would also remain.

Fallback Position #3

Assumption: Because of personnel restrictions or other reasons, the contracting of an IC is delayed (for example, no suitable candidate bids on the Project).

Implications: The MoH would implement the studies and seminars under resources allocated directly to the MoH. The Mission would take responsibility for initiating selected activities until a suitable IC can be identified and contracted.

(1) USAID would buy into centrally-managed contracts for implementation of IEC activities for support in epidemiologic surveillance.

(2) USAID would directly contract with an institution or university to implement all short-term, in-country clinical training activities and contract a Project-funded PSC employee to implement this Project component under the guidance of the Project Officer.

(3) ODIT would implement the short- and long-term out-of-country training proposed under the management component. This is likely to strain the human resources of that office.

(4) Selected studies and surveys would be directly contracted by USAID as human resources become available to prepare PIO/Ts, RFPs and other required documentation.

(5) USAID would directly contract with a Peruvian firm to provide regional technical assistance and logistical support for implementing child and maternal health programs. The Alpha Consult, S.A. contract, under CSAP offers a model for this type of activity.

All other A.I.D.-funded activities would be delayed until a contractor is in place.

3. Speed of Project Implementation

Recognizing the personnel constraints under which USAID/Peru operates, the PP design proposes the use of an Institutional Contractor to implement the majority of the proposed activities. It is anticipated that an Institutional Contract will be signed by September 1994 and that some long-term technical assistance will be in place by late 1994. Full Project implementation will probably not begin until early 1995 -- over 16 months from now. While the current Child Survival Action Project Extension will continue to the end of 1994, thus providing direct assistance to MoH priority health programs until Project 2000 activities are underway, discussions with the MoH and MEF on the PP design have generated enthusiasm for immediate actions in the health financing and quality management areas. In order not to lose this momentum, the PP design recommends that USAID/Peru take the following actions to ensure that momentum is maintained and implementation of Project 2000 begins as quickly as possible:

(1) USAID/Peru should prepare the scopes of work for the cost study and demand survey described in this document. Once the Project Authorization is signed, the Mission can then move ahead promptly to use Project funds to directly contract an institution(s) to provide the required services.

(2) HPN should begin drafting the PIO/T and RFP for the Institutional Contractor immediately following Project Authorization. A notice regarding this RFP should go into the Commerce Business Daily (CBD) as soon as possible.

(3) Soon after project authorization, the USAID/Controller's Office will complete the required analysis of the MoH's financial capacity to use and monitor A.I.D. funds. If necessary,

technical assistance related to any recommended improvements should be provided to the MoH as soon as the analysis is completed.

4. Workload Burden on USAID/Peru

While the PP design presented here has attempted to minimize the amount of work assigned to the Mission by placing responsibility for many actions under the Institutional Contractor or, implementation of the Project will inevitably increase the workloads of various offices within the USAID.

- Institutional Contractor: The identification of a suitable Institutional Contractor will require the development of a Request for Proposals (RFP), the preparation of a notice for the CBD, the evaluation of proposals, and the negotiation of a contract. These tasks will increase the workload of HPN and the RCO.

- Cost Study/Demand Survey Contracts: The contracting of an organization to carry out the cost survey will require similar, albeit more limited, tasks to those described above for the Institutional Contractor. In addition, a consultant may be required to prepare the scopes of work for the contracts and assist in evaluating proposals. Again, the workload of HPN and the RCO will be increased.

Even after the contract is awarded, this workload burden will not diminish appreciably for either the HPN Office or the RCO and his staff people based in Lima. The size and complexity of this contract argue for additional staff in the contracts section of the EXO Office.

To minimize the additional burden placed on the HPN Office, the PP team recommends that the Mission fill at least one of the staff positions as soon as possible. The PSC Project management specialist may be the more appropriate.

5. Availability of PL480 Funds

Guarantees of appropriate levels of PL480 funds are increasingly problematic. Best judgments at the present time are that insecurity in PL480 funding will, at best, continue, but is even more likely to escalate, both because of dynamics on the international scene and possible shortfalls in US grain production in coming years. In the case that PL480 funds are reduced, some of the activities below will have to be scaled back or dropped from the Project.

Should PL-480 funds not become available in the necessary quantities, alternative options for scaling back or omitting some activities will be discussed with the Project Committee and the most appropriate options chosen. Some activities programmed for PL-480 funding could be funded in dollars, but this would have an effect on dollar-programmed activities in other areas, given the tightly planned budget. The options for scaling back will be based on continuous Project monitoring of the relative accomplishments and needs of the various Project activities, as well as coordination with other major donors, so that the synergism of donor efforts is not jeopardized, even though complementary activities may be scaled back.

If the entire Project amount could not exceed $40 million ($30 million A.I.D. grant plus $10 million minimum counterpart contribution), for example, Project 2000 could still be successful, albeit in a more limited way. The Information, Education and Communications component could be omitted, since a complementary activity is planned under the IBRD-financed Basic Health and Nutrition Project (BHNP). That Project could be prevailed upon to take over aspects envisioned under Project 2000. The savings would amount to $9.7 million. Additional considerable savings could be achieved by not going to national scale with activities under the Strengthening Child and Maternal Health Services component, as presently called for. Clinical training in three pilot regions, rather than nationally, would save at least $4.4 million (two-thirds of the $6.5 million currently budgeted). A similar reformulation of support to priority health programs would reduce Project costs by at least $5.3 million. These three changes, then, would reduce Project costs by $19.4 million. Concomitant reductions in personnel for the Institutional Contractor would easily bring the figure to $20 million. The result would be a downsized Project, but still one with every reason to have the desired impact in selected regions, rather than at the national level.

6. Conditionality

Members of the Project Committee have advised that conditionality under Project 2000 refer to an institutional assessment of financial systems in the MoH, resolution of outstanding payments due to A.I.D. by the MoH, and the establishment of a functioning Interagency Committee on coordination and polity dialogue that would discuss budgetary and other financial and management reforms. Thus, **Conditions Precedent** for the Project Agreement are:

By the time of the first disbursement under the Project, Peru will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.

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

(b) A statement of the name(s) of the person(s) holding or acting in the office of the Grantee specified in Section 8.2 of the Agreement and of any additional representatives, together with a specimen signature of each person specified in such statement;

(c) An explicit commitment on behalf of the Government of Peru to correct any institutional weaknesses in its financial management. A.I.D. has been analyzing the possibility of financing a technical assistance contract to support the Ministry of Health in d\the design of an administrative and accounting system compatible with A.I.D. norms and regulations, thus ensuring transparency of accounts and facilitating audit requirements. Under such a contract, key Ministry personnel that handle A.I.D. funds would receive appropriate training. A letter from the Ministry of Health confirming its interest in this type of assistance would constitute such an explicit commitment.

(d) Resolution of an outstanding debt of US$123,600, by receipt of payment of no less than one-third of that amount by September 30, 1993, and a timetable for remaining payments agreed upon.

Prior to any award of the Institutional Contract under this grant, Peru will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(a) Resolution of an outstanding Bill of Collection in the amount of US$1,190,647, either through direct payment in US dollars or alternative resolution satisfactory to USAID/Peru. The immediate first step in this regard would be for the Ministry to designate a working group to attempt to locate any relevant supporting documentation that might still exist, in the hope of reducing the amount that must be paid.

(b) Proof of the establishment by the Government of Peru of an Interagency Advisory Committee on Health Management and Financing, minimally with representation from the Ministry of Health, which shall chair the Committee, the Ministry of Economy and Finance, and representatives of the major donors of A.I.D., the IDB and the IBRD. By way of regularly scheduled meetings, the Committee will provide an ongoing forum and additional source of technical expertise for the Ministry of Health in the areas of health management and financing. The Committee will be specifically tasked by the Ministry of Health to examine

prevailing policies in health management and financing, with a view toward suggesting areas where reforms might be contemplated and outlining, for the consideration of the Ministry of Health, options for the design and implementation of reforms that would strengthen management and financing. Verifiable indicators that would constitute proof of the establishment of a viable Committee are:

> 1) Specifically-named members have been appointed to the Committee by official letter to A.I.D.; and 2) the Committee has held at least two meetings, at which the Minister of Health or his official designee has chaired, and topics for dialogue have been identified, with written minutes for the meetings having been recorded.

The **covenants** for the Project Agreement are:

Peru covenants that, except as A.I.D. may otherwise agree in writing, it will:

(a) agree to absorb an increasing share of recurrent costs over the life of the Project: and

(b) agree to continue financing Project activities beyond the life of the Project.

The IGV tax. Differences of opinion existed on the merit of making the issue of the IGV tax, which the GoP currently assesses on purchases and imports financed by A.I.D., part of the conditionality for Project 2000. On the one hand, a grant agreement of this magnitude offers policy leverage to address this issue. On the other hand, the IGV tax is a matter above the level of the Ministry of Health, affecting all transactions in Peru and all agreements between the GoP and A.I.D. In short, the issue affects the entire bilateral program. Thus, it may make more sense not to tie this macroeconomic and policy discussion to a sectoral project, especially since the discussion is likely to be protracted and delicate. Further, the GoP may consider any exoneration from the IGV to be misguided macroeconomic policy, given the shallow tax base that currently exists in Peru.

In sum, the practicality of including the IGV issue as a condition precedent is extremely low. An indirect route, whereby the issue can be raised in the policy agenda of the Interagency Advisory Committee, which is a part of the conditionality of this agreement, is the recommended route.

This indirect route, however, is not the only way in which the Mission and the entire donor community have attempted to influence this issue. At the June meeting of donors in Paris, the subject was raised. Letters have been sent on the subject to

the Ministry of Economy and Finance. The U.S. Embassy has intervened, as have other foreign embassies. The issue is of importance and concern to donors and will not be abandoned lightly.

II. BACKGROUND

A. Country Setting

Peru has widely diverse physical, demographic, social and economic characteristics. Although rich in natural resources, the country is suffering a longstanding economic and social crisis. Of the total Peruvian population of 22.3 million (1990), at least 6 million live in conditions of absolute poverty, and another 3.5 million are deemed relatively poor, according to World Bank data. In 1990, Peru's per capita GNP was $807.[2] That average masks the intensity of impoverishment of major segments of the population over the past ten years, during which time the per capita GNP fell 25 percent , investment declined 54 percent and the annual inflation rate climbed from 61 percent in 1980 to 7,650 percent in 1990. From 1980 to 1990 real salaries fell in the private sector by 69 percent, in the public sector by 83 percent, and the minimum wage fell by 73 percent (Instituto Cuanto, 1991b).

Further, income distribution in Peru is one of the most regressive and uneven in Latin America. The ratio of income earned by the highest 20 percent of the population compared to the lowest 20 percent is 32 to 1. Over 70 percent of Peru's economically active population is unemployed or underemployed. The lack of jobs and government restrictions have contributed to the generation of an informal economy that provides very low incomes to many workers with none of the social benefits provided by law to workers in the formal sector.

Peru's population is concentrated in urban areas, where over two-thirds of Peruvians live. Largely due to high rates of rural to urban migration, the urban areas are growing at twice the rate of rural areas. One-third of the national population now lives in metropolitan Lima, which has grown by 1,000 percent since 1940. An increasingly large proportion of Lima's residents live in squatter settlements and slums known as "pueblos jóvenes." Residents of these "pueblos jóvenes" are primarily young families and adolescents, many of whom have recently migrated to Lima. Not only has urban migration placed a tremendous strain on urban services, but it has also left rural communities depleted of human and economic resources and relatively lacking in social or economic progress.

Geographic barriers, which restrict both the amount of arable land and the access to rural areas, have kept Peru's large indigenous population relatively unassimilated. The geography,

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[2]Expressed in 1985 dollars, Instituto Cuanto, 1991a.

in combination with poor transportation, communications and logistical systems, also presents a major obstacle to the delivery of health, social and educational services, particularly in the poor rural areas of the central and southern mountains. In these areas, terrorist activities constitute an additional threat. Not surprisingly, regional development has been grossly unequal, especially in the distribution of schools and such public services as potable water, sewerage systems, health facilities and health personnel. Government and development agencies face the dilemma of concentrating their efforts in the urban areas, where they can reach the largest number of people, or promoting more costly and time-consuming rural development. The former choice, of course, reinforces unequal development.

B. Status of Maternal/Child Health in Peru

Peru has some of the worst health indicators for child survival in Latin America. Over 40,000 infants die each year in Peru, most of them from preventable causes. In addition, far too many women die each year in childbirth. Moreover, an alarming 37 percent of children under five suffer from chronic malnutrition, that is, low height for age. There are wide disparities in health conditions within the country -- between geographic areas, between rural areas and coastal cities, between the educated and the non-educated, and between upper and lower income groups.

1. Child Morbidity and Mortality

Peru entered the 1990s with the third highest infant mortality rate (IMR) in Latin America and the Caribbean. Although the national infant mortality rate has declined from 88 deaths (per 1000 live births) in 1987 to approximately 55 in 1991, the rate varies greatly from region to region, reflecting social, educational and geographic inequities. For example, the IMR ranges from 22 for infants of women with post-high school education to 100 for women with no formal education; from 30 in Lima to 101 in the region of Mariátegui; from 47 in urban areas to 90 in rural areas. Available data indicate that 36 percent of all reported deaths in Peru occur in children under five years of age. Approximately 70 percent of deaths under age five occur before the age of one year. Of all deaths in infants under age one, approximately 50 percent occur in the first month of life and 75 percent in the first six months.

Immuno-preventable diseases have dropped as a cause of infant mortality, largely due to advances made in the GoP expanded immunization program. Today approximately 82 percent of under-one deaths are caused by four major problems: perinatal complications (which are frequently related to poor maternal health), mismanaged pneumonia, diarrheal diseases and nutritional

deficiencies. Studies indicate that acute respiratory infections (ARI) account for one-third of childhood mortality in Peru. Only some 9 percent of rural children and 20 percent of urban children are treated with appropriate antibiotics for pneumonia, and malnutrition is an unreported underlying cause of perhaps 50 percent of all infant mortality.

Aside from the morbidity and mortality associated with conditions originating in the perinatal period, the majority of illnesses in the first six months of life, in particular those due to acute respiratory infections and diarrheal diseases, are preventable with improved nutrition and hygiene.

2. Maternal Morbidity and Mortality

At 303 deaths per 100,000 births, Peru has one of the highest maternal mortality rates in Latin America. This is a result of problems with both the quality of care and coverage. While there is little reliable information on the causes of maternal mortality, a study of maternal deaths in hospitals indicated that hemorrhage, infection and pre-eclampsia were major contributors. It is thought that perhaps as many as half of these deaths are secondary to unsafe abortion. Unsafe abortion in Peru has been estimated at two abortions for every ten live births (Singh et al., 1991), and recent studies indicate that in urban areas as many as half of all pregnancies are terminated by abortion.

High maternal mortality rates are also closely linked to lack of prenatal care and the high proportion of deliveries occurring at home. Demographic Health Survey (ENDES 1991-92) results indicate that over half of rural women receive no prenatal care. Eighty percent of rural Peruvian women give birth in their homes, and only 19 percent of them are assisted by a trained professional. In contrast, 10 percent of women in Lima give birth at home, and 94 percent are assisted by a trained professional.

Maternal malnutrition, especially chronic anemia, high levels of fertility and short birth intervals also contribute to high maternal mortality rates. Preventive measures to identify and reduce risks of maternal mortality are urgently needed.

3. Family Planning

Conceptually, family planning is an integral part of maternal and perinatal health. High-parity women and women with short intervals between births are at higher risk of illness and death during childbearing, as well as malnutrition. And family planning is the single most effective way to prevent abortion, which is related to a large proportion of maternal mortality in Peru. Similarly, high-birth-order children and children on

either side of a short birth interval are at higher risk of illness, malnutrition and death.

Although levels of fertility have declined substantially in recent years, the fertility rate in Peru remains high, and substantial differentials in fertility remain by education, urban/rural residence and geographic region. The total fertility rate for rural women, at 6.2 births, is more than twice that of urban women (2.8 nationwide; 2.1 in Lima). The total fertility rate for women with some secondary education, at 3.1, is less than half that of women with no formal education, which is 7.1. Although Peru's population is 70 percent urban, about half of all births occur in rural areas. This underscores the need to intensify efforts in those rural areas.

The demand for family planning services has increased rapidly in recent years. The prevalence of modern contraceptives among women aged 15-49 who are in union increased from 23 percent in 1986 to 33 percent in 1991. National surveys indicate, however, that the demand for contraception is much higher than the use. Further, the estimated abortion rate for Peru evidence a clear unmet need for family planning. As might be expected, there are substantial differentials in contraceptive use between regions. The quality of the services offered in the rural and marginal urban areas needs to be greatly improved, and services must be expanded to areas that are currently not reached.

C. Health Services Availability and Utilization

In Peru, the Ministry of Health (MoH) is the major provider of primary health care services. The services provided by other public and private institutions are significant only at the tertiary (hospital) level and in major urban areas, particularly Lima. Private institutions, which include fee-for-service physicians as well as private hospitals and clinics, provide services to an estimated 11 percent of the total population. The Peruvian Institute of Social Security (IPSS) is charged with providing hospital and ambulatory care to workers and their dependents in the formal sector, including employees of the GoP. While some 28 percent of the population should be covered by IPSS services, actual coverage is much lower. An estimated 3 percent of the population is covered by the Armed Forces and Police and other public and parastatal facilities. All other Peruvians (or approximately 58 percent of the population) are considered to be under the care of the MoH. However, since the MoH currently provides services to only 26 percent of the population, an estimated 32 percent of all Peruvians have little or no access to modern health care services.

Geographic distribution of MoH health facilities shows a strong bias toward Lima and Callao, where 42 percent of all hospital

beds are located. Table 2 shows the distribution of health establishments in the public sector by type of facility and administrative entity.

Logically, health personnel are distributed in a similar fashion to health services: most are concentrated in large cities, where higher salaries are paid. Although data available on human resources are not precise, it is estimated that 20,000 general physicians practice in Peru. Of these, 49 percent (9,793) are employed by the public sector (Ministry of Health and IPSS). Of a total of 20,687 professional nurses in the country, 44 percent work in the public sector. Professional midwives ("obstetrices") number 2,868; 67 percent work for the Ministry of Health and IPSS. It is estimated that 30,000 nurse auxiliaries and nursing technicians exist in Peru, of which 69 percent work for the Ministry of Health and IPSS.

Staffing of health facilities depends on type and location. In health posts, usually one professional and one auxiliary nurse implement all health programs. In isolated rural areas, usually only one auxiliary nurse or health technician serves. Health centers located in rural areas are often staffed like a health post, that is, with non-physician personnel. In periurban areas, health centers frequently have a physician and a professional midwife. Similarly, hospitals are staffed according to location. Urban hospitals have a larger number of personnel than those in rural or marginal urban zones, where staff for hospitalization services are frequently lacking.

The use of health services is closely related to their accessibility and to such factors as socio-economic status, age, education and severity of illness. All population groups use both formal and informal systems for various reasons, however, the poor are more likely to seek health services through such informal sector practitioners as pharmacists, traditional healers, traditional birth attendants, and volunteer community promoters.

D. Constraints to Improving the Health Status of Women and Children in Peru

As described above, geographic factors have played an enormous role in determining the unequal distribution and coverage of health services throughout Peru. Peru's large size, poor road system across the Andes and lack of communication facilities inhibit the expansion of services into remote rural areas. As a result, there are fewer facilities in these areas to service a poorer, less educated population. However, it is precisely this poor, remote, rural population that is in greatest need of primary health care.

TABLE 2
HEALTH SECTOR FACILITIES
BY TYPE OF FACILITY AND ADMINISTRATIVE ENTITY, 1992

	TOTAL	HOSPITALS	HEALTH CENTERS	POSTS	OTHER
PUBLIC SECTOR	4073	242	932	2889	10
MoH	3682	134	763	2783	2
SOCIEDAD BENEFICENCIA	10	1	7	0	2
INTEGR. MINSA & IPSS	6	0			
IPSS	200	59	84	56	1
FFAA Y P	98	31	34	32	1
STATE COS.	8	5	3	0	
LOCAL GOVTS.	41	1	29	10	1
OTHER	28	5	12	8	3
PRIVATE SECTOR	288	185	86	14	3
PRIVATE CLINICS	219	148	64	6	1
PRIVATE COS.	38	24	11	3	0
PHILANTHROPICS	7	5	1	0	1
AGRO-INDUSTRIAL COOPS	3	1		0	
SAIS	5	0			
OTHER ORGS	16	2	9	4	1
TOTAL	4361	427	1018	2903	13

	TOTAL	HOSPITALS	CENTERS	POSTS
PUBLIC SECTOR	93.4%	5.5%	21.4%	66.2%
MoH	84.4%	3.1%	17.5%	63.8%
SOCIEDAD BENEFICENCIA	0.2%	0.0%	0.2%	0.0%
INTEGR. MINSA & IPSS	0.1%	0.1%	0.0%	0.0%
IPSS	4.6%	1.4%	1.9%	1.3%
FFAA Y P	2.2%	0.7%	0.8%	0.7%
STATE COS.	0.2%	0.1%	0.1%	0.0%
LOCAL GOVTS.	0.9%	0.0%	0.7%	0.2%
OTHER	0.6%	0.1%	0.3%	0.2%
PRIVATE SECTOR	6.6%	4.2%	2.0%	0.3%
PRIVATE CLINICS	5.0%	3.4%	1.5%	0.1%
PRIVATE COS.	0.9%	0.6%	0.3%	0.1%
PHILANTHROPICS	0.2%	0.1%	0.0%	0.0%
AGRO-INDUSTRIAL COOPS	0.1%	0.0%	0.0%	0.0%
SAIS	0.1%	0.1%	0.0%	0.0%
OTHER ORGS	0.4%	0.0%	0.2%	0.1%
TOTAL	100.0%	9.8%	23.3%	66.6%

NOTES: Hospitals include private clinics; health centers include polyclinics, medical centers, and medical posts.

Source: MINSA, Of. de Estadís. e Informática, Boletín Preliminar, Censo de Infraestructura Sanitaria y Recursos Humanos, Peru: 1992.

Second, recent urbanization has resulted in rapidly increasing concentrations of generally young people in marginal urban areas. It has been difficult for the MoH to respond to such rapid growth. The Ministry lacks both the financial and human resources to provide adequate health services to these new marginal urban areas.

Third, the enormous variety of social, cultural and religious backgrounds among Peruvians makes delivery of health services difficult. In particular, it is difficult to design nationwide IEC campaigns that transcend cultural barriers. In rural areas language barriers also exist.

Fourth, the public health sector has historically devoted more resources to curative, hospital-based care than to preventive care. There is little recognition that prevention is a cost-effective, long-term solution, compared to the short-term, expensive nature of curative care. Health centers and posts, which should be able to provide preventive services through prenatal care, well baby care and family planning services, are underutilized because they lack necessary staff, equipment and supplies. The national average user rate for IPSS clinics, for example, is only 49 percent. However, because MoH and IPSS hospitals are relatively better equipped than health centers or posts, they have become the principal service delivery point for primary health care. The overemphasis on hospital-based curative care has also led to an overabundance of hospital beds, which drains limited resources.

Public Sector Constraints. A number of factors affect the ability of the MoH to develop an integrated, sustainable health care system. Public resources available for social services in Peru have become scarcer with the sharp decline in overall government expenditures during the last five years. Health's share of central government budget allocations has remained fairly stable since 1970, at 4-5 percent, or one percent of the Gross Domestic Product (GDP). The MoH, however, received only 30 percent of its budget allotment from the MEF in 1992. On a per capita basis, spending by the central government on health increased from about $5 in the early 1970s to $14 in the early 1980s, then declined to $8 by 1990.

Further, although the number of doctors and nurses in Peru rose at an annual average rate of nearly 5 percent between 1985 and 1990 and nationally both the physician:population and nurse:population ratios are acceptably close to World Health Organization (WHO) recommended minimal levels, the distribution of professional resources is uneven. A disproportionate number of trained health personnel remain in Lima or other urban centers, often preferring to work in the private sector. They are frequently underutilized and underemployed, while large rural areas go without qualified health care professionals.

Many MoH personnel also lack practical training in jobs they are being asked to perform. At the central level, this is most evident in health administration and management. At the peripheral level, both hands-on clinical training and management training are needed. Trained staff are frequently reassigned by the MoH and top managers are often replaced as political changes occur. This has led to a lack of continuity in program implementation. Low salary levels have contributed to a serious lack of morale among public sector employees. Frequent strikes compound the problem.

While the MoH, with USAID support, has instituted the manual HIS/MIS system in 100 percent of Peru's health posts and health centers and the computerized HIS/MIS system in 85 percent of the upper-level health delivery systems, administrators are still not using the data, particularly for making decisions. In addition, in certain types of statistics (for example, maternal mortality) there continues to be a lack of data.

Management and supervision of MoH activities are constrained by lack of management training, lack of well designed management and supervision systems and lack of funds and vehicles for making supervisory visits. Political instability and terrorist activities have made supervisory visits difficult in recent years, although GoP officials have managed to supervise nationwide immunization activities and a nationwide AID-financed Demographic Health Survey in the emergency zones. Finally, monitoring and evaluation activities have not received high priority and are not systematically used as tools for improving service delivery.

E. Project Relationship to GoP, A.I.D. and Other Donor Efforts

1. Government of Peru (GoP)

GoP policies and priorities. In May 1993, the GoP issued a poverty alleviation strategy that set forth GoP priorities and policies. The second principle of the strategy is to improve the living conditions of the population in extreme poverty through programs in food, health, education and employment generation. To achieve this, the strategy recommends an increase in the level and efficiency of social spending by the government, in part through the reallocation of expenditures and the provision of more responsibility to local government. For health, the goal of the GoP's poverty alleviation strategy is to improve the attention and quality of primary-preventive services in rural and marginal urban populations in order to reduce mortality and protect the health of women. The strategy targets children under three years of age, poor pregnant and lactating women, and populations at risk of epidemics.

As a complement to this strategy, President Fujimori has been outspoken in stressing the importance of family planning to reduce population growth rates, so that economic growth can translate into sustainable development.

The three components of Project 2000 respond directly to the goals set forth in the poverty alleviation strategy -- by helping to improve primary-preventive health services, by assisting in efforts to provide more responsibility to the local level, and by helping increase the efficiency of social spending.

Ministry of Health priorities and policies. The three Project 2000 components also respond directly to ambitious MoH goals to improve maternal and child health in Peru. As a result of the 1990 World Summit for Children, a 1992-1995 National Action Plan for Children was prepared and approved on January 11, 1993 (Supreme Decree No. 0023/RE-92). In addition, the Minister of Health has approved national plans for immunization, cholera control, reproductive health and maternal health.

The first component of Project 2000, **Strengthening Child Survival and Maternal Health Programs**, directly supports programs contained in these plans both by helping to develop human resources and by providing commodity and logistical support.

Although decentralization efforts were interrupted by President Fujimori's April 1992 extra-constitutional actions, the MoH remains committed to delegating health care responsibilities to the regions and subregions, so that the central ministry can concentrate on health sector policy (including planning and resource allocation), health sector norms and regulatory roles, supervision and evaluation, and multisectoral coordination. In October 1992 the Minister of Health convened a national meeting to discuss decentralization. At the meeting, regional presidents and health authorities discussed MoH plans for decentralization of health programs. Decentralization efforts continue to move ahead slowly, but erratically. Project 2000's second project component, **Initiatives for Efficient Management**, will help facilitate this process by improving management. Faced with severe budget constraints, the MoH has recently initiated efforts to improve health financing policies. The MoH is studying models to collect fees consistently from clients with private insurance or social security, to introduce cost-saving measures and to allow patients in some MoH hospitals to select higher priced, more comfortable wards that are intended to generate profits. In addition, the MoH is investigating cost recovery schemes and alternative resource allocation policies. The **Health Financing** component will support MoH efforts in this direction.

The MoH requested assistance in the three priority areas described above to improve the efficiency and quality of their health services. USAID/Peru has worked closely with the MoH in

the design of Project 2000 to ensure that the activities outlined in this Project Paper respond to the priorities of the MoH.

2. Other Donor Activities

The Ministry of Health receives assistance from a series of bilateral donors and international agencies. Table 3 provides a list of governments and international agencies working in the health field in Peru and indicates the types of programs in which each is involved. Within the MoH, the Office of Financing, Investment and External Cooperation is responsible for coordinating the activities of the donors. Its ability to do so is evidenced in the successful implementation of health programs throughout Peru. The Expanded Program Immunization, on which was implemented by the MoH under the coordination of the Interagency Coordinating Committee, is an outstanding example of how agencies can work together to achieve a common objective.

During the development of this Project Paper, every attempt was made to coordinate activities with those of other donor agencies. In particular, incoming USAID HPN staff held meetings with the World Bank and International Development Bank staff responsible for developing the new health projects that those two donor organizations will be funding in the near future in Peru. The formation of the Interagency Committee that is a covenant to this agreement will be an excellent forum for coordinating efforts and reaching consensus on policy dialogue issues.

World Bank (IBRD). Over the past decade the IBRD has worked with the MoH to increase the availability of and improve access to primary health care services in Peru, particularly in the coastal and jungle geographic regions. Funds have been provided for equipment, supplies, medicines and nurses' training. For political reasons, the disbursement of IBRD funds was indefinitely suspended in the mid-1980s. It is only recently that the Bank has renewed activity in Peru.

The IBRD is currently negotiating a new $34 million health loan with the GoP for a Basic Health and Nutrition Project (BHNP), the implementation of which should begin in early 1994. This project seeks to increase the utilization of maternal-child health and nutrition services by extending access and improving the quality of services; and by promoting better health and nutrition practices, with an emphasis on preventive care and education. The project, which hopes to reach 1.7 million people, will principally be implemented in the unserved areas of Grau, Nor Oriental de Marañón, Inka and northern Lima. However, IEC activities will be on a national level. The total cost of the project is US $42 million, with $34 million from the IBRD and $8 as the GoP contribution. The project will principally be implemented through non-governmental organizations.

Table 3

INTERNATIONAL COOPERATION 1993

Priority Action Areas	A.I.D.	O.P.S.	UNICEF	UNPA	PMA	Germany GTZ	Japan JICA	Korea	Holland	Italy		BID/OPS	World Bank	Interagency Committe	CARE (PRODIA)	PRISMA
										Trapecio Andino	SMALP					
Strengthening Institutions	X	X							X	X	X					
Maternal/Infant Health	X	X	X						X	X	X			X		
Transmitable Diseases		X								X						
Nutrition	X	X	X		X										X	
Environmental Health		X	X		X				X	X	X	X				
Reproductive Health	X			X			X									
Mental Health		X								X						
Pharmaceuticals		X	X						X	X						
Disasters		X														
Information Systems	X	X							X			X				
Communication	X															
Research and Evaluation		X									X	X	X			
Equipment	X					X		X	X	X						
Decentralization		X														

This new IBRD project has much in common with Project 2000 -- particularly in the areas of maternal and child health. It will be very important that USAID and the IBRD coordinate regularly to ensure that activities are complementary and that resources are used with maximum efficiency. One joint decision that needs to be made soon is whether or not Project 2000's pilot projects and regional advisors should be located in the areas already targeted by the IBRD. In addition, both agencies will have to work closely with the MoH's Office of Communications when carrying out their IEC programs.

The IBRD-financed Basic Health and Nutrition Project does not directly address policy dialogue. Policy changes have resulted from the Bank's structural adjustment loans to the GoP. The present project is seen as a second prong of the GoP poverty alleviation strategy, i.e., investing in the human capital of the poor, to help them participate fully in and benefit from the expanding economy. It is projected, however, that a subsequent health operation will build on the experience of the Basic Health and Nutrition Project to support health reforms in areas such as drug procurement and user fees. Thus, A.I.D. and the IBRD can consolidate and coordinate efforts at policy dialogue in health financing.

Interamerican Development Bank (IDB). In the past, the IDB has cooperated with the GoP by constructing health facilities, rehabilitating hospitals, training health personnel, constructing potable water and sanitation systems, and developing electricity schemes. In contrast to these past infrastructure projects, the IDB recently approved a four-year, US $98 million project aimed at strengthening MoH administrative and operational systems. Of the program amount, the IDB will provide US $68 million in loan funds, the Government of Japan will co-finance US $20 million, and the GoP will provide US $10 in counterpart funds.

The new IDB project, known as the "Strengthening Health Services Program" (SHSP), will have externalities for Project 2000. It will support a series of institutional and preinvestment studies on a gamut of topics including management, health financing, personnel policies and incentive schemes, targeting services to enhance cost-effectiveness, privatization and private/public partnerships, among other topics. A second component of the SHSP seeks to strengthen the normative role of the MoH at the central level, while it redesigns and transfers seven administrative subsystems to a decentralized level. These include supervision and monitoring, commodity supply, maintenance, communications, hospital waste management, health information systems and human resources. And the third SHSP component furnishes direct support to local health delivery networks, through basic equipment, drugs, other supplies, management strengthening and training.

These considerable inputs will complement ones provided under Project 2000: The studies will enhance the work of the Interagency Advisory Committee that is a condition precedent to the Project Agreement, furthering the agenda of reform by providing empirical data to inform and support recommendations, including ones aimed at personnel reform; the decentralization of subsystems will promote institutionalization of child survival services at the local level, while consolidating an appropriate role for the central MoH in establishing overarching norms and policies; and the support to local health services will further programmatic institutionalization through training and supplies. One idea that has been discussed with the IDB is the possibility that the IDB replicate the pilot projects implemented and evaluated by A.I.D. under the **Initiatives for Efficient Management** component. Continued cooperation during the implementation of the two projects will be critical. The donor liaison that has been established will thus be carefully continued and nurtured, particularly via the forum of the Interagency Committee proposed in this document.

Complementarity with the IDB and IDRB Projects. Project 2000 complements the SHSP of the IDB and the BHNP of the IBRD. The SHSP also deals with health policy, decentralized management and support to health services. The BHNP deals less with policy and more with support to maternal-child health and nutrition services and with promotion of preventive care and education. With the exception of its nationally-focused IEC component, however, the BHNP targets four regions: Grau, Nor-Oriental de Marañón, Inka and Lima North. If Project 2000 is able to be implemented nationwide, fewer inputs would then be needed in these regions. If Project 2000 is not able to move beyond a pilot stage, it would logically work in three areas other than the ones targeted by the IBRD.

In a like manner, since the IDB's SHSP features a major thrust in decentralization, it is apt to take over successful innovations from Project 2000's pilot studies in Initiatives for Efficient Management, replicating them on a national scale. As pointed out earlier, the ambitious IDB agenda for policy studies will dovetail well with Project 2000's policy reform agenda, by providing empirical data to support the need for and design of policy reforms.

Organizationally, A.I.D.'s comparative advantage lies in its hands-on, in-country presence, both at the Mission level and in technical skills within the HPN Office. This will allow A.I.D. to monitor Project 2000 carefully, ensuring complementarity with other donors and making any mid-course corrections necessary. Conceptually, the similarities among the projects are further testimony that these indeed are the major health issues in Peru. In broad strokes, Project 2000 can be considered more of a pilot project in the areas of management and financing. Its successes

might then be picked up by the larger IDB project for replication. The support that all three projects will give to health service delivery presents a unique opportunity for the GoP to make much more than mere marginal improvements in health services and in the health and nutrition status of its citizens. For the donors, the three projects present an excellent opportunity for coordination in field activities and in policy leverage at the central level.

United Nations Children's Fund (UNICEF). UNICEF provides support to community-level self-help groups for women in very poor areas of Peru. Support is principally used to finance participant training, educational materials in subjects such as child survival, and some equipment and supplies. UNICEF has also given continued assistance to important MoH initiatives in controlling diarrheal diseases, reducing pneumonia and improving nutritional standards. A recent UNICEF project, known as the Baby Friendly Hospital Initiative, promotes improved hospital practices for breastfeeding.

Pan American Health Organization (PAHO). PAHO provides a wide variety of assistance to Peru, particularly through support to programs in immunizations, diarrheas, family planning and nutrition. In addition, PAHO has provided support for human resource development, information systems, statistics, epidemiological studies and environmental health. Through the Interagency Coordinating Committee for EPI, PAHO, along with UNICEF, the Rotary Club and A.I.D., participates in Peru's national immunization program. USAID/Peru recently bought into PAHO's regional grant from AID/LAC for a two-year, US $2 million program of continued support to EPI through the provision of training, cold chain inventory, the purchase of equipment, and other services.

German Technical Cooperation Agency (GTZ). The GTZ has been one of the principal bilateral donors in Peru in recent years. In Cuzco the GTZ helped design an integrated maternal-child monitoring system (PIMI), which is currently being evaluated. Initial comments are very positive. Project 2000 will possibly work with the PIMI system and help popularize its use.

Other. The Government of Italy, the United Nations Population Fund (UNFPA), the Government of the Netherlands, the Japan International Cooperation Agency (JICA), the Government of Korea, CARE, and the World Food Program all provide varying degrees of support for health programs in Peru. In addition, the GoP is currently negotiating with the governments of Great Britain and Sweden.

3. USAID Policies and Strategies

Improving health status through increasing access to quality primary health care is one of the strategic objectives of USAID/Peru's overall program.

Child Survival Strategy. In 1986 A.I.D. designated Peru as one of six (since amended to nine) child survival emphasis countries in Latin America and the Caribbean, because of its high rates of infant and child mortality. USAID/Peru's programs in child survival comprise an important portion of its health assistance to Peru.

The Mission's child survival strategy presents a plan for helping the country develop and sustain the institutional capacity in both the public and private sectors to reduce infant and child mortality and improve the quality of survivorship. The strategy focuses on long-term, preventive health measures and short-term curative interventions that are cost-effective, technologically appropriate, and sustainable. The principles guiding the strategy are: institutional strengthening; increased private sector participation; integrated health and communication programs; targeted, data-based program decisions; and an emphasis on gender considerations.

Project 2000 builds on the ongoing Child Survival Action Project to reinforce progress already made in the immunization and diarrhea programs and to develop new activities that will help achieve the goals of the child survival strategy. In particular, Project 2000 will improve and sustain MoH programs that target the five primary causes of death in infants, support programs that target high risk pregnant and lactating women, provide continued support to the integrated system of disease reporting (HIS/MIS), support integrated health education, particularly at the community level, will provide institutional strengthening services to the MoH.

Nutrition Strategy. USAID/Peru's Nutrition Strategy identifies the need to improve infant and child feeding in Peru as a primary objective to prevent morbidity and mortality. Improved growth and development of children through proper breastfeeding and weaning and proper dietary management of infections will ensure reduction of illness and its negative impact on growth. All of this will contribute to an improved quality of survivorship, as children are better able to grow, play and learn. The nutrition strategy identifies five major areas of activity for project support within child survival and food aid programs: health professional training, social communications, community-based education programs and growth monitoring, a high-risk approach to supplementary feeding programs and linkages with health care services, and development of data bases to support policy making. Project 2000 responds to the nutrition strategy by supporting

activities in all priority areas except supplemental feeding. This activity is covered under other USAID/Peru programs.

Population Strategy. USAID/Peru's population strategy emphasizes the need to expand public and private sector capacity to provide effective family planning services to couples who are at high reproductive risk or who want no more children. It focusses on providing a constant supply of contraceptive commodities while expanding the delivery of long-lasting methods. Family planning has been shown to be effective in preventing abortion.

Project 2000 will support this strategy by expanding MoH capacity to provide effective, inexpensive and culturally sensitive family planning information and services to families who wish them, and especially to women at the same time they receive prenatal, postnatal and interval care. In particular, the Project will expand services in rural and marginal urban areas, where families currently have little or no access to family planning information or commodities. The 1991-92 ENDES survey showed wide disparity in fertility and contraceptive prevalence between urban areas, on the one hand, and rural and peri-urban areas, on the other hand. By targeting rural and peri-urban areas, the Project will help strengthen services in exactly the areas where they are most needed for continued advances in family planning. Among activities will be health education that strengthens women's knowledge about their reproductive cycle, so that they can become more efficient users of the contraceptive method of their choice.

In addition, Project 2000 may provide some medical equipment beyond that provided by other A.I.D. programs. At this time, the Project does not anticipate funding contraceptives; it is expected that Peru will receive contraceptive assistance through A.I.D. central mechanisms. Currently, contraceptive supplies for the MoH are distributed to the departmental level by PRISMA, as part of the Mission's family planning projects. It is USAID's intention to continue this arrangement. Should A.I.D. arrangements for contraceptive procurement change, however, the procurement plan will be revised to include contraceptives. Project 2000 will coordinate family planning support with the coordinating entity for centrally-funded A.I.D. projects in Peru (Development Associates).

Relationship of Project to other USAID Projects in Peru. Project 2000 builds on and complements several USAID projects that are currently being implemented under the Health, Population and Nutrition (HPN) portfolio, particularly the Child Survival Action Project and the Strengthening Health Institutions Project. It also complements child health activities implemented by food assistance PVOs through the USAID Office of Rural Development, Food and local Development Division.

Child Survival Action Project (CSAP). The implementation of CSAP was hampered by U.S. Government sanctions, security issues, and labor problems that resulted from the GoP's structural adjustment program. Of the activities planned under CSAP, only the immunization program, HIS/MIS and VEA received consistent assistance. Project 2000 will consolidate the advances in immunization made under CSAP, while it also expands support to other child health programs so that similar advances can be made. In addition, Project 2000 will make use of the training courses and capability being developed under a CSAP extension to implement its training activities.

Strengthening Health Institutions Project (SHIP). Project 2000 and SHIP complement each other by working toward similar goals (improving the health status of the population), but by using different strategies. Project 2000 will work through the MoH to reach marginal populations; SHIP is working through the private sector with local NGOs and other private institutions. Both projects investigate methods to improve sustainability through various health management and financing mechanisms. In addition, both seek to improve the delivery of information and services to high-risk populations. USAID/Peru believes that to be successful in making health services available and affordable to the majority of Peruvians, both the public and private sectors must participate fully and in a coordinated manner. Thus, Project 2000 staff should liaise regularly with SHIP coordinators and managers to exchange information and compare service delivery and health management and financing models.

USAID Food Assistance Programs. The USAID/Peru Food and Local Development Division works through four private voluntary organizations (ADRA-OFASA, CARE, CARITAS, and PRISMA) that utilize monetized funds to carry out maternal and child health programs as adjunct activities to food distribution. Each of these PVOs has its own unique food distribution mechanism and MCH program strategy that should be coordinated with Project 2000. ADRA-OFASA works through community organizations and includes training of health promoters to do growth monitoring and nutrition education. The CARE Prodia Project, which distributes food principally to community kitchens, could potentially feature more of an MCH focus by promoting weaning foods through community kitchens. Another CARE project, called Wawawasi, provides an excellent model of improving young child nutrition and parent education through child care facilities. CARITAS distributes food through approximately 34 Catholic dioceses in Peru, and supports MCH activities through parish-affiliated health posts. These could be coordinated with Project 2000 activities through MoH health centers and posts in the same areas. The PANFAR (Program for Food and Nutrition for High-Risk Families) program is managed by PRISMA on behalf of the MoH; it distributes food through MoH health facilities. The PANFAR project supports extensive MCH activities such as training for MoH health

personnel and community health promoters, growth monitoring programs, and others that offer important points of collaboration with Project 2000.

Lessons Learned from USAID Projects. This Project will benefit from USAID's experiences in implementing child survival and primary health care projects in Peru over the past decade. In particular, the extension of Integrated Primary Health Care Project (527-0219), the Integrated Health and Family Planning Project (527-0230) and the Child Survival Action Project (527-0285) provide valuable lessons that have been incorporated into the design of Project 2000.

Administrative/management lessons. Major administrative and management constraints experienced under all three of the projects listed above include: (1) overcentralization and ineffective integration of regional and local personnel into the planning process; (2) an extremely high turnover rate of central and regional management and professional personnel; (3) deficient financial and administrative management; (4) lack of budget planning on the basis of past experience and available resources; (5) lack of orientation and motivation of administrative personnel; (6) unrealistic expectations concerning the MoH's ability to produce technically acceptable operational plans to meet Conditions Precedent for disbursement of Project funds; and (7) counterproductive MEF control over the MoH budget. In response to these concerns, the design of Project 2000: (1) includes activities that promote decentralized management and budgeting and improved administration; (2) attempts to improve employee morale through increased training, the provision of equipment, the upgrading of facilities, and improved management and supervision; (3) makes use of an Institutional Contractor to avoid overly complex MoH systems; (4) includes an institutional analysis of the MoH financial and administrative systems, with the provision that technical assistance from Project funds will be used to correct deficiencies in these systems before project implementation; and (5) contains only the most necessary Conditions Precedent.

Lessons in logistics. Analyses of procurement and logistics procedures under previous projects reveal cumbersome logistics systems within the MoH. Shortages and poor distribution of many basic supplies, medicines and equipment were found in hospitals, health centers and health posts. In addition, vehicles are scarce and poorly maintained, customs procedures are lengthy and cumbersome, and warehouse storage and transportation are inadequate. Better inventory control systems and training for selected logistics personnel were areas identified as requiring increased attention and support. Project 2000 addresses these issues by providing assistance to the MoH to improve logistics and management systems and by providing training in those systems.

Use of data. The health information system in Peru has been revolutionized as a result of major technical assistance and computer equipment provided during the past decade. USAID supported the design of computer software and provided training at all levels of the MoH system in use of computers and the new health information and management information systems (HIS/MIS). This system needs to be strengthened by improving analytic capability at all levels on the use of information for decision-making. The Project 2000 management component addresses this issue.

The epidemiologic surveillance capability of the MoH at the central and regional levels is being greatly improved under the CSAP-funded Field Epidemiology Training Program. In the remaining eighteen months of the program, the network of laboratories for microbiologic diagnosis still needs to be strengthened. However, at the end of CSAP, regional MoH epidemiologists will still require continued training and support, and the vital registration system will still need to be improved. Regional Project 2000 advisors will work with the MoH to improve the utilization of data from the Active Epidemiological Surveillance (VEA) system to overcome this weakness.

Training and supervision. In previous projects, training and supervision were found to be critical areas for continued support at all levels of management and service delivery. During the 1993-94 CSAP extension, clinical training for MoH hospital personnel will be carried out through a private sector university program. Project 2000 will use this model for extensive training of MoH personnel. In addition, Project 2000 will provide funds for improving the MoH's supervisory system.

MoH use of PL480 funds. Due to the 620Q and Brooke-Alexander Amendment sanctions, a large portion of the USAID grant funds to be provided under CSAP were unable to be obligated during the initial five years of the project. Partly as a result of this restriction in funding availability, the MoH acquired an increased capability to program and spend PL480 counterpart funds under the project. PL480 funds were utilized mainly for selected training activities, for meetings, for supervision of central level personnel to the regions, and for the purchase of some supplies and antibiotics.

Under CSAP, the Mission established a "phasing approach" to apply PL480 local currencies to EPI. Initially, syringes and needles were purchased with A.I.D. grant funds. As an interim step, the MoH used some of the PL480 monies to supplement inadequate Public Treasury funds for procurement of syringes and needles. Finally, the MoH received budget approval from the Public Treasury for their syringe and needle requirements.

Under Project 2000, syringes and needles for EPI will continue to be funded from Public Treasury funds; PL480 funds will be used to support other activities.

In summary, the Project 2000 design has attempted to address and/or take into consideration recommendations that have been made on the basis of evaluations and observations of previous USAID projects. While Project 2000 cannot expect to resolve all weaknesses within the MoH, the Project will address many of the most serious problems.

III. PROJECT RATIONALE AND STRATEGY

A. Project Rationale

A healthy population is essential for the economic development and growth of a country. With good health come higher levels of productivity and increased participation in the economic and political processes that sustain a nation. In Peru, poor health continues to inhibit economic development. Infants, young children and women of childbearing age are particularly vulnerable to infectious diseases and malnutrition.

Over the past decade Peru has made enormous strides in reducing infant mortality. Five years ago, Peru's infant mortality rate was the third highest in the Latin American and Caribbean region. Today, according to the recent national Demographic Health Survey, the rate has improved markedly from approximately 88 to 55 deaths per 1000 live births. Much of this decline can be attributed to successful nationwide programs in immunizations and the reduction of deaths related to diarrheal diseases.

With deaths from vaccine-preventable diseases and the dehydration caused by diarrheal diseases under better control, Peru is now ready to shift the emphases of its child survival programs to the current primary causes of death among infants and young children: perinatal complications (frequently related to poor maternal health or obstetrical emergencies) and acute respiratory diseases (pneumonia). These are the frontiers along which Peru can now make the greatest progress in further lowering infant mortality. While deaths from these causes occur throughout Peru, their incidence is highest among the rural populations of the sierra and jungle, as well as the marginal urban population.

With the decline in infant mortality, moreover, it is opportune to focus greater efforts on the quality of survivorship: This implies greater attention to morbidity and to malnutrition. The area of malnutrition is one in which Peru has not made advances concomitant with those in mortality and fertility.

Project 2000 therefore focusses great efforts on improving the quality and efficiency of nationwide MoH health services that target perinatal complications and pneumonia, and on preventing malnutrition among the most vulnerable population groups. Continued support is provided, nonetheless, to the nationwide immunization program and the national diarrheal disease control program, to further promote their sustainability.

As a corollary to improving infant health, the Project will help develop programs that improve the health and survival of women of reproductive age. By improving prenatal care, increasing the number of births attended by qualified personnel, and expanding

family planning services, the Project will help ensure not only that infants are in better health at birth, but also that the women to whom they are born similarly enjoy good health.

B. Project Strategy

Project 2000 addresses the problem of poor infant, child and maternal health by directly supporting MoH programs for maternal and child health (MCH), by improving the efficiency of these programs, and by improving the financing of health care in Peru. The direct support to priority MCH programs is viewed as the activity that will provide immediate assistance to the MoH in helping to reduce infant and maternal deaths and improve the quality of survivorship. Activities to improve the efficiency of service delivery and rationalize health care financing will contribute to the long-term sustainability of child and maternal health programs by helping to ensure that the MoH will be able to continue to support these programs in the future.

The first component of Project 2000, **Strengthening Child and Maternal Health Services**, focusses on the provision of services at the community level, with an emphasis on providing services in rural and marginal urban areas. This Project component will strengthen existing MoH priority child and maternal health programs by improving the coverage and quality of maternal health and selected infectious disease control programs. Specifically, the Project will focus on helping the MoH expand the reach of maternal/perinatal health (including family planning) and acute respiratory infections programs, while providing continuing support to the nationwide immunization and diarrheal disease programs. Malnutrition issues will be addressed through support for health professional and public education in breastfeeding and weaning, including growth monitoring.

The emphasis of the programs supported by this component is on long-term, preventive measures that will, for example, reduce perinatal complications, prevent malnutrition and keep children from contracting vaccine-preventable diseases. However, given that not all child/maternal health problems can or will be prevented, some short-term curative interventions will also be supported, especially in infant pneumonia and diarrheas.

Active community involvement is an essential element in all the programs supported under this component. By training community level volunteers and workers, by involving the community in activities such as supporting community birthing homes, and by carrying out "community epidemiology" activities (for example, talking with a group of women about why a woman died in childbirth and what can be done to prevent future deaths), the programs supported by this Project will be better accepted and institutionalized within communities.

While the scope of the **Strengthening Child and Maternal Health Services** component is nationwide, innovative activities will initially be implemented in selected high risk areas. Studies and evaluations of the new activities will be carried out at the community level to ensure that the programs are culturally sensitive and accepted. Once the programs are working well in the initial target areas, the models will be replicated on a wider scale.

The **Strengthening Child and Maternal Health Services** component will provide regional administrative offices, health centers and health posts with technical assistance to improve their management, supervision and record keeping systems. Targeted clinical training-of-trainers will be provided for multidisciplinary teams of hospital personnel in hospitals selected to be model hospitals. These teams will conduct replica clinical training programs for hospital, health center, and health post staff, health promoters and traditional birth attendants. In addition, health centers and posts will be provided with selected equipment, commodities and medicines required for successfully implementing these programs. Finally, this Project component will support a large information, education and communications (IEC) program, with national campaigns that focus on maternal-perinatal health and acute respiratory infections, and local campaigns on these and other health issues. Ethnographic and KAP studies will be implemented as part of the Project at baseline; these studies will inform IEC and training efforts and will contribute to Project evaluation.

The second Project component, **Initiatives for Efficient Management**, will assist the MoH in its efforts to decentralize administration and improve the management and allocation of resources and budget levels for child and maternal health programs. The Project will develop pilot activities in decentralized management and "total quality management" that will be geared toward increasing the quality of and efficiency with which health care services are delivered. These pilot programs will be initiated in two regions and then reviewed and evaluated for their potential replication. In addition, this component will introduce a cost-based programming and budgeting process into the MoH, which will help the MoH rationalize its budget requests and disbursements. Better budgeting procedures will strengthen the MoH's position and give it more leverage in budget negotiations with the MEF. To support these activities, the Project will finance short- and long-term technical assistance.

In order to build up a "critical mass" of persons trained in efficient and effective health management, this component will provide short- and long-term training opportunities in public health and health administration. If final approval for this activity is given by the MoH, 15 MoH employees will be selected for Master's Degree out-of-country training. In addition, some

50 MoH employees will participate in short-term out-of-country courses or observational visits. Finally, this component will support the development of limited in-service training for health administrators through a local institution.

The third Project component, **Health Care Financing**, will support MoH efforts to increase resource levels for primary health care through increased mobilization of resources. Efforts to increase the amount of resources available for child survival programs will primarily revolve around policy dialogue discussions between USAID, the MoH and the Ministry of Economy and Finance on budgetary issues. Development and implementation of rational user fee and cost recovery systems will also contribute to increasing the resources available for priority programs. This Project component will finance long- and short-term technical assistance, operations research and targeted policy analysis studies and surveys.

IV. PROJECT GOAL AND PURPOSE

The goal of this Project is to improve the health status of young children and women of childbearing age. The purpose of the Project is to increase utilization of priority maternal and child health interventions. The project addresses issues of sustainability maintaining that higher levels of utilization can be achieved only if services are made more available, accessible and acceptable. This higher level of utilization contributes to sustainability.

V. PROJECT DESCRIPTION

This action contains a fuller description of the three Project components.

A. Strengthening Child and Maternal Health Services

Under the **Strengthening Child and Maternal Health Services** component, the Project will support programs and activities directly related to child and maternal health. In particular, the Project will support ongoing MoH programs in:

- Maternal-perinatal health, including family planning (Mat/P);
- Acute respiratory illnesses (ARI), fundamentally oriented toward the diagnosis and opportune treatment of pneumonia;
- Exclusive breastfeeding, weaning, and growth monitoring (EBF/W/GM);
- Vaccine preventable diseases (IMM); and
- Diarrheal diseases (DDC).

The principal activities to be supported under this component include:

- Clinical training; and
- Information, education, and communications (IEC).

To improve the delivery of services under these programs, and thus their sustainability, this component will also address the improvement of administrative support systems, including:

- Information and management;
- Supervision;
- Logistics, e.g., storage and distribution; and
- Physical infrastructure repair.

In addition, some medical supplies, pharmaceuticals and equipment will be provided in support of this component, particularly for the maternal-perinatal and acute respiratory infection subcomponents. It is expected that A.I.D. funding for pharmaceuticals and supplies will gradually be replaced by MoH funds, so that by the end of the Project the MoH will be paying for these recurrent cost items.

1. Priority Child and Maternal Health Programs

Conditions originating in the perinatal period are the leading cause of infant mortality in Peru. In addition, Peru has the second highest maternal mortality rate in Latin America: 303 maternal deaths for every 100,000 live births. Maternal/perinatal health care is therefore a priority program for the MoH and this Project.

This subcomponent has a double objective. The first is to improve the quality of life and survival of infants, in recognition of the high proportion of infant deaths and complications occurring in the neonatal period (first 28 days of life) that are related to conditions surrounding pregnancy and birth. The second objective is to protect the life and health of women, especially during the most vulnerable periods of pregnancy, childbirth, and puerperium. This includes the prevention of reproductive risk and abortion through family planning for spacing or limiting births. It is estimated that one-third to one-half of all maternal deaths in Peru are related to clandestine abortion for unwanted pregnancies. Induced abortion, in turn, is responsible for one-third of maternal morbidity in hospitals. A risk approach to maternal and child health should be strengthened to reach those with the greatest need for services, given the limitations in resources.

Prenatal Care. Presently only 69 percent of pregnant women receive prenatal care: 48 percent from doctors and 21 percent from midwives or nurses. Percentages differ radically between urban (82 percent) and rural (45 percent) areas; between regions (93 percent for Lima and 40 percent for Loreto); and among education levels (97 percent for those with a higher education and 37 percent for those with little or no education).

Prenatal care can help reduce infant and maternal mortality by identifying early women at high risk of birth complications. Prenatal care is especially important to detect and treat chronic anemia, hypertensive disorders and reproductive tract infections; and to identify predictable obstetrical complications, such as cephalo-pelvic disproportion, so that timely arrangements can be made for delivery in an appropriate facility. Some high-risk factors can be identified before pregnancy occurs: reproductive tract infections, multiparity, extremes of reproductive age,

short birth spacing, history of chronic illness, low pre-pregnancy weight and previous birth complications. Women with these risk factors who do become pregnant need to be monitored carefully during pregnancy. It is important to promote family planning for women in these categories to avoid high-risk pregnancies.

Some pregnancy-related problems can be corrected or managed as pregnancy progresses. These include low weight gain, gestational anemia or diabetes, and pre-eclampsia. Hospitalized delivery for such high-risk women is very important. The prenatal visit also provides a chance to counsel women on proper self-care during pregnancy and lactation, and to promote proper infant care and feeding. Finally, it provides an opportunity to promote postpartum family planning to space or limit pregnancies, especially for high- risk women.

The Project will help the MoH meet its goal of providing prenatal care and education to the most under-served populations. The Project will strengthen peripheral facilities (health centers and posts) with equipment, materials, manuals and copies of MoH norms. Common antibiotics will be supplied for treating the most prevalent reproductive tract infections. MoH health care providers in health centers and posts will be trained to offer quality prenatal care, as they are the closest to the most needy population. Also, the training of community health promoters and traditional birth attendants (TBAs) should include simple techniques of obstetric and reproductive risk detection, including training in how to motivate women to go to a health service facility for prenatal and delivery care.

Chronic anemia is a widespread condition; recent studies show 64-75 percent prevalence among women in Lima. Post-partum hemorrhage that is complicated by severe iron-deficiency anemia contributes to the high rates of maternal mortality in Peru. Thus, the Project will supply iron and folic acid tablets for distribution to pregnant women, and will support concurrent studies to investigate the factors influencing women's compliance in taking the tablets, since this is a frequent problem of the intervention. Support will also be provided for studies of anemia prevalence in women at high altitudes, for which no information is currently available in Peru, as well as for women who reside in the jungle, where high prevalence of parasitic infections and low nutritional status may be complicating factors.

The Project will support MoH efforts to immunize all pregnant women with two doses of tetanus toxoid vaccine in geographic areas noted for high risk of neonatal tetanus. This measure will reduce neonatal deaths from this preventable illness. TBA training will, accordingly, also transfer this kind of skill.

Birth-related health and survival for women and infants. The majority of maternal deaths that are unrelated to unsafe abortions and over one-third of all infant deaths occur during the month prior to delivery, during delivery itself or during the month following delivery. Nearly 50 percent of all deliveries in Peru occur at home, attended by a traditional birth attendant, family member, or other lay person. Thus, many women do not have access to appropriate resources in case of an emergency. A key to survival of the mother and newborn is management of obstetrical emergencies during and immediately following birth. Experiences from other countries show that when a high proportion of births occur at home, a dual strategy should be adopted. At the community-level, obstetrical emergencies that occur at home must be identified, immediate care provided, and transportation provided to a health facility. At the institutional level, emergencies must be attended by qualified personnel in well-equipped health care facilities. Home care of emergencies is not generally effective. Thus, all persons involved must have a clear understanding of obstetrical risks, as well as an emergency plan for immediate care.

The Project will support improvement of the quality of hospital management of obstetrical complications through a training-of-trainers program for up to 45 major hospitals. This training of a multidisciplinary team of four health professionals as trainers, plus additional T.A. support, will be provided to these hospitals to qualify as model hospitals and local clinical training centers in maternal-perinatal health.[3] Replica training courses will be provided within these model hospitals and for their peripheral health centers and posts. Basic equipment, supplies, and medicines will also be provided to health establishments. This will include such items as stethoscopes, specula, equipment for reading blood pressure and fetal monitoring and infant weighing scales. Support will be given for implementation in the model hospitals of the System for Perinatal Information (SIP) originally developed by CLAP/PAHO to monitor quality of care. This will consist of T.A. support for analysis and utilization of data for decision-making and some computer equipment for selected hospitals. The SIP is complementary to the HIS/MIS system.

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[3]Model hospital and local clinical training center is the name given by the Project to the MoH hospitals that will have teams of trainers who received or will receive training under either the Child Survival Action Project (CSAP) or the current Project. These hospitals will qualify themselves as model hospitals by strictly instituting all protocols and procedures according to the norms of the Ministry of Health for a particular clinical area of specialty. For example, under the Project, a model hospital in maternal-perinatal health will have a team of trainers specialized in training for that clinical area. See the component specific training plan for more information.

The Project will develop effective methods to identify, train, and supervise TBAs in the catchment areas of the model hospitals; these TBAs can serve as medical back-up. Also, a system will be developed to identify and train other community members who attend births, but are not necessarily considered as TBAs. In delivery care, TBAs should be trained to prevent birthing complications by using an aseptic delivery technique, massaging the uterus externally, initiating breastfeeding immediately to induce uterine contractions and avoid hemorrhage, and removing the placenta manually if it is still retained after one hour. TBAs also need to know how to identify the most frequent obstetrical and perinatal emergencies such as hemorrhage, retained placenta, toxemia, prolonged or obstructed labor and postpartum infection. Usually TBAs, like professional midwives, are not trained to manage the problems of the infant, as their training has been centered around the care of the mother. They may not know how to revive a "depressed" infant. Training will be provided in immediate resuscitation of the newborn, as well as such basic newborn cares as keeping the newborn warm and maintaining unrestricted air passage. The Project will supply TBA birthing kits and provide basic resuscitation equipment to complement this training.

The Project will support a major IEC effort in maternal-perinatal health, both to promote preventive self-care and to generate a demand for prenatal and delivery care. Given that very little is known in Peru about traditional practices related to prenatal care, home deliveries and immediate care of the newborn, the Project will fund ethnographic studies of factors that govern utilization of informal and formal health care services during pregnancy, childbirth, and postpartum. The results of these studies will be used in the development of nationwide and local IEC messages that promote improved maternal and perinatal care. The studies will also be used to develop training programs for health personnel and community health workers, especially TBAs.

During the first year of the Project, the MoH will organize a large national conference with international experts in maternal/perinatal health, with the objective of raising the interest of the entire medical community. This can be followed by a series of similar regional seminars.

A national mass-media IEC campaign will also be conducted through the Project, utilizing television, radio, and printed materials. Local mass-media IEC campaigns will be implemented, with region-specific orientation of the educational messages. To complement clinical training of personnel at all levels, the IEC component will support production of self-instructional training materials (training videos and manuals) and publication of a periodic technical bulletin that encompasses current research and programmatic experiences in maternal-perinatal health.

The Project will strengthen the epidemiological surveillance of maternal deaths and perinatal infant deaths. At the community level, health personnel will use each identified maternal death as the focal point of a community training effort. TBAs, community leaders, and women will be encouraged to discuss the death, so that the underlying causes are identified and actions can be planned to avoid similar deaths. On a national level, the Project will support a survey on women of reproductive age and maternal mortality. The Project will also support a survey and case-control studies of perinatal mortality (stillbirths and neonatal deaths).

Through operations research, the Project will explore the possibility of creating or identifying rural maternity homes for attention of deliveries. These "homes" could be part of the community, with easy access to a hospital where normal births are attended by a trained TBA under clean conditions, with the possibility of transfer in case of complications. Or, these can be intermediate "waiting" facilities very close to a hospital, where a known high-risk women can spend the last days or weeks of her pregnancy. The system of maternity homes has been used in other developing countries and found to be very successful.

Specifically, for this Project activity, A.I.D. will finance: medical equipment and materials for prenatal care, deliveries, and the management of perinatal problems at both the community and primary health care level; support for a master training team and training center; training-of-trainers from selected hospitals, plus T.A. support to develop those hospitals into model hospitals/local clinical training centers; replica training of health care personnel in hospitals, health centers and posts, health promoters, and TBAs; national and local level IEC campaigns; self-instructional training materials and manuals; publication and distribution of a periodic bulletin on maternal-perinatal health; ethnographic research for development and testing of IEC messages and training content; resources for epidemiologic surveillance of maternal deaths; a survey on maternal mortality and perinatal mortality of infants; operations research on maternity homes; and development of models for management of reproductive risk and obstetrical complications at the level of the community, primary care, and referral hospitals. The MoH will finance such recurrent costs as printing of training manuals and supervision. The MoH will also finance national and regional seminars and workshops to raise awareness among the medical community of the importance of maternal-perinatal health problems and interventions for improvement.

<u>Family planning.</u> Peru's five-year National Plan for Family Planning, which was approved in 1987, set a goal of reducing the national total fertility rate from 4.2 to 3.7 births. This goal has been surpassed, with the 1992 total fertility rate standing at 3.5 births. Another objective of the National Plan was to

increase the use of modern contraceptives in women in union from 28 to 32 percent. 1992 data show that use of modern contraceptives reached 33 percent, also surpassing the original target. A special focus was placed on women of high reproductive risk, with the goal that 75 percent of them would use modern contraceptives on a regular basis.

The principle target population for family planning should be women in union in the age groups of 15-19 and 20-24 years. These women currently have some of the lowest rates of use of modern contraceptives (11 and 27 percent, respectively) and have the highest levels of unsatisfied demand for services (43 and 28 percent, respectively). The 15-19 year-old group is particularly important, since women under age 18 are at high reproductive risk. The offspring of 15-19 year-old mothers have the second highest rates of infant and under-five mortality, after mothers who are 40-49 years of age. The focus should be on avoiding unwanted pregnancies, with the goal of reducing unsafe abortion and mortality.

To raise prevalence of modern methods above 33 percent, family planning programs must concentrate on those regions with very low usage, such as: Libertadores, Loreto, Cáceres, Inka and Mariátegui, where the public sector is essentially the only source of counseling and services. Although one cannot ignore the need for infrastructure and supplies in populous areas, there is a great need to equip rural health centers and posts with family planning supplies, equipment and services. In addition, hospitals should be enabled to offer voluntary surgical sterilization with the donation of appropriate equipment and necessary materials. Further, MoH personnel need more training in family planning.

This Project will support those aspects of family planning that are currently receiving little attention from other A.I.D. projects or other organizations working in the field. The Project will also finance training in family planning for MoH personnel, community volunteers and traditional birth attendants as part of the training program in maternal-perinatal health. At least one of six days of that training program will be used for training in interpersonal relations and counselling for family planning methods. Health personnel will be encouraged to provide family planning messages as a regular part of perinatal care. Further, community-level education in fertility awareness will help women use all types of contraception more efficiently, including supply methods and periodic abstinence, which is presently the most prevalent method in Peru.

As it is anticipated that contraceptives will be procured for Peru through centrally-funded A.I.D. projects and other international donors, this Project does not expect to procure contraceptives. Should centrally-funded projects not provide

contraceptives, however, this Project may provide these. The Project will coordinate activities with the coordinating entity for A.I.D. centrally-funded family planning assistance to Peru (Development Associates).

Acute respiratory infections. With the decrease in infant deaths due to vaccine-preventable diseases and diarrhea, acute respiratory infections (ARI) have become the second leading cause of death in children under age one. ARI is undoubtedly the area in which Peru can now make the greatest strides in reducing its overall infant mortality.

Under the general term ARI, pneumonia is by far the most common cause of infant death. Approximately 20,000 children die annually in Peru from pneumonia. For this reason, it is imperative to focus on pneumonia when dealing with child survival. The fatality rate of this disease without treatment is around 26 percent in Peru. However, this percentage is reduced to less than one percent when treatment is available and sought. The great majority of pneumonias are produced by bacteria sensitive to accessible and inexpensive antibiotics. It has been observed that the incidence of all types of ARI is not substantially greater in developing countries than in more developed countries, but that the incidence of pneumonia in particular is greater in the former group. Moreover, the survival rate in the developed world is considerably higher because of opportune medical treatment.

The great majority of deaths attributed to pneumonia occur in the first year of life and especially in the first three months. ARI is the most common cause of morbidity and is the reason for about half of health care visits in this age group.

This Project will help the MoH strengthen its program to control ARI. Particular emphasis will be given to education and training to improve case management of pneumonia by health care personnel and community volunteers through training-of-trainers and development of model hospitals/local clinical training centers. The Project will also give high priority to community-level education on this topic, so that traditional health workers and families can more readily detect the symptoms and early signs that should prompt them to seek health care. Early detection and early treatment of pneumonia with appropriate antibiotics will be stressed. Indiscriminate use of antibiotics for viral ARI must be discouraged, since it entails an unnecessary high cost and creates antibiotic resistance. Both care givers and patients must be taught that ARI associated with a cold will not eventually turn into a more serious type of ARI. This is the most often cited reason for the indiscriminate use of antibiotics.

The Project will support nationwide mass-media campaigns using television, radio, and print materials, and community level mass-media and face-to-face IEC campaigns concerning the diagnosis of ARI, the correct practices for managing pneumonia cases, and preventive measures. IEC programs will emphasize the seriousness of pneumonia, while stressing that the illness is highly curable if treated promptly and correctly. Families will be taught that the first and most recognizable sign of pneumonia is rapid, shallow breathing and that children experiencing such shortness of breath should be immediately taken to a health center. Families will also be informed as to risk factors for pneumonia and ways to prevent the illness from occurring. The IEC component will also support production of self-instructional materials and manuals, and publication of a bulletin that encompasses recent research and programmatic experience on ARI and pneumonia.

To support the training and IEC efforts, the Project will provide short-term T.A. in the first year of the project for ethnographic studies about ARI, as well as studies among health care providers. Research on infant deaths due to pneumonia will also be carried out, and a regular system for recording and investigating causes of deaths will be developed. Operations research projects will be supported to find the best ways to reach families with information regarding early home recognition of that danger signs that warrant immediate formal health care. In all of the IEC activities, the Project will collaborate closely with the MoH program in ARI, as well as with the MoH Communications Office, which will provide technical oversight to the communications endeavors.

To ensure that required antibiotics are available when and where needed, the Project will help improve the supply and distribution system, as discussed below. The Project will also provide limited equipment for ARI to major health centers. Finally, the Project will support periodic surveys of antibiotic resistance for ARI in Project areas.

To support the expanded ARI program, A.I.D. will finance: the purchase of nebulizers, watches, syringes, needles, otoscopes, pharmaceuticals and micronutrients; short-term clinical training through training-of-trainers and replica courses for health personnel from hospitals, health centers and posts, and community health promoters and TBAs; short-term technical assistance; nationwide and local IEC campaigns; and ethnographic studies to develop and test appropriately focussed educational messages and materials that will help bring ARI education into the community. The MoH will finance any regional seminars, as well as such recurrent costs as supervision at all levels.

<u>Breastfeeding, weaning, and growth monitoring.</u> Traditionally, nutrition programs have focused on providing food to those who

are already malnourished, as if malnutrition were a dichotomous situation: nourished versus malnourished. In reality, malnutrition is a progressive process intricately related to other factors. Attention must be given to the growth process itself; the evolution of growth determines the final nutritional status of a child. This is extremely important, as nutritional "recuperation" is a misleading term; growth lost is not always recuperated, and damage to the intellect can be permanent.

In Peruvian children, acute malnutrition, or an abrupt decline in the relationship between weight and height, is infrequent. In addition, the deficit of weight-for-age (defined as below two standard deviations of the U.S. NCHS child growth standard) is relatively low (11 percent) in children under 5 years. However, the corresponding deficit of height-for-age is 37 percent, indicating that chronic malnutrition is the major problem (with significant urban-rural differences of 26 and 53 percent, respectively). Data indicate that Peruvian children begin to experience problems with growth during the first year of life, the period in which the most accelerated extra-uterine growth occurs. Chronic malnutrition accelerates during the first two years of life, but levels off by year three. However, the nutritional damage suffered during the first year of life permanently impairs growth. In the end, these children are relatively short and chubby for their age group. Reducing the damage to growth in the first year will thus reduce related problems later on. So programs to prevent malnutrition should concentrate on assuring adequate growth of an infant during the first two years of life, with special emphasis on the first 12 months.

The problem of chronic malnutrition in Peru is related in part to inappropriate feeding practices in both weaning and breastfeeding. Breastfeeding, practiced appropriately, contributes to infant and child health by providing immunological protection against infectious illness, avoiding contaminants, and fulfilling all nutrient (except vitamin D) and energy needs for the first six months.

Over 95 percent of Peruvian children are breastfed from birth. At one year of age, 70 percent of infants are still breastfed, and by two years 43 percent are still breastfed. A recent assessment of breastfeeding and weaning in Peru showed that although most hospitals claim to have rooming-in policies, they continue to provide prelacteal feeds and feature many other practices that interfere with the establishment of full and exclusive breastfeeding. That study estimated that improved hospital practices for breastfeeding could save the country up to an estimated $4 million a year.

The duration of exclusive breastfeeding in Peru is quite low, with a mean duration of only 2.1 months. In Lima, the mean

duration of exclusive breastfeeding is only 0.5 months. The problem is the extremely early introduction of water, teas, other liquids (such as juices and broths) and non-breast milk. This leads to high rates of infectious illness in infants, especially diarrhea, and interferes with continued production of breast milk. Weaning food practices are also inappropriate. They begin before the recommended six months of age, with first foods generally consisting of diluted soups and broths that replace breastmilk and do not fulfill the high nutritional and energy needs of growing infants. Total complementary food intake for infants aged 10-12 months meets on average less than 80 percent of requirements for energy. Micronutrient intake is also low. It is important to note that in the most impoverished populations of Peru, the weaning problem may include the scarcity of animal proteins in the diet, in addition to the practice of giving overly watery preparations.

The above points to the need to provide information, education, and assistance to women regarding the importance of exclusive breastfeeding for the first six months of life, as well as techniques for the establishment and maintenance of that type of breastfeeding. Further, families need guidance in what are the best weaning foods to give beginning at six months, while continuing with breastfeeding for up to two years. Health care providers must also be trained in lactation management and proper weaning, since they have an important influence on mothers' feeding decisions; currently, however, they frequently provide women with misinformation on infant feeding. IEC campaigns must also be directed to grandmothers, husbands, and other family and friends who influence feeding decisions.

It is also important to monitor, from birth, children's height and weight -- especially during the first year of life, but optimally through the first three years. The Project will develop and operationally test a model for multipurpose monthly community gatherings, at which families will meet with the health promoter and other health staff. At these meetings, infants will be weighed and their growth monitored on growth charts; family members of those who have not demonstrated adequate growth for two consecutive months will receive special education. Discussion groups will be formed in which family members whose children are demonstrating good growth can coach or tutor family members of children who have slow or inadequate growth. In addition, health care providers will use these forums to deliver health messages on proper breastfeeding, appropriate weaning, and the care and feeding of a child during illness. Health messages will be based on concrete examples and cases, so that results will be visible to the participants at the next monthly gathering.

These community meetings will also be used to disseminate information on other topics (pneumonia, family planning,

immunizations, diarrhea) and could be used for vaccination campaigns. Ideally community gatherings should develop a census-type methodology that permits the monitoring of the health of this population group in areas such as vaccination and growth. The community itself should design its own method of organizing its meetings and discussions. Initial activities might focus on infants under one year, expanding later to include older children. The "community gathering" activity will be developed initially in only three areas (those with Subregional Advisors) and then will be evaluated to determine the feasibility of extending the model to other areas.

Another viable possibility is to add a growth-monitoring component to food programs in "comedores populares", taking advantage of that opportunity to reach young children most at risk of malnutrition. Accordingly, the Project will provide for some growth-monitoring equipment materials and educational tools for use in "comedores populares".

The Project will provide training for health care providers and develop activities at the health center and health post level. Community involvement will be essential to the success of exclusive breastfeeding promotion, weaning food improvement, and growth monitoring activities. The goal will be to ensure that lack of growth and potential malnutrition are recognized within the family and/or the community. The focus will be on preventing malnutrition through proper breastfeeding and weaning. The project will not provide supplementary feeding.

Project 2000 will focus on young children in the following areas: exclusive breastfeeding and improved weaning practices; correct techniques of measurement taking and appropriate use of equipment such as weight scales and measuring boards; growth monitoring for early signs of stunted growth; and development of strategies for immediate action so as to avoid progressing to a state of malnutrition.

To support these activities, A.I.D. will finance: anthropometric equipment and materials; short-term clinical training in breastfeeding, weaning, and growth monitoring through replica courses for multidisciplinary personnel from hospitals, health centers and posts, and for community health workers and TBAs; local mass-media IEC campaigns; production of self-instructional materials and manuals; publication of a bulletin that encompasses content on infant feeding and growth; support for development of a model for community growth and development meetings; and ethnographic research and audience testing for development of messages and materials for clinical training efforts and IEC campaigns. The Project will also provide T.A. for studies and evaluations on nutrition-related topics.

Because the World Bank-financed Basic Health and Nutrition Project envisions a large-scale IEC campaign, a major part of which will focus on breastfeeding and weaning, Project 2000 and USAID/Peru will make great efforts to promote the closest coordination possible. Some meetings have already been held, and both donors are members of the MoH Working Group on IEC and Breastfeeding.

Vaccine-preventable diseases. A decade ago, vaccine-preventable diseases were the cause of some 7 percent of infant deaths in Peru. Today, they account for less than 3 percent. This decrease can be attributed principally to increased vaccination. Since 1987, A.I.D. (through CSAP), PAHO (using LAC regional project funds), UNICEF, and Rotary International have collaborated with the MoH to implement the MoH's Expanded Program on Immunizations (EPI) National Plan of Action. International donor agencies have provided cold chain equipment and other material, as well as training and technical assistance in related areas. Vaccination campaigns and the increased availability of vaccines at the community level have achieved substantial gains in the number of protected children in each successive cohort.

Despite the notable successes of immunization campaigns, however, it is essential to continue efforts to increase immunization coverage in the first year of life and to assure this level through regular and permanent systems of vaccination. Although recent data show that 58 percent of all children between 12 and 23 months of age are up-to-date with their vaccinations, only 41 percent have received their vaccinations during their first year of life, as is necessary for optimum protection. This statistic has remained fairly constant for the last five years.

The number of children receiving their first vaccination during the first year of life is high: 94 percent for the first dose of polio. However, only 60 percent of the children receive the second and third (final) doses within their first year of life. This demonstrates that there are a number of children "lost" between the first and second as well as between the second and third doses. Children who are not vaccinated during the first year of life have a lower probability of being vaccinated later on. This is a serious problem, because the absolute number of unprotected children can build to high enough levels for epidemic outbreaks to occur.

This Project will support efforts of the MoH to at least maintain and, hopefully surpass, vaccination coverage, by reducing the percentage of children who reach their first birthday without being fully immunized against childhood diseases (measles, polio, diphtheria, whooping cough, tetanus and tuberculosis). This will be accomplished by designing a system for registration of newborns and monitoring of their vaccinations, and testing the system in three areas where there will be Subregional Advisors

for the Project. These activities may be later expanded to other regions. The Project will provide updated training for MoH personnel. It will also contribute to the consistent and adequate functioning of the cold chain, thus ensuring the maintenance of the quality of the vaccines and their availability at all levels of health care. In addition, the Project will try to assure that 90 percent of women of child- bearing age residing in high risk areas have at least two doses of tetanus toxoid vaccine. The Project will also help to eradicate the wild polio virus by maintaining and improving polio immunization coverage.

Under this Project, A.I.D. will continue to actively participate in the Interagency Coordinating Committee (ICC) for EPI and will finance: cold chain equipment; vaccine, needles and syringes, specifically for tetanus toxoid[4]; short-term, in-country training through training-of-trainers and replica courses for multidisciplinary personnel from hospitals, health centers and posts, and for community health promoters and TBAs; ethnographic research and KAP studies on immunization; local level mass media IEC programs; production of self-instructional materials and manuals; publication of a periodic bulletin on child survival topics that includes recent research and programmatic experiences in immunizations; and short- and long-term technical assistance. The MoH will finance: vaccination cards; supervision at all levels of service; the periodic testing of vaccinations for potency; the purchase of needles and syringes for childhood vaccinations; and printing and distribution of manuals and national norms.

Diarrheal diseases. The control of diarrheal diseases is one of the most notable successes of Peru's health system. In 1985, dehydration due to diarrheal illness was responsible for 22 percent of all infant deaths. In 1992, this was reduced to 12 percent. As a result, diarrheal diseases have dropped from the second to the third leading cause of death in infants.

Peru has achieved this by undertaking a multi-faceted effort to control diarrheal diseases, including improvement of sanitary conditions, improvement of the quality of potable water, general education on how to prevent diarrhea and a variety of efforts to promote oral rehydration therapy to prevent dehydration. The installation of institutional oral rehydration units in health centers and hospital outpatient departments in rural and urban areas and of community oral rehydration units in the homes of community volunteers has facilitated access to oral rehydration therapy.

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[4]Commodities for tetanus toxoid immunizations will be provided by the Project for the first several years, with a gradual decrease in funding level, assuming that the MoH will gradually assume these costs with public funds.

In 1991, Peru experienced a severe cholera epidemic, for which a huge effort was channeled into prevention and early treatment of acute diarrhea. This epidemic was successfully controlled, partly because the country already had in place a successful system for oral rehydration treatment in children. As a result, 99 percent of those contracting cholera survived, the highest survival rate ever recorded. These activities also had a notable impact on reducing the number of diarrhea cases due to other causes.

The CSAP Project is currently providing, through the end of 1994, substantial support to the National Plan for Diarrheal Disease Control of the MoH. This support will continue under Project 2000. Under the CSAP, support was provided for installation of oral rehydration centers for health personnel training, case management, and research. Also, doctors and nurses, as well as family members and others, are being trained in the correct use of ORT. Because of this training, ORT has been accepted as the most effective and appropriate treatment for the management of dehydration, even though medical personnel were initially reluctant to abandon intravenous therapy.

There are two areas currently warranting further emphasis in the area of diarrheal diseases. The first is to reduce the overuse of pharmaceuticals (antibiotics and antidiarrheal drugs) for treatment of diarrhea. Even though most cases of diarrhea do not need pharmaceutical treatment, 60 percent of cases are currently treated with them (frequently in combination with ORS), causing an unnecessary economic drain on families and the health care system. Antibiotics, when improperly used, can cause resistant strains of bacteria to develop. Most importantly, antidiarrheal medicines can have fatal side effects when used in young children.

Secondly, emphasis is also warranted on proper dietary management of children during and following bouts of diarrhea, in order to avoid negative nutritional consequences of the illness and to promote post-illness catch-up growth. Often health care providers do not mention nutritional aspects to family members when treating a case of diarrhea. Training and IEC messages on these two topics need to be disseminated among both health care providers and families.

This Project will continue to support the MoH activities that have already attained these notable successes. Various programmatic options (clinical training, health education, in-service training on proper use of antibiotics) will be reviewed for their relative strengths and weaknesses, with the interventions that have been most successful chosen for greatest support in this component. Among the possibilities are clinical training for MoH health care providers through training-of-trainers for model hospitals; replica courses for

multidisciplinary personnel in hospitals, health centers and posts; training of community health workers; local mass media IEC campaigns; production of self-instructional materials and manuals; publication of a periodic bulletin that includes research and implementation experiences in diarrheal diseases in children; the purchase of ORS; ethnographic studies for development of IEC messages; and short-term technical assistance to carry out a feasibility study of the production of ORS in Peru. The MoH will finance such recurrent costs as the printing and distribution of ORT manuals, the production of evaluation sheets (for the state of dehydration), and supervision.

2. Clinical Training

Project 2000 includes extensive support for in-service clinical training of Ministry of Health (MoH) personnel who work in hospitals, health centers, and health posts. Improvements in health personnel's knowledge, attitudes and clinical skills in the child and maternal health interventions addressed through the Project should result in an overall higher quality of care in public sector health facilities. Specifically, diagnosis, treatment, and patient counseling and education should improve. Training of community health workers, including health promoters and traditional birth attendants, will also be supported in order to ensure outreach into the community with health education, basic treatments, emergency care, and promotion of demand for preventive and curative care at formal health facilities.

Major training needs exist in the areas of child and maternal health, since there has been little systematic training of clinical staff of the MoH in the past decade, despite the availability of donor funds to support training through the MoH. Most MoH training has been done through seminars, but not clinical practice. Also, past MoH training strategies have focused on developing regional or departmental-level "training units" in administrative offices that are removed from the reality of health service delivery. It is important that a clinical training program have strong links with health care delivery facilities for clinical practice.

All training provided under Project 2000 will be skill-oriented and participatory, and will include a strong element of clinical practice. The training system to be supported by the Project includes: 1) support for the establishment of a master training center, centrally located in Lima, specifically for maternal-perinatal health training; 2) support for training of multidisciplinary teams of trainers from selected regional hospitals at the master training center; 3) support to these selected regional hospitals and training teams to develop into model hospitals and local clinical training centers; and 4) support for these model hospitals and local clinical training

centers to provide clinical training to health personnel from surrounding hospitals, health centers, and health posts. MoH counterpart funds will pay diem and travel for personnel from health posts, and health centers will support continuous training and supervision of community health workers. The component-specific training plan contains a more detailed implementation plan for this activity.

3. Information, Education and Communications

The Project 2000 goal is to improve the health status of young children and women of childbearing age, by both reducing mortality in these two groups and enhancing the quality of survivorship. This will be accomplished by focusing on geographic areas of greatest need for improvement of health services and quality management. However, there remains a need in the entire country, including the urban areas where the great majority of Peruvians live, for an overall higher quality of care and better education of the general population in prevention, early home recognition, home treatment and referral of the main health problems in women and children.

Therefore, Project 2000 will feature a component on information, education, and communications (IEC) along the following lines:

- A national-level communications campaign using the mass media, especially television and radio, with a focus on maternal-perinatal health and acute respiratory infections.

- Local-level mass-media communications campaigns in selected regions and sub-regions on the topics of ARI and maternal health, with additional communications efforts on the topics of diarrheal diseases and cholera, exclusive breastfeeding, appropriate weaning, growth monitoring and immunizations. These may contain radio spots and programs, flipcharts, poster/calendars, photonovels, newspapers and other print media.

- Seminars for health care personnel on maternal-perinatal health and ARI in the first and second years of the Project.

- Development and distribution of supplementary learning materials for health personnel and community-level health workers, such as self-instructional training videos and simple manuals or guides on the major maternal health and child survival topics.

- Publication and distribution of a continuing education bulletin on maternal-perinatal health and child survival topics.

- A communications campaign to generate public support for user fees in selected regions where new policies may be instituted under the Project.

The information, education, and communications plan contains a more detailed implementation plan for this activity. As noted elsewhere, the World Bank-funded Basic Health and Nutrition Project also plans to carry out a national IEC campaign, with emphasis on breastfeeding. If, in donor coordination, it appears that the two efforts overlap, some of Project 2000's IEC activities may be cut back.

4. Support Systems

Information and management system. In the last decade the MoH has begun to standardize its information system. The Office of Technical Management of Information and Documentation (DTID) has been responsible for the automation of all the MoH's information system, as well as for other management information systems. The Health Information System/Management Information System (HIS/MIS) includes budgetary and financial management software, personnel management software, and logistical software, in addition to health statistics and epidemiological data.

The HIS/MIS system is presently operating, but, in the opinion of key personnel at the UDES level, it is not offering the information required for making decisions. Some of the problems that were identified were:

- computer print-outs are not in a readable format;
- key personnel at the UDES level are not trained to evaluate and act on the information supplied; and
- the flow of information, the levels of analysis and the collection of information have not been defined.

To support the continued implementation of HIS/MIS activities, AID will provide additional short-term technical assistance, program support, hardware, software, and supplies to assist the MoH (particularly the DGE and OGEI) to:

- Define essential indicators to monitor progress towards Project 2000 goals and to provide the data necessary to make decisions regarding the management of Project 2000 programs.

- Determine which indicators are now adequately monitored by ongoing information systems.

- For monitored indicators, develop a reporting and feedback mechanism to provide relevant information to all levels of the health system.

- For indicators not currently monitored, develop at least one community-based surveillance system to accomplish this task and similarly provide information.

Supervisory system. For a variety of reasons, monitoring and supervisory systems within the MoH have never been very strong. The lack of a strong organizational structure, lack of resources, poorly defined job descriptions, poor morale and other factors have all contributed to a lack of interest in supervision. Yet, a good supervisory system is essential if programs are to be implemented and succeed.

To support the activities proposed in this Project, it will be necessary to strengthen the supervisory system so that supervision is regular at the primary level. To this end, the Project will design a supervisory system for health centers and posts that is realistic and responds to the needs of the health units. Personnel will be trained in the system and resources provided to implement it. For these activities, A.I.D. will finance short-term technical assistance and the procurement of vehicles. The MoH will finance travel and per diem costs for supervisory visits and gasoline.

Logistics system. Any national health program requires a functioning, efficient system of procurement and distribution for basic supplies. In Peru, this system is weak. DIGEMID (Dirección General de Medicamentos, Insumos y Drogas) is responsible for distributing medicines and supplies from Lima to the regions. However, DIGEMID is greatly in need of central and peripheral storage areas.

A three-pronged strategy is proposed for this area. The first is the strengthening of the storage network at the departmental (UDES) level through the MoH and DIGEMID. This process is already under way. A substantial proportion of the funds to buy medicines for the regions will be pooled at the central level, decreasing costs through economies of scale. This indicates that DIGEMID will manage a larger volume of supplies. A second strategy is to use an NGO for the distribution to the local levels, with the guarantee that the key supplies will be received into the country and distributed on a consistent basis. Finally, a third possible strategy is to aid the local system to assure the distribution from the regions to the health facilities. The three strategies are compatible and complementary. There exists in Peru an NGO that has a successful history of distribution of contraceptives. These experiences should be used to benefit the new Project. Also, the UTES of Cuzco has developed, with the cooperation of the Italian government, the Local System of Medicines (SILOMED), which apparently functions well. The new Project could look to this system for guidance.

Infrastructure Repair. The physical conditions of some health clinics and posts are deplorable: walls in need of painting, floors damaged, leaks in the ceilings. To attract service utilization, health facility should be clean and orderly. Thus, the Project will develop a system of preventive maintenance for MoH health centers and posts. The MoH will finance the purchase of basic maintenance materials, such as paint, boards, nails and plaster.

B. Initiatives for Efficient Management

GoP Decentralization Initiative and Project 2000'S Approach to Improving MoH Management. Growing poverty, especially rural poverty, falling levels of real MoH resources, the persistent overconcentration of MoH resources in the Lima Metropolitan Area, and the inability of the MoH to maintain in operation anything approaching its full complement of rural health facilities have all made the achievement of child and maternal health goals increasingly difficult and have drawn attention to the MoH's managerial deficiencies.

The improvement of MoH management, while decentralizing decision-making authority, and the refocusing of MoH efforts and resources onto the public health system outside of Lima, particularly on the rural areas where the major battle for child and maternal health is being waged, are the central goals of the management efficiency component of Project 2000.

The current administration's new decentralization scheme will introduce an important change in the process to date. In the health sector, it is expected that decentralization will focus on the ZONADIS (Zona de Desarrollo Integral de Salud, or Integrated Health Development Zone), with the Ministry of Health as the overall coordinating entity for all the components that make up the national health system. The GoP's general decentralization plan seeks to:

- reinforce the decentralization process by strengthening managerial capabilities; and
- promote operational and administrative coordinating mechanisms between central, departmental and local levels, to enhance both efficiency of resource use and equity.

The GoP's new scheme holds significant promise for improving the MoH's efficiency and accountability and for increasing its responsiveness to people's needs. It therefore constitutes a potentially important mechanism for helping to sustain child survival programs. As such, it figures prominently in the design of Project 2000.

Efficient management's contribution to child and maternal health services. All MoH services and facilities would benefit from increased efficiency at the MoH central office. Improved efficiency lessens resource constraints by doing more with less, thereby effectively increasing resource availability for all services. Child and maternal health services supported by A.I.D. are expected to benefit from the **Initiatives for Efficient Management** component at the local level in two major ways. First, a higher quality of care will result from improved managerial oversight and monitoring, as well as from improved planning that is based on service and epidemiologic data. Second, a greater quantity of services will result from more resources available because of better allocation of existing resources to the neediest populations, and a reduction in the proportion of primary health care services provided in relatively more expensive hospitals, with an accompanying increase in the share provided in less costly health centers and posts.

Project 2000 plans to increase the efficiency of MoH planning for use of resources with three programs. The first and most basic effort will introduce a cost-based planning program that will be adopted nationwide. The supplementary efforts will be a decentralized management improvement model and a total quality management model. The latter two efforts will not be undertaken until the cost-based planning program has been implemented and is running smoothly throughout the country. If this is not the case, resources that were originally planned for the DMIM and TQM models will be devoted to the successful implementation of the cost-based planning program.

Cost-based programming and budgeting. Improvements in global MoH programming, in the overall coordination of MoH efforts and activities, and in the coincidence of identified needs and the availability of resources to address those needs are all key to strengthening MoH management. This will require a process by which local, regional and national health policy goals are made compatible and become the basis on which resources are allocated. Project 2000's management component will pursue this goal by introducing a cost-based programming and budgeting process. This system will require that estimated budget requirements derive from national goals and service delivery program goals established by the MoH decentralized structures. These will be based on the simultaneous consideration of relative needs within the local area, the real cost of providing services and the anticipated resource availability.

This cost-based programming and budget activity will take the place of the current MoH allocation mechanism, which relies on extrapolations of the historical budget and assumes continuation of ongoing activities at the same levels. The current system takes into account neither changing national priorities, locally expressed needs nor changing epidemiological conditions.

The cost-based programming and budgeting system will begin by rationalizing budget categories. A cost accounting system will group inputs and costs into cost categories that are at once meaningful and manageable by health care providers and managers. The system will allow them to understand and alter the relationships between the quantities and costs of inputs and the quality and quantity of the different services provided.

Next, a decentralized budget allocation system needs to be developed at the central level. MoH resources are presently allocated primarily on the basis of the historical budget, with only minor modifications introduced to respond to new policy initiatives. Replacing this decision-making process with a funding formula approach, in which resources are allocated on the basis of health status and other indicators embodying pertinent MoH priorities, will improve the degree of coincidence between MoH priorities and activities.

Further, annual work plans and budgets need to be developed at lower levels, and the cost accounting systems used to report expenditures needs to be revised. The cost accounting system will be a multiple year effort. The MoH's need for information about the costs of producing services, however, is immediate and cannot be put on hold until the first data are generated by the new cost accounting system. At the same time that the cost accounting system is designed, then, a cost study will be carried out. The cost study, as further discussed in the Economic Analysis, will be a basic input into the design of the user fee system.

In order to develop the cost accounting system and carry out the cost study, AID will finance an estimated 18 person months of short term technical assistance, training, printing of reporting forms, computer rental, data input and other costs. The MoH will provide personnel for the study.

Supported by cost data, annual programming and budgeting exercises will become much more meaningful and important. According to MoH Planning Department and MEF officials, MoH budget requests to the MEF will then have greater legitimacy and credibility. The MoH will also be more effective in its annual budget negotiations with MEF. By programming activities by a set of service delivery goals, combined with a cost accounting system that provides estimates of the funding required to achieve those goals, MoH managers will be able to monitor and evaluate programs through performance benchmarks.

The process of developing the cost-based accounting system will be an incremental one, meaning, that as each year passes, the process and the system will be evaluated and improved accordingly. This intense refinement process will occur with heavy participation of the Management Advisor.

A.I.D. inputs into the development and implementation of the new cost-based programming and budgeting system will involve technical assistance and training at the central, regional and local levels. Ten person-months of T.A. will be provided to develop the system and to develop a training course for MoH officials at each of these levels. A total of about 60 MoH officials from all levels will be trained.

Decentralized management improvement model (DMIM). The DMIM will be a pilot project limited to two departmental structures and focusing on the development of an overall management model for the decentralized management units, however they might be defined by the new constitution. To develop this model, Project 2000 will work with all first-tier, MoH organizational units within a defined department or ZONADIS. This will include all relevant administrative and operational activities. The end product should be an integrated, well-coordinated, efficiently functioning, locally-oriented, departmental MoH facilities network.

The DMIM will require A.I.D. inputs in the form of technical assistance, training and evaluation. Sixteen person-months of T.A. will be required to develop and test the model. Approximately 20 administrative and clinical personnel from both of the two local units participating in the pilot project will receive training in management systems in a six-day training course. Training will be followed by a one-month trial implementation and by periodic evaluation at bi-monthly intervals thereafter for one year.

A number of specific courses will be developed to teach MoH officials and managers to operate all administrative and operational systems developed through the DMIM activity. This training activity will take place in only the two local units selected for the DMIM. Six person-months of T.A. from management training experts will develop the exercises for the courses and serve as facilitators for the first course. MoH officials from the two pilot project sites will then be trained in each of the system modules. These officials will subsequently serve as the monitors and trainers for any additional training.

Total quality management model (TQM). A second pilot management project will involve the design and implementation of a total quality management (TQM) approach within the DMIM of the two pilot sites. This will consist of working with all MoH facilities within the selected sites. The TQM approach involves establishing specific quantitative and qualitative goals, and then constructing organizational mechanisms that permit permanent monitoring and adjustment of the production processes and outcomes, in order to facilitate the achievement of those goals. The TQM approach improves efficiency by reducing waste, improving the performance of participating agents (including patient self

care), and developing increasingly stringent standards for the quality of care provided.

The TQM Model will be developed and implemented on a pilot basis in the health centers and posts of two sites. The chief performance criteria to evaluate and adjust the model will be:

- quality of services, including patient counseling, (as measured, for example, by the percent of women who receive prenatal care, of high-risk women who request family planning, and of one-year-olds who are fully immunized),
- average cost of services (efficiency), and
- patient satisfaction.

The objective is to develop a model that can be implemented throughout all MoH health centers and posts, with MoH resources.

In preliminary discussions held with the IDB during the development of this Project, it was suggested that the IDB consider incorporating the final TQM model into its more comprehensive package of management improvement activities. This would help generalize the implementation of the final model throughout the country. While IDB participation in the generalized implementation of the model is not essential, it would be preferable. These discussions, therefore, are continuing. Regardless of the IDB's level of participation in this activity, A.I.D.'s inputs will include 10 months of T.A. and the development of training modules based on the experiences of the pilot sites, to facilitate replication in other sites.

Coordination and evaluation meetings. Combining cost-based programming and budgeting with periodic (perhaps quarterly) meetings of MoH central office and local administrators to review progress towards achieving goals can be a useful way to improve both service delivery performance and the efficiency of operations. The allocation of fixed budgets based on actual costs of achieving quantified service-delivery targets will enhance understanding of the relationships between inputs and outputs. These periodic meetings will help to motivate and will provide a structured forum to review progress towards established goals, as well as furnish any necessary technical assistance to administrators and managers.

Strategic considerations. One major constraint to the approach proposed here is that, while the resources dedicated to this component are limited, the MoH management improvement effort will be comprehensive. This Project is foremost a child and maternal health project, and the bulk of Project funding will go to directly supporting the improvement of child survival and maternal care programs. This is why the Project will need to work first and foremost on the planning and budgeting model and promote its implementation nationally, working only later on a

pilot basis in several of these management initiatives. This approach is consistent with the priorities and economic constraints of the Project, at the same time that it lends itself well to maintaining the flexibility essential in the present fluid organizational environment.

As presently planned, the World Bank's Basic Health and Nutrition Project does not prominently feature activities in management systems and managerial capacity. It focuses on health centers and posts in some of the poorest areas of Peru. In contrast, a substantial portion of the IDB health project will be dedicated to improving the administrative systems of the MoH, particularly at the hospital and central office levels. While the IDB project will start work in only five provinces, it is intended to be replicated to encompass eventually all of Peru's 76 provinces.

Project 2000's administrative improvements for priority MoH programs, as well as the DMIM activity component, have been designed to complement the proposed IDB effort. While both Project 2000 and the IDB project will be working in hospitals, the management issues they will address are distinct and complementary. It is hoped they will have a synergistic effect.

During the preparation of this Project Paper, meetings were held with other donors, particularly with IDB officials and project personnel, in order to highlight the need to coordinate the projects and to take the first substantive steps in doing so. Discussions included presentations of the major conceptual issues involved, the justification for their selection, the identification of critical goals and objectives, tentatively proposed methodologies, the scope and timing of key activities, and elucidation of how the projects could complement one another and avoid counter-productive competition. The discussions were open and frank, and agreements were made to work together in principle. Continuing these efforts, both in Peru (at the Mission level) and in Washington, D.C. (at the Agency headquarters level) will be important to ensure that these projects remain complementary and synergistic.

C. Health Care Financing

Throughout most of the past decade the real funding level for the MoH was stagnant. It then began to decrease in 1987 and has since fallen precipitously -- by more than half of 1987 levels. Decreased funding has been an important causal factor in the MoH's faltering level of service provision. The MoH's service provision trends -- both hospitalizations and outpatient consultations -- have also been affected, with the Ministry currently providing about 10 percent less care than it did in 1987.

Paradoxically, while MoH financing and service provision have faltered, its infrastructure has continued to expand. The number of functioning health centers grew 20 percent, from 649 to 777 between 1987 and 1990, while the number of health posts in operation increased 35 percent, from 2,465 to 3,328. With a decreasing number of services being provided in an increasing number of facilities, it is evident that the average productivity of the Ministry's health centers and posts has decreased significantly. Furthermore, each year throughout the 1985-1990 period, more than 300 MoH health centers and posts have not been in operation because of inadequate funding. Clearly, the MoH's financing has been a major constraint on its ability to provide health care, and, more fundamentally, to keep its infrastructure in operation.

Financing shortfalls have also contributed to erosion in the quality of MoH care because of decreased availability of drugs, equipment and medical supplies. This helps explain the reduced use of MoH facilities. Clearly, more physical infrastructure is not needed to improve access to and utilization of MoH health facilities.

More indicated are two key health financing strategies:

- Increased mobilization of GoP resources for priority child and maternal health care programs; and

- Increased cost recovery for MoH programs.

An important part of the health financing strategy of Project 2000 focuses on the development of a formal, more rational national user fee system for the MoH, though the exact nature of that system has not been pre-determined. Although there is no official GoP policy regarding user fees for public health care, some MoH facilities have levied charges for more than a decade. While the proportion of total MoH financing that is generated by these idiosyncratic, facility-specific user fees remains relatively small, the level of revenues they have raised and their significance have been growing. Since the onset of the financing crisis in 1988, a substantial and growing proportion of MoH drugs and medical supplies have been purchased by MoH facilities with the proceeds of their individual user fees. These funds have played an important role in maintaining the credibility and the viability of the MoH, especially its health centers and health posts. In the health care financing component of the Project, however, a careful balance will be sought that takes full account of the responsibility of the State to provide quality health care accessible to the poor. Cost recovery, in some instances, may hinge more on fee for service, for example, than on real costs. Cross-subsidization of services may be another way to underwrite quality health services for the poor, without overly taxing the financial resources of the State.

Resource mobilization for health services. Through policy dialogue, the Project will attempt to influence the proportion of the MoH budget devoted to child survival and primary health care. Most of the activities in this area will involve policy discussions with the Ministry of Economy and Finance. The specific aims of this component of the financing strategy will be to increase GoP resources for priority child and maternal health care programs, and to enhance cost recovery.

The resource mobilization efforts will also involve policy dialogue with the Ministry of Economy and Finance and/or the MoH Planning Department. The objective will be to agree on allocating, minimally, a constant proportion of MoH resources to health centers and posts, and ideally an increasing proportion, with a decreasing or constant proportion going to hospitals.

The policy dialogue efforts for resource mobilization will be undertaken early in the project by the long-term health economist, in conjunction with A.I.D. staff, and will not require any additional A.I.D. resources. MoH inputs will be minimal, limited to the dedication of at most one person month of time of current MoH Planning Department employees, who will provide any data that might be required to effectively demonstrate the significance of the proposed policy reforms.

Cost Recovery. The cost recovery portion of the health financing component will involve a series of studies based on primary data. The specific aims of these studies will be to:

- provide information for development of a national user fee policy, with rationalized price and exoneration policies;
- assess existing ad hoc cost recovery schemes throughout the country and determine whether those deemed valuable are replicable;
- design and implement pilot projects and perform operations research on new cost recovery schemes; and
- encourage the development of the private sector and the MoH's ability to take advantage of its development by, for example; (1) collecting fees from persons with private or IPSS insurance; and (2) allowing persons to choose higher-priced, income-generating private wards in hospitals.

Demand study. As already noted, the major activity of the health financing strategy -- the development of a national user fee system -- will require inputs from a major study consisting of two components: the cost analysis described in the preceding section, and a demand study based on household interviews.

The analysis of the household interviews will generate at least two reports. The first will discuss general findings, analyzing differences in the coverage and utilization rates of each subsector and geographic area. The second will be an econometric analysis of the demand for services. The demand analysis will identify the factors influencing the decision to seek care, the choice of subsector and the level of care obtained.

A critical portion of the econometric analysis will consist of quantifying the price elasticity of demand for health care services, the cross-price elasticity of demand and the income elasticity of demand, including an investigation of how elasticity of demand varies with income.

A.I.D.'s technical and programmatic inputs into the demand study will include the household survey, the sector-wide workshop to develop the interview form, the preparation of the two reports, and a national conference to discuss and publicize the results.

Development of the MoH fee structure. The findings from the cost study and the demand study will provide the fundamental building blocks to guide the development of the MoH's fee structure. The plethora of idiosyncratic, facility-specific user fee systems include significant inefficiencies, inconsistent policies and incentive structures, as well as inequities that need to be addressed as expeditiously as possible. The MoH should develop a national cost recovery scheme that systematically addresses these significant shortcomings by providing a uniform structure for rationalizing user fee and other cost recovery policies, bringing them into accordance with the MoH's mandates and policy goals of providing access to quality care, providing free care to the indigent, and promoting primary health care.

The development of that structure should be undertaken by a working committee comprised predominantly of MoH officials, but including the long-term Project health financing specialist and other representatives of A.I.D., as well as representatives of MEF, the Inter-American Development Bank Project, the World Bank Project, and others. The working committee will be provided with a technical support staff that is well acquainted with the MoH cost and demand studies. The Economic Analysis presents an outline of the steps to be followed in developing the fee structure, and identifies several quantifiable indicators to be considered.

To complete this task A.I.D. will finance 5 person-months of short-term T.A. The MoH and other GoP agencies that participate in the working committee or as technical staff to the committee will provide personnel time and salaries.

Evaluation of existing cost recovery efforts and operations research of new pilot projects. The final component of the health financing component involves developing a systematic understanding of the experiences and potential replicability of the various idiosyncratic cost recovery efforts that have sprung up at the local level in the past few years, in response to the financial crisis. This work should begin with the development of an inventory of existing efficiency-enhancing and cost recovery efforts, which currently include:

- the Loayza National Hospital's "trueque social" program, wherein poor patients or members of their families pay for care in-kind by performing some simple chores (e.g., cleaning) at the hospital;
- the Honorio Delgado (Arequipa) Hospital's private ward;
- the María Auxiliadora Hospital's private ward;
- the María Auxiliadora Hospital's private company contracts;
- the possibility of renting idle MoH health centers to NGOs or private physicians;
- the possibility of functionally integrating redundant facilities (e.g., the Honorio Delgado and Goyeneche Hospitals of Arequipa);
- one or more of the more successful rotating drug funds that are currently operating in a substantial number of facilities.

One product of the health care financing conference to be held in November 1993, will be the further development of this inventory.

The long-term health financing specialist, in consultation with the MoH, will select those schemes that are to be developed into case studies. The goal will be to identify and select those that have the greatest promise and to evaluate them, not only from a financial perspective, but from a more comprehensive set of criteria, including equity, administrative requirements, and replicability, always keeping in mind the responsibility of the MoH to offer accessible, quality care that will be utilized by the less advantaged, among other groups.

During the first year of the project, when the demand and cost studies and the development of the new fee structure will fully absorb the time and energies of the long-term health financing specialist, no special studies will be conducted. In each subsequent year, a few such studies will be conducted. No more than 10 such studies will be conducted over the course of the Project.

Policy dialogue. A condition precedent to the agreement on which Project 2000 is based calls for the Government of Peru to establish an Interagency Advisory Committee on Health Management and Financing. This Committee will provide an ongoing forum and additional source of technical expertise for the Ministry of Health in the areas of health management and financing. Minimally, the Committee will consist of officially-designated representatives from the Ministry of Health, which will chair the Committee, the Ministry of Economy and Finance, and representatives of the major donors of A.I.D., the International Bank for Reconstruction and Development (World Bank) and the Inter-american Development Bank.

The Committee will be specifically tasked by the Ministry of Health to examine prevailing policies in health management and financing, with a view toward suggesting areas where reforms might be contemplated and outlining, for the consideration of the Ministry of Health, options for the design and implementation of reforms that would strengthen management and financing. Preliminary consultations with GoP entities, as well as donor agencies, have identified a preliminary list of possible topics for policy dialogue. This illustrative list will be scrutinized by the Interagency Advisory Committee and modified as deemed necessary:

a. Processes for programming, budgeting and accounting. These could move to a cost-based system that more directly supports GoP health priorities.

b. Waiver of the current MEF requirements that "ingresos propios" (e.g., user fee revenues) be included in the annual process for MoH budget allocation.

c. The proportion of MoH resources that are dedicated to hospitals. Optimally, this could be reduced over time.

d. Reunification of the entire MoH budget, which is currently segmented into Lima\Callao and the rest of the country. The present practice is conducive to urban bias.

e. Development and adoption of a funding formula to decentralize the MoH budget, so that a greater proportion of resources is dedicated to the regions. This includes the rational assignment of personnel.

f. Discussion on the merits of a national user fee system that safeguards access to quality services for the poor.

g. Discussion on the merits of other appropriate modalities for public/private partnerships in health financing and management.

h. Discussion of how the HIS system can play a more dynamic and influential role in making decisions about health policies and programs.

Reforms such as these will increase the efficiency of MoH programs, heighten local responsibility for management and resources, and help allocate resources both by need and performance. The result should be improved availability and utilization of quality health services, thus enabling the GoP to reach its goal of improving health status. These suggested areas for policy dialogue and reform are specified in Annex 1 to the Project Agreement.

The illustrative list of policy agenda items was identified in two ways. First, during the PP design, team members interviewed key MoH and MEF officials, who suggested many of the items as important bottlenecks to improved resource mobilization, generation and allocation. Second, HPN senior staff met with IDB and IBRD counterparts in Washington to discuss various areas of collaboration, including needed policy reforms. Several of the items on the illustrative list were mentioned in those meetings, as reflected in the discussion, elsewhere in this document, of the IDB agenda for policy studies.

D. End of Project Status

Project 2000 is designed to support the policies and programs developed by the GoP, through its Ministry of Health, in the area of child and maternal health. With the collaboration of A.I.D. and other international agencies, the MoH has developed programs for specific actions to control illnesses and deaths due to childhood diseases, nutritional status and childbearing. Recent advances in controlling diarrhea and vaccine-preventable diseases must be strengthened. Acute respiratory infections, growth and development, breastfeeding, maternal health and family planning programs require increased attention. This Project will help the MoH strengthen the operation of health establishments and will promote increased community participation and involvement in health care. At the end of the Project, a greater proportion of children will survive infancy; the quality of that survivorship will be enhanced in the first years of life, which are so critical to long-term health and nutrition; a greater proportion of women will achieve their reproductive intentions in the number and timing of the children they bear without recourse to abortion; they will also bear them more safely, thus contributing to their own health as well as that of infants; and the GoP will be better able to continue these improvements without over-reliance on donor funding.

Project 2000 is part of a national effort that includes the Peruvian government and international development agencies. This Project, in conjunction with GoP and other donor efforts, will result in the increased use of child survival and maternal health interventions, as detailed in the Logical Framework.

Specifically, it is expected that by the end of the Project:

- the proportion of pregnant women who receive prenatal care will rise from 68 to 80 percent;[5]
- the proportion of births attended by qualified personnel will increase from 52 to 67 percent;
- the prevalence of modern contraceptives will increase from 33 to 40 percent;
- total contraceptive prevalence will increase from 59 to 67 percent;
- the proportion of children under 5 with pneumonia who receive care at a health facility will increase from 48 to 67 percent;
- the average duration of exclusive breastfeeding will increase from 2.2 to 3 months;
- the proportion of children aged 6-9 months who receive two portions of appropriate weaning foods in addition to breastmilk will increase from 62 to 75 percent;
- the proportion of infants who receive at least 5 growth and development check-ups will stand at 75 percent;
- coverage of the recommended schedule of vaccines against 6 childhood diseases will stand at an average of 75 percent;
- coverage of women of fertile age with 2 doses of tetanus toxoid vaccine will increase in high-risk areas from 20 to 60 percent;
- the proportion of women with children under 5 who used ORT in the most recent episode of diarrhea will increase from 31 to 50 percent.

Further, in the area of health management, budget categories will be rationalized; a decentralized budget allocation formula will be adopted at the central level; annual workplans will be

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[5]Wherever current percentages are given in this list of outputs, the figure is from the 1991-92 ENDES.

designed and budgets developed at sub-national and lower levels; a revised cost accounting system will be used to report expenditures; 75 percent of ambulatory services will be provided at health centers and posts (up from 62 percent in 1991); and 90 percent of health centers will be functioning, as will 98 percent of health posts.

Finally, in the area of financing, it is expected that under Project 2000: the proportion of the MoH budget dedicated to child and maternal health services will rise from 48 to at least 55 percent; an increased proportion of MoH spending of the GoP will be in the neediest 25 percent of departments; increased amounts of GoP funds will be applied to health centers and posts; and a national fee collection system will be designed, implemented and functioning, collecting some double the amount of revenues collected in 1993.

VI. FINANCIAL PLAN

A. Overall Project Estimated Budget

The total cost of this seven year Project is estimated to be $60 million. The financing will be provided by a grant from A.I.D. of up to $30 million and $30 million equivalent from the Government of Peru. The GoP contribution will flow from Host Country-Owned Local Currency (HCOLC) generated by the monetization of PL480 Title III commodities, in the amount of $22 million equivalent, and $8 million equivalent in supportive MoH operating expenses. The breakdown of program costs by component and administrative costs is presented in Figure 2.

A breakdown of the financial plan for the Project is presented in Table 4. Table 5 presents projected obligations and expenditures by fiscal year. Table 6 provides a summary of Project costs by funding source and foreign exchange and local currency costs. Budget calculations consider as much as reasonably possible inflation and foreign exchange fluctuations. In-country procurement estimates include the cost of sales tax (IGV). When the IGV issue is resolved, the funds will be available for redistribution.

B. Methods of Implementation and Financing

The majority of A.I.D. dollar-funded activities will be implemented through an Institutional Contractor. The IC will be charged with providing technical assistance, commodity procurement, training, and all other needs required to effectively implement the Project. A separate technical assistance contract will be executed by A.I.D. to procure the services needed to carry out a base line demand study for the cost recovery component to be developed by the IC. The demand study will be contracted as soon as feasible after the Grant Agreement has been executed, obligating incremental funding for fiscal year 1993. The detail and nature of the IC's implementation interventions are found in Section V. Project Description.

A.I.D. will directly contract for and manage project implementation support personnel (PSC), periodic evaluations and financial reviews. Financial Reviews as a line item include procurement of financial and administrative management technical assistance where needed.

Table 7 presents a method of implementation and financing mechanisms matrix that will provide the basics for dollar grant funds financial management.

Figure 2
PROJECT 2000
PROGRAM AND ADMINISTRATIVE COSTS ($'000)

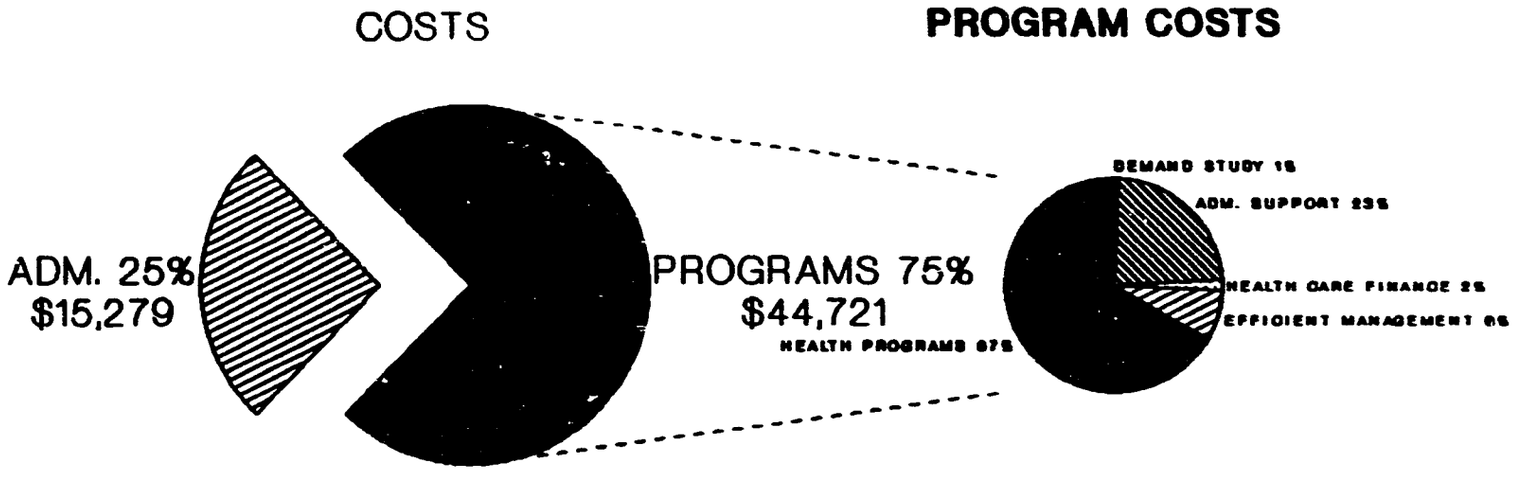

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Table 4

BREAKDOWN OF FINANCIAL PLAN

(U.S. $'000)

ITEMS	A.I.D. GRANT[1]			GOP			TOTAL PROJECT
	FX	LC	TOTAL	ECOLC	BUDGET SUPPORT	TOTAL	
Program Costs							
Strengthening Child Survival and Maternal Health Programs							
1. Priority Health Programs	4,001	1,173	5,174	3,900	0	3,900	9,074
2. Clinical Training	30	4,892	4,922	1,505	0	1,505	6,427
3. Information, Education, and Education	1,049	1,270	2,319	5,737	0	5,737	8,056
4. Support System	632	1,024	1,656	4,551	0	4,551	6,207
Initiative for Efficient Management	2,080	1,030	3,080	378	0	378	3,458
Health Care Financing	160	600	760	0	0	0	760
Project Administration Support	10,204	0	10,204	210	0	210	10,414
Technical Assistance - Demand Study	325	0	325	0	0	0	325
	18,451	9,989	28,440	16,281	0	16,281	44,721
Administrative Costs							
USAID Management Support	0	1,170	1,170	0	0	0	1,170
Evaluations	300	0	300	300	0	300	600
Financial Reviews	0	90	90	0	0	0	90
Operating Costs-MoH	0	0	0	5,369	8,000	13,369	13,369
Total Administrative Costs	300	1,260	1,560	5,719	8,000	13,719	15,279
TOTAL PROJECT COSTS	18,751	11,249	30,000	22,000	8,000	30,000	60,000

[1] Subject to availability of funds to A.I.D. and to mutual agreement of the Parties to proceed.

TABLE 5

PROJECTED OBLIGATIONS AND EXPENDITURES OF PROJECT FUNDS BY FISCAL YEAR

(U.S. $'000)

U.S. Fiscal Year (Project Year)	1993	1994 (FY1)	1995 (FY2)	1996 (FY3)	1997 (FY4)	1998 (FY5)	1999 (FY6)	2000 (FY7)	GRAND TOTAL
1. Beginning Balance	0	6,063	14,193	14,682	17,542	12,333	7,467	3,291	0
2. Program Allocations	6,063	8,732	6,332	8,873	0	0	0	0	30,000
3. Expenditures	0	602	6,123	5,733	5,209	4,866	4,176	3,291	30,000
4. Ending Balance	6,063	14,193	14,682	17,542	12,333	7,467	3,291	0	0

TABLE 6

SUMMARY OF TOTAL PROJECT COSTS BY FUNDING SOURCE AND FOREIGN EXCHANGE (FX) AND LOCAL CURRENCY COSTS (LC)

(U.S. $'000)

Founding Source	FX		LC		TOTAL	
	$	%	$	%	$	%
USAID	18,751	100	11,249	27	30,000	50
GOP						
- HCOLC	0	0	22,000	53	22,000	37
- BUDGETARY SUPPORT	0	0	8,000	20	8,000	13
TOTAL	18,751	100	41,249	100	60,000	100

TABLE 7

METHODS OF IMPLEMENTATION BY TYPE OF ASSISTANCE AND FINANCING METHOD

(U.S. $'000)

Inputs	Method of Implementation	Method of Financing	Estimated Amounts
Program Costs			
Institutional contractor	Contract executed by RCO (PIO/T)	Letter of credit or direct payment	28,715
Technical Assistance Contract or Demand Study	Contract executed by RCO (PIO/T)	Letter of credit or direct payment	325
Administrative Costs			
USAID Management	Personal Services Contract executed by EXO (PIO/T)	Direct Payment	570
Evaluations	Contract executed by EXO (PIO/T)	Direct Payment	300
Financial Reviews	Contract/ Purchase Orders by EXO (PIO/T)	Direct Payment	90
TOTAL:			30,000

The GoP will agree to provide local cost support financing in the amount of $22 million equivalent from HCOLC generated from the monetization of PL480 Title III donated commodities. This local currency will provide local cost support to interventions managed by the IC. The A.I.D. Project Officer and the IC will provide the MoH guidance in the programming of these funds. Also, the MoH will provide personnel and other in-kind support whose value is estimated at $8 million equivalent in soles.

C. Host Country Contributions

MoH contributions to the Project will be through actual monetary inputs from HCOLC, as well as in-kind contributions, in the form of personnel support costs financed from the MoH operating budget.

The HCOLC and HCC requirements interface with dollar grant funds that will be managed by the Institutional Contractor. These funds have been estimated by year of need and by inputs or elements, as shown in Tables 8 and 9. The yearly requirements will be determined in conjunction with the IC annual work plan. The MoH will present its requirements to the Ministry of Finance Special Unit, for inclusion in the GoP monthly budget needs. The MoH will coordinate closely with the IC to ensure that intended interventions are funded adequately and on a timely basis. The MoH will report monthly to the Special Unit on the utilization of HCOLC funds, with a copy to A.I.D. The Project Officer will establish a separate tracking system of funds provided and utilized that will be managed by the IC. The IC will include HCOLC information in its periodic reporting to A.I.D.

The MoH will maintain identifiable accounting records for the assignment of its personnel to Project activities. This accounting will present information in detail on which personnel are assigned to which specific activities, as well as information on how the value of these assignments has been determined. The MoH will report quarterly to the Project Officer on the assignment of personnel and the costs of those assignments, as evidence of the required counterpart contribution.

D. Audit Requirements

The methods of implementation determined for the A.I.D. grant envision project execution by Institutional Contractors who provide technical assistance. The Contractors will be responsible for maintaining auditable accounting records for three years after the contract termination date. The cost of the audit is usually borne by the cognizant contract audit agency. Accordingly, there is no provision for audit costs in the IC budget nor in the Technical Assistance Contractor budget. Audit management responsibility for the U.S. IC resides in FA/OP.

TABLE 8

PROJECTED HCOLC OBLIGATIONS AND EXPENDITURES BY FISCAL YEAR

(U.S. $'000)

U.S. Fiscal Year (Project Year)	1993	1994 (FY1)	1995 (FY2)	1996 (FY3)	1997 (FY4)	1998 (FY5)	1999 (FY6)	2000 (FY7)	GRAND TOTAL
1. Begining Balance	0	3,000	4,000	4,000	3,800	3,000	3,000	2,777	0
2. Program Allocations	3,000	2,880	3,960	3,686	2,947	2,917	2,610	0	22,000
3. Expenditures	0	1,880	3,960	3,886	3,747	2,917	2,833	2,777	22,000
4. Ending Balance	3,000	4,000	4,000	3,800	3,000	3,000	2,777	0	0

TABLE 9

PROJECTED MoH IN-KIND CONTRIBUTIONS BY PROJECT YEAR

(U.S. $'000)

Project Year	1993	1994 (PY1)	1995 (PY2)	1996 (PY3)	1997 (PY4)	1998 (PY5)	1999 (PY6)	2000 (PY7)	GRAND TOTAL
In-Kind Contribution	0	800	800	960	1,170	1,280	1,440	1,600	8,000

There are no formal audit requirements for Personal Service Contracts under A.I.D. procurement regulations, although PSCs do receive annual performance evaluations. This procurement is subject to formal regulations and policy and is provided adequate fiscal review through other means.

There is, however, a formal audit requirement for HCOLC. Accordingly, the HCOLC budget includes funding for annual audits; and the scope of work will include GoP budgetary assistance to MoH operating expense requirements. While funds are included in the HCOLC budget audit, management responsibilities will be exercised by the MEF Special Unit. The MEF Special Unit will request that audit services be procured by the Controller General of Peru, based upon a scope of work and listing of eligible audit firms provided by A.I.D. The audit findings will be presented to A.I.D. as well as a plan for resolving reported deficiencies.

E. Reporting Requirements

The IC, in coordination with the MoH, will prepare annual work plans for the approval of A.I.D.. These work plans will present in monthly increments all interventions planned for the year. The plans will also present monthly HCOLC and HCC requirements to support planned activities. The IC will submit quarterly progress reports that present execution compared to planned activities. This quarterly report will also relate the financial consequences of executed and in-progress activities. The report will be comprehensive in that it will present the financial activity. Finally, the quarterly reporting will also show accrued expenditures at the end of the reporting period. Reporting will be presented no later than five work days after the end of the quarter.

F. Evaluation Requirements

Three Project evaluations are scheduled: one in year three, one in year five and a final evaluation at the conclusion of the Project. Each evaluation will require an estimated four weeks of effort by a team of experts in the various child survival intervention areas, as well as experts in health financing and quality management.

G. Recurrent Costs

Project recurrent costs are incremental expenditures associated with Project activities that must be made on a regular basis during the Project to achieve objectives and after the Project to sustain accomplishments and continue activities. During the life of the Project, both A.I.D. and the MoH will be financing

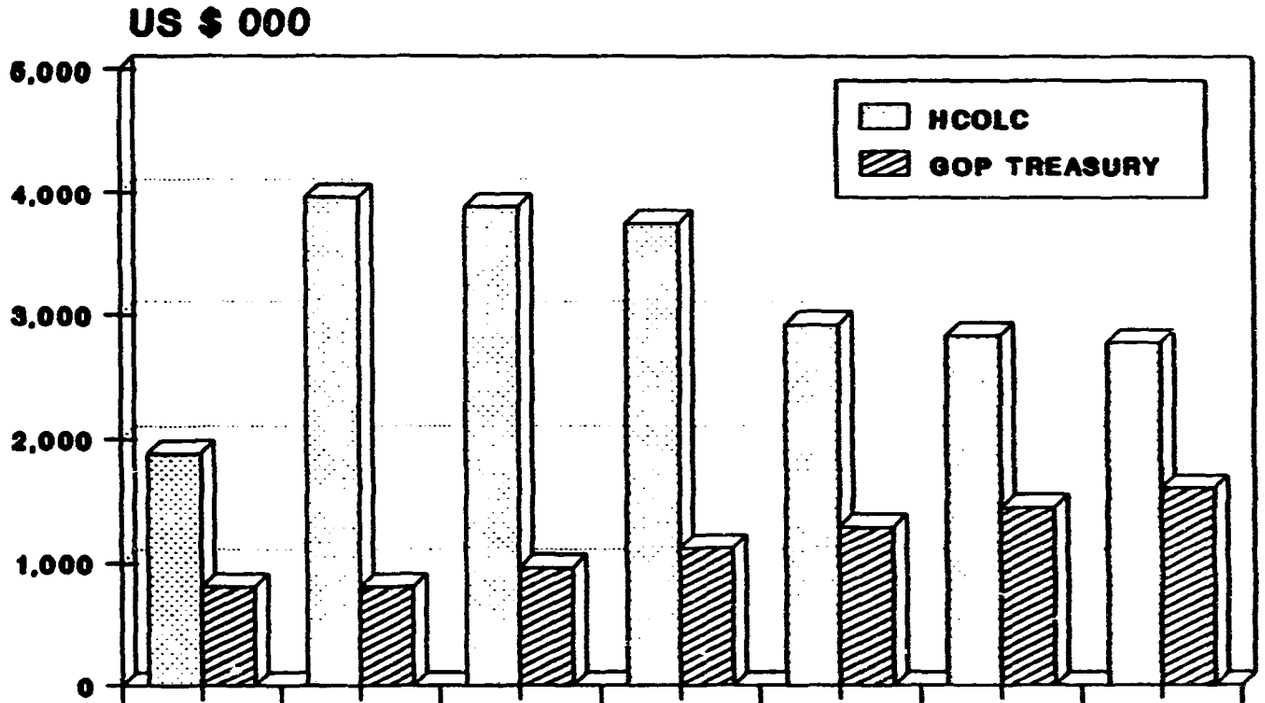
recurrent costs. Many of these recurrent costs are additional to the regular budget of the MoH. Both financial expenditure categories, program and administrative costs, contain recurrent costs.

Recurrent cost can be identified for each Project component, i.e., pharmaceuticals, micronutrients, vitamins, syringes, ORS, spare parts for the cold chain, clinical training, national or regional mass media campaigns, per diem and related travel expenses for supervision and training, maintenance costs for infrastructure, operating equipment, office supplies and other inputs to maintain support systems in information, logistics, financial and personnel management.

Recurrent costs are addressed in two ways. First, in a covenant to the Project Agreement, the GoP agrees to assume an increasing proportion of recurrent costs over the life of the Project. Funding will come from both PL480 funds and an in-kind contribution that covers salaries. In the first year of the Project, for example, the GoP covers $800,000 equivalent in recurrent costs from the National Treasury; this rises incrementally over the years, ending at a figure double that amount in FY 2000. The HCOLC contribution rises even more rapidly, more than doubling in FY 95 ($3.9 million) over the FY 94 level ($1.9 million). These data are presented in Table 10, while Table 11 breaks down the GoP counterpart contribution.

Second, in a further covenant to the Project Agreement, the GoP agrees to continue financing Project activities once the Project is completed. Recurrent cost estimates have an average annual level of about us $5.3 million during the life of the Project. This is the level of recurrent costs that must be financed by the MoH after the Project ends in order to sustain accomplishments, continue the maternal and child health care programs, and maintain the initiatives for efficient management and financing reforms. This recurrent cost level is a relatively small share -- 2.8 percent -- of the total 1994 MoH budget of $213,256,569. This amount thus represents a minor additional expenditure burden on overall central GoP expenditures in health. Further, increased revenues that result from financing reforms should help relieve the financial burden on the GoP treasury, ideally even making the services self-supporting, as explained in the Economic Analysis. The health financing reforms and efficiencies in management effected under the Project should bring about a balanced supply and demand of health services that is both programmatically and financially sustainable by the Government of Peru.

Table 10
TOTAL GOP COUNTERPART CONTRIBUTION BY CALENDAR YEAR AND FOUNDING SOURCE



YEAR	1994	1995	1996	1997	1998	1999	2000
HCOLC	1,880	3,960	3,886	3,747	2,917	2,833	2,777
GOP TREASURY	800	800	960	1,120	1,280	1,440	1,600
TOTAL	2,680	4,760	4,846	4,867	4,197	4,273	4,377

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Table 11

BREAKDOWN OF GOP US$ 8 MILLON IN KIND COUNTERPART CONTRIBUTION SALARIES BY LEVEL OF PERSONNEL AND YEAR OF PROJECT

No. PERSONS

LEVEL/YEARS	1994	1995	1996	1997	1998	1999	2000	TOTAL
CENTRAL LEVEL	6	6	6	6	6	6	6	42
REGIONAL	8	8	8	8	8	8	8	56
SUBREGIONS	50	50	66	66	66	66	66	458
HOSPITALS	60	60	70	77	87	96	106	556
HEALTH CENTERS	140	140	198	250	300	350	400	1,818
HEALTH POSTS	180	180	200	250	300	350	400	1,800

ESTIMATED US$ SALARIES (YEAR)

LEVEL/YEARS	1994	1995	1996	1997	1998	1999	2000	TOTAL
CENTRAL LEVEL	3,600.00	3,600.00	3,600.00	3,600.00	3,600.00	3,600.00	3,600.00	25,200.00
REGIONAL	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	21,000.00
SUBREGIONS	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	21,000.00
HOSPITALS	2,400.00	2,400.00	2,400.00	2,400.00	2,400.00	2,400.00	2,400.00	16,800.00
HEALTH CENTERS	1,800.00	1,800.00	1,800.00	1,800.00	1,800.00	1,800.00	1,800.00	12,600.00
HEALTH POSTS	900.00	900.00	900.00	900.00	900.00	900.00	900.00	6,300.00

TOTAL GOP CONTERPART US$ SALARIES (YEAR)

LEVEL/YEARS	1994	1995	1996	1997	1998	1999	2000	TOTAL
CENTRAL LEVEL	21,600.00	21,600.00	21,600.00	21,600.00	21,600.00	21,600.00	21,600.00	151,200.00
REGIONAL	24,000.00	24,000.00	24,000.00	24,000.00	24,000.00	24,000.00	24,000.00	168,000.00
SUBREGIONS	150,000.00	150,000.00	198,000.00	198,000.00	198,000.00	198,000.00	198,000.00	1,386,000.00
HOSPITALS	144,000.00	144,000.00	168,000.00	184,800.00	208,800.00	230,400.00	254,400.00	1,334,400.00
HEALTH CENTERS	252,000.00	252,000.00	356,400.00	450,000.00	540,000.00	630,000.00	720,000.00	3,702,400.00
HEALTH POSTS	162,000.00	162,000.00	180,000.00	225,000.00	270,000.00	315,000.00	360,000.00	1,674,000.00
TOTAL	753,600.00	753,600.00	948,000.00	1,103,400.00	1,263,400.00	1,419,000.00	1,582,000.00	8,621,000.00

VII. IMPLEMENTATION ARRANGEMENTS

A. Administrative and Monitoring Arrangements

As the parties to the Project Agreement, the Ministry of Health and A.I.D. are the primary implementers of Project 2000. A U.S. Institutional Contractor, which A.I.D. will directly contract in consultation with the MoH, will assist them in this effort. Major management decisions will be take jointly by the MoH and A.I.D., with input from the Institutional Contractor.

1. Ministry of Health

Central Level. Within the MoH, the Office of Financing, Investment, and External Cooperation (OFICE) shall serve as the overall coordinating office for the Project and as the first-line MoH counterpart to A.I.D. The Director of this office shall be designated as an authorized representative of the GoP for the purposes of this Project and may be designated as the MoH Project Director. Or, if the Minister of Health so determines, a Project Director may be designated from within another MoH office, thus providing an additional source of technical input and monitoring for the Project. The designated Project Director shall have central coordination, monitoring and evaluation responsibilities for the Project, with specific regard to:

-- liaising with A.I.D./HPN in formulating overall Project policy and making major Project management decisions;

-- providing guidance to the Institutional Contractor in Project implementation;

-- ensuring that the Project is carried out by the MoH in accordance with the terms and conditions in the Project Agreement;

-- ensuring the coordination of inputs and activities among offices and administrative units at the central level of the MoH and between the central and regional levels;

-- preparing requests for disbursement of MoH counterpart and A.I.D. grant funds to finance local costs;

-- arranging for the receipt and delivery of all Project-financed commodities at both the central and departmental levels;

-- ensuring the efficient and appropriate use of Project-financed technical advisors, commodities and vehicles;

-- ensuring the timely identification and release of trainees for overseas training, if that training does eventuate;

-- ensuring that PL480 funds programmed under the Project reach the regional levels in a timely manner;

-- submitting annual detailed plans for the use of Project funds being provided directly to the MoH;

-- complying with all reporting requirements; and

-- ensuring that the long-term advisors provided under the Institutional Contract or are provided with office space in the relevant MoH office.

Subregional Level. The MoH will assign a technical counterpart for each of the three subregional child and maternal advisors. In addition, the MoH will assign one administrative person from each subregion to work exclusively on the Project. Regional MoH offices will be responsible for:

-- submitting annual regional plans and budget requests to the central MoH for Project activities;

-- participating in selecting candidates for training;

-- submitting annual detailed training plans;

-- developing operations research studies;

-- working with community leaders; and

-- working with the IC technical advisors to develop and implement pilot projects and other program activities.

2. A.I.D.

Overall management and guidance for the Project will be provided by USAID/Peru's Office of Health, Population and Nutrition, in collaboration and consultation with the MoH Project Director, who will be designated by the Minister of Health. For its management, A.I.D. will use Project funds to directly contract the services of an Institutional Contractor to implement the Project, as well as the full-time services of two staff members (a Project Coordinator and a Project Management Specialist) for the HPN Office. From its own operating expenses budget, A.I.D. will furnish the part-time services of one Foreign Service National (FSN) and of the U.S. Direct Hire (USDH) career foreign service officers assigned to the HPN Office.

PSC Project Coordinator (Project-funded). The Project Coordinator will provide technical leadership for the Project and work with the MoH and Institutional Contractor to ensure that Project implementation proceeds on schedule and that Project activities conform to the goals of the Project. Among other things, the Coordinator will be responsible for monitoring Project progress and for ensuring that evaluations are undertaken at the proper time and that evaluation results are incorporated into the continued implementation of the Project.

PSC Project Management Specialist (Project funded). The Project Management Specialist will monitor IC compliance with A.I.D. administrative requirements and personnel policy. S/he will prepare PIO documents, as required, and work with USAID's Procurement Office to ensure that all Project procurement is undertaken on a timely basis and in accordance with A.I.D. procurement regulations.

Direct Hire Support. Staff of the Office of Health, Population and Nutrition will provide overall guidance and management of Project 2000, as well as specific technical inputs. The Chief of the HPN Office will take a lead role in policy dialogue and interagency leadership and coordination, as well as technical guidance in the area of health financing. The Deputy Chief will provide technical guidance in the areas of nutrition; maternal health, including responsible parenthood; qualitative research; information, education and communications activities; and community-level activities. The Foreign Service National Public Health Advisor will provide overall Project management and technical guidance in the areas of training, facility-based services and management.

Other A.I.D. Support. The support of the Training and Social Development Division of the Mission may be required for certain training activities. The health economist in the Office of Project Development and Programs will provide support and guidance in policy dialogue and in the area of health financing. In addition, the support of the Executive Office and the Controller's Office will be required during certain stages of Project implementation.

Mission staff resources shall be supplemented by AID/W technical and project development backstop staff in the Office of Development Resources in the Bureau for Latin America and the Caribbean (LAC/DR) and by various offices within the Bureau for Research and Development (R&D), as well as by the Regional Legal Advisor and Regional Contracting Officer, located in Quito.

USAID/Peru will be responsible for the following activities:

-- directly procuring the services of an institution to carry out a cost study;

-- directly procuring the services of an institution to carry out a demand survey;

-- directly procuring the services of an Institutional Contractor;

-- overseeing the Institutional Contractor's activities;

-- directly contracting evaluations;

-- directly contracting the services of two PSCs; and

-- participating in and reviewing project evaluations to determine what modifications are needed to keep Project implementation on track.

In all of these activities, A.I.D. will consult extensively with the MoH. The MoH Project Director will personally approve all Project documents that authorize procurement of services and will participate fully with A.I.D. in guiding and monitoring the Project.

3. Institutional Contractor

In these responsibilities, the MoH and A.I.D. shall be assisted by the technical counterparts furnished through the Institutional Contractor. The major responsibility of the Institutional Contractor in-country team will be to support the MoH and A.I.D. in Project implementation, providing specific types of technical assistance, as follows:

Chief-of-Party (COP) for six years. The COP will have a Doctorate (preferably) or Master's Degree in Public Health or a related field and at least five years of experience in public health. In addition, the COP should have a broad understanding of health financing, health administration and child and maternal health issues. S/he will have a minimum of five years of management experience as the supervisor of technical teams on health issues in developing countries, preferably with A.I.D. The COP will be fluent in both Spanish and English (FSI 4/3+). The COP will be responsible for overall Project personnel systems, procurement and Project coordination. Under the direction of the MoH Project Director and A.I.D., the Chief of Party will have first-line responsibility for Project implementation and management, with specific responsibility for the **Initiatives for Efficient Management** component of the Project. The COP's main counterpart will be the Director, General Health Care (Atención a las Personas).

Deputy Chief-of-Party for six years. The Deputy COP should have a Doctorate (preferably) or a Master's Degree in health or

business administration or a related field. S/he will have responsibility for vehicles and logistic support, administration of sub-contracts, reporting, and support to the regional advisors. In subcontracting, this person will establish selection committees that contain strong representation from both the MoH and A.I.D. S/he will have at least three years of experience in administering bilateral or multilateral agency contracts. Preferably s/he should be knowledgeable about A.I.D. procedures, regulations and reporting requirements. The Deputy COP must be fluent in both Spanish and English (FSI 3+/3+). The Deputy COP's counterpart will be named by the Ministry of Health.

Child and Maternal Health Specialist for six years. The Child and Maternal Health Specialist will have at least five years of experience working with health programs in developing countries. S/he might be a medical doctor or otherwise have strong clinical training and have a public health degree or substantial public health experience. The Health Specialist will be fluent in both English and Spanish (FSI 3+/3). S/he will have first-line responsibility for implementing the **Strengthening Child and Maternal Health Services** component, under the overall guidance of the MoH and A.I.D. This person will liaise with an advisory committee made up of representatives from each relevant vertical child and maternal health program, as follows:

- Director, Expanded Immunizations Program
- Director, Control of Acute Respiratory Infections
- Director, Control of Diarrheal Diseases
- Director, National Family Planning
- Director, Maternal/Perinatal Health
- Director, Information, Education and Communications
- Director, Statistics
- Director, Epidemiological Vigilance
- Director, Integrated Health
- Director, Social Programs

Health Training Specialist for four years. The Health Training Specialist will have a Doctorate (preferably) or Master's Degree in public health, with an emphasis on maternal and child health, or have a degree in a related field. S/he will have at least five years of experience working with health care training and will have at least two years of experience with IEC programs. The Health Training Specialist will be responsible for overseeing all long- and short-term training and observational tours funded under the Project and will work with the IEC subcontracts. S/he will be fluent in both Spanish and English (FSI 3+/3).

Health Economist for four years. The Health Economist will have a Doctorate (preferably) or Master's Degree in health economics, with broad policy exposure. Experience in designing and conducting health surveys in developing countries and a background in econometrics and statistical analysis is desirable.

S/he will be fluent in both Spanish and English (FSI 3+/3). The Health Economist will be responsible for implementing the activities outlined in the **Health Financing** component of the Project, under the overall guidance of the MoH and A.I.D.

Three Subregional Advisors for six years each. The Subregional Advisors will be medical doctors with administrative experience and at least three years of experience working with disadvantaged communities on child and maternal health programs, preferably in Peru. Each Advisor will also have some experience working with health administration, inventory control and related issues. The Advisors will preferably have a working knowledge of English; knowledge of regional, indigenous languages is a benefit. The Regional Advisors will be responsible for implementing activities at the community level and in health facilities under the supervision of the Child and Maternal Health Specialist. Each will receive administrative assistance from an MoH-assigned administrative assistant.

The Chief-of-Party and Deputy Chief-of-Party will, ideally, be international experts, if prevailing regulations permit the entry of greater numbers of international personnel; the subregional advisors will be Peruvian. Potential contractors will be encouraged to recruit Peruvians and/or U.S. citizens already residing in Peru for as many of the positions as possible, given current limitations on international personnel.

Each technical advisor shall have first-line responsibility for all aspects of implementation of their specific components of the Project, under the overall guidance of the MoH and A.I.D., including:

-- ensuring the timely coordination of the activities of his/her components with those of the other components and other offices and administrative units of the MoH;

-- participating as resource personnel in Project evaluations and audits;

-- facilitating implementation of his/her component at the regional and subregional level, as appropriate; and

-- working with the long-term advisors to plan and implement Project activities.

Second, the Contractor will provide an estimated 100 person-months of **short-term technical assistance** as described more fully in another section of the Paper. It is anticipated that short-term technical assistance will feature a mix of Peruvian and international experts (approximately two-thirds Peruvian and one-third international). The ability of the contractor to use international experts, however, will be subject to U.S.

Government personnel restrictions in place at the time of the consultancy. A.I.D. will approve all consultants and scopes of work.

Third, **long-term out-of-country training** may be provided. The desirability of this component will be assessed with the MoH at the time of Project initiation. An alternative to it is in-service, in-country training furnished by international experts who come to Peru on short-term consultancies. If the outside training does take place, in conjunction with the MoH and in accordance with A.I.D. Handbook 10 regulations, the IC will develop selection criteria, disseminate information about training opportunities and select fifteen MoH employees to receive two-year training at the Master's Degree level in Public Health, with an emphasis in health administration, epidemiology or maternal/child health. The IC will be responsible for placing the participants in Master's level programs and for providing all logistical support, monitoring and follow-on activities associated with their overseas training. The IC will ensure that Policy Determination 8, which requires that participants return to their jobs for a specified period of time, is included in all agreements with participants. The IC will also monitor compliance until the contract ends.

The annexes to this Project Paper include a waiver for travel costs for long-term participants.

Fourth, **local training will be provided**. In accordance with the Training Plan, the IC will: (1) enter into local subcontracts for the development and provision of clinical training courses for health professionals, health administrators, health economists, and community health workers; and (2) work with the MoH's School of Public Health to improve their teaching and training capacity.

Fifth, the IC will subcontract a firm to implement **pilot activities in total quality management** in at least two subregional health centers and related health service areas.

Sixth, the IC will enter into subcontracts for **field studies, surveys and operations research** as more fully described in the Project Description and in an annex.

Seventh, the IC will oversee an **Information, Education and Communications** sub-component. The IC will enter into subcontracts with Peruvian research/ communications/advertising firms to research, design, test and disseminate health messages on maternal-perinatal health and ARI. Alternatively, a buy-in mechanism could be used with a centrally-funded project; in that case, funds for this activity would be withheld from the Institutional Contractor and the Scope of Work amended. The IEC program is outlined in detail elsewhere in this paper. A.I.D.

experience in other countries has shown that large IEC contracts can become very political. For this reason, the IC will be encouraged to enter into a series of smaller IEC subcontracts rather than one large subcontract.

In all subcontracting, the MoH and A.I.D. will have strong representation in subcontractor review and selection.

Eighth, the IC will **procure commodities**. The IC will be responsible for all grant-financed local and offshore procurement required for Project implementation, as fully described in the Procurement Plan, and as listed in the illustrative list of commodities in the annexes.

Finally, the IC will provide overall logistics and support. While the MoH will provide the long-term advisors with work space within the relevant MoH office, the IC will also establish, equip and staff a central office in Lima to provide logistical and administrative support to the team of long- and short-term advisors.

The IC will have the following responsibilities:

-- establish a Project Office and hire support staff;

-- collect and organize data required by A.I.D./W's annual report on child survival programs;

-- establish a reporting system for project monitoring;

-- coordinate closely with USAID and the MoH to ensure smooth project implementation;

-- assist USAID in the preparation of scopes of work for evaluation contracts and serve as a resource for evaluators;

-- directly subcontract, with the advice and consent of the MoH and A.I.D., the services of local and/or international entities to carry out studies, seminars, IEC programs and short-term training activities as described in the Project Paper;

-- coordinate long-term training for 15 individuals, if this activity eventuates;

-- procure local and offshore commodities as described in the Procurement Plan;

-- monitor all subcontracts; and

-- comply with all reporting requirements.

B. Implementation Schedule

1. Implementation Strategy

The activities under the **Child and Maternal Health Services** component will be implemented by the Institutional Contractor. In particular, the child and maternal health specialist, health training specialist, and the three subregional advisors will be responsible for the activities described in this component. The IC will first coordinate with the MoH, USAID and the World Bank to decide where the three Subregional Advisors should be located. These three subregions will serve as the initial focus areas for **Strengthening Child and Maternal Health Services** component activities; new activities will be initiated and evaluated in these three areas before being expanded to subregions. In particular, labor-intensive activities such as the design and implementation of new monitoring systems, the development of local communications campaigns and the initiation of activities that require extensive community involvement (e.g., the establishment of maternity homes or the convening of regular community meetings on health) will first be tested in these three subregions.

Short-term clinical training programs will be implemented nationwide, although it is likely that the first trainees will be selected from the three focus regions. It is anticipated that training activities will begin to take place in the second year of the Project.

Formative research for IEC activities will begin no later than the second year of the Project. Selected nationwide information campaigns on ARI and maternal/perinatal health will begin later that year. Local IEC activities will not begin until sufficient research data have been collected and analyzed. In all cases, care will be taken to ensure that IEC messages do not create a demand for services that the MoH cannot yet provide.

Upon arrival in country, the IC will immediately initiate implementation of activities to improve warehouse, inventory and distribution systems for pharmaceuticals. The IC will evaluate various options: subcontracts to local NGOs or private entities; improvements in MoH capability: and buy-ins to centrally-managed activities. The IC might implement pilot activities to evaluate the different options.

The activities under the **Initiatives for Efficient Management** component will be implemented principally by the IC. In particular, the COP will be responsible for this Project component. Upon arrival in country, the COP, with the assistance of the Health Training Specialist, will initiate dialogue with the MoH on the desirability of the long-term, out-of-country training. If desirable, selection of long-term participants will

proceed soon after, so that the long-term overseas training can commence as quickly as possible (preferably by fall 1995/winter 1996).

Short-term out-of-country training will be coordinated by the IC with the assistance of the USAID/Peru ODIT Division of Training and Social Development.

The IC will begin implementation of the cost-based programming and budgeting activity within the first four months of the contract. Training will begin as soon as the course is developed. Periodic evaluations and coordination meetings will take place quarterly, once the system is in place.

Implementation of the Decentralized Management Improvement Model will take place in two subregional structures. The IC will work with the MoH during the beginning of the second year of the contract to identify the two units in which this pilot activity will take place. The units should be identified by July 1995, and implementation should begin immediately thereafter.

Implementation of the Total Quality Management models will take place in the health centers and posts of two local health units. The IC will not initiate this activity until the DMIM is functioning well in both subregions.

With respect to the **Health Financing** component, policy dialogue regarding financing issues has already begun. This will be an ongoing activity that will continue throughout the life of the Project. The demand survey will begin as soon as possible after the Project Agreement is signed, either under an AID direct contract or under PD&S funds. The IC, and in particular, the Health Economist, will be responsible for implementing all other activities under this component. The demand survey and cost survey will require most of the attention of the Health Economist for at least his/her first year on the Project. Other component activities will begin once these two studies are completed and the data are analyzed.

2. <u>Project Start-Up Activities</u>

-- At least one PSC should be assigned to this Project as soon as possible after the signing of the Project Agreement.

-- The scopes of work for the cost study and demand survey should be prepared as soon as possible, so that institutions can be contracted to begin the work as soon as the Project Authorization is signed. PD&S funds could be used for this purpose.

-- The RFP for the Institutional Contractor must be drafted and issued, proposals evaluated, and a contract negotiated.

3. Chronological Implementation Plan

Date	*Event*	*Responsible Agent*
1993		
September	Authorize Project	USAID
September	Make Congressional Notification	USAID
September	Sign Project Agreement	USAID/MoH
October	One PSC begins working on Project	USAID
October	Complete Controller review of MoH	USAID
October	Complete scopes of work for cost study and demand study	USAID
November	Draft PIO/T for Institutional Contractor	USAID
December	Award contracts for cost study and demand survey	USAID
December	Begin cost study/demand survey	Contractor
1994		
January	Issue RFP in Quito	USAID
February	Implement upgrading of DIGEMID warehouses	MoH
March-April	Begin national and regional seminars on technical issues	MoH
March	Receive proposals in Quito	ICs
September	Award IC	USAID/MoH
September	Hire PSC Project Coordinator	USAID
November	Long-term TA arrives in Peru	IC
December	IC submits detailed workplan	IC/MoH
1995		
January	Decide on desirability of long-term overseas training	IC/MoH
January	Begin negotiation for subcontract for clinical training for ARI/DDC and EBF/W/GM/I	IC/MoH
January	Select team of master trainers for Mat/P/H and obtain training at CLAP (Uruguay) and one other site	IC/MoH
January	Negotiate subcontracts for ethnographic studies and baseline KAP studies on Mat/P/H and ARI	IC/MoH
January	Prepare PIO/C's for commodities (medicines, equipment, vehicles)	IC
February	Negotiate subcontracts for national mass media campaigns for Mat/P/H and ARI	IC/MoH
February	Negotiate subcontracts for local mass media campaigns	IC/MoH
February	Begin production of self-instructional training materials and manuals in	

	various technical areas	IC/MoH
March	Hold quarterly coordination meeting	IC
March	Begin implementation of cost-based programming and budgeting	IC
March	Begin T.A. to define indicators for information system	IC/MoH
March	Begin implementation of ethnographic and KAP studies in Mat/P/H and ARI	IC
April	Begin clinical training for ARI/DDC and EBF/W/GM/I (continues through PACD)	IC
April	Begin Mat/P/H course development by mastertrainers in Mat/P/H	IC
April	Negotiate subcontract to manage short-term out-of-country training	IC/MoH
May	Begin field work of Regional Advisors	IC
May	Begin T.A. for development of Career Development Required In-Service Training	IC
May	Implement feasibility study of ORS production	IC
June	Hold quarterly coordination meeting	IC
June	Begin design of supervisory system	IC
June	Begin design of logistics system	IC
June	Begin implementation of infrastructure maintenance system	IC
July	Implement pilot training-of-trainers course in Mat/P/H	IC
July	Begin development of models in pilot regions for management of obstetrical complications and reproductive risk	
September	Conduct initial evaluation	USAID
September	Hold quarterly coordination meeting	IC
September	Begin Long-term overseas training (if agreed upon)	USAID
September	Implement ethnographic and baseline KAP studies in DDC, EBF, W, GM, and I	IC
October	Begin implementation of DMIM	IC
October	Implement and evaluate pilot replica courses in Mat/P/H	IC
November	Begin negotiation for subcontract for clinical training for Mat/P/H	IC/MoH
November	Negotiate subcontract(s) for maternal and perinatal mortality study(ies)	IC/MoH
December	Hold quarterly coordination meeting	IC
<u>1996</u>		
January	Begin development of models in pilot regions for community growth monitoring and improved immunization coverage	IC

February	Begin clinical training for Mat/P/H (continues through PACD)	IC
February	Begin maternal and perinatal mortality study(ies)	IC
March	Begin operations research in two pilot areas on maternity homes	IC
March	Hold quarterly coordination meeting	IC
April		
May		
June	Hold quarterly coordination meeting	IC
July		
August	Begin implementation of TQM	IC
September	Hold quarterly coordination meeting	IC
October		
December	Hold quarterly coordination meeting	IC
1997		
January		
February		
March	Hold quarterly coordination meeting	IC
April		
May		
June	Hold quarterly coordination meeting	IC
July		
August		
September	Hold quarterly coordination meeting	IC
October		
November		
December	Hold quarterly coordination meeting	IC
December	Complete Mid-term evaluation	USAID
1998		
January		
February		
March	Hold quarterly coordination meeting	IC
April		
May		
June	Hold quarterly coordination meeting	IC
July		
August		
September	Hold quarterly coordination meeting	IC
Oct - Nov		
December	Hold quarterly coordination meeting	IC
1999		
January		
February		
March	Hold quarterly coordination meeting	MoH
April		

May		
June	Hold quarterly coordination meeting	MoH
August		
September	Hold quarterly coordination meeting	MoH
October		
November		
December	Hold quarterly coordination meeting	MoH
2000		
January		
February		
March	Hold quarterly coordination meeting	MoH
March	Complete Final Evaluation	USAID
April		
May		
June	Hold quarterly coordination meeting	MoH
July		
August		
September	Complete project	

C. Procurement Plan

Institutional Contractor. After the Project Agreement is signed in Fiscal Year 1993, USAID will prepare and issue a Request for Proposals (RFP) by January 1994 to contract an Institutional Contractor. This entity will provide long- and short-term technical assistance; provide management and logistic support; and enter into subcontracting arrangements, as appropriate, for studies, long- and short-term training and IEC activities.

Cost and Demand Studies. If possible, even before Project 2000 funds are obligated, USAID will develop a scope of work for the proposed Cost Study. As soon after the official obligation of funds as is practicable, USAID will directly contract an institution to carry out the study. Similarly, during this same time period, USAID will develop a scope of work for the proposed demand survey. As soon after the signing of the Project Agreement as is practicable, USAID will likewise directly contract an institution to carry out this study.

Commodities. Eight categories of commodities will be financed by A.I.D. under the project: a) needles, syringes and related equipment, b) cold chain equipment, c) medical and laboratory equipment and supplies, d) audio-visual and other training equipment and supplies, e) computers, hardware and software, f) vehicles and spare parts, and g) local miscellaneous program supplies and materials for the MoH facilities. An annex contains an illustrative list of commodities to be procured.

Evaluations. All short-term consultants required for evaluations

Evaluations. All short-term consultants required for evaluations will be contracted directly by USAID or through buy-ins by USAID to central AID/W health, population and nutrition projects or IQCs.

Audits. All audits required by the Project will be carried out according to the audit requirement described elsewhere in this Project Paper.

D. Component-Specific Training Plan

1. Strengthening Child and Maternal Health Services

Training in this component will target both health personnel and community health workers.

Health Personnel. Project 2000 will strengthen a network of model hospitals and local clinical training centers in diarrheal diseases, ARI, breastfeeding and weaning. The specific criteria for being designated a model hospital will be developed by the MoH. Participating hospitals and training centers in the network will train health personnel from hospitals, health centers, and health posts in the sub-regions.

As such, the project will provide participating institutions with teaching equipment, and PL480 funds may be used for local purchase of furniture and some refurbishing of physical facilities. The institutions will also require technical and management support. This support could be provided by the Institutional Contractor or through a subcontract to a local institution.

Through replica courses, personnel from multidisciplinary health centers and selected health posts in the catchment area of each participating hospital or center will receive clinical training during normal working hours in the technical areas specified above. They will also receive training in how to train and supervise community health workers. The institutional contractor will provide T.A. for the development of curricula on this subject, building on other curricula used in Peru in the past ten years. Experienced local MoH personnel and NGO personnel will be recruited to train others in how to train and supervise community health workers.

The Project will also provide training in maternal and perinatal health, in support of the National Plan for the Reduction of Maternal Mortality (1992). The Project will support qualitative, formative research on the views, beliefs and practices of community women, trained and untrained traditional birth attendants, and health personnel in the area of maternal and perinatal health, i.e., pregnancy, childbirth and immediate

infant care. For this research, the Institutional Contractor or sub-contractor will utilize national (and international, if necessary) expertise. The results will be used for the development of training programs for health workers as well as educational activities in the community.

The Project will support a program with links to one or more health care facilities for a clinical training program for the training of trainers in maternal-perinatal health. A multidisciplinary health team of master trainers will be in charge of the training program. This team will make observational and training visits to at least two out-of-country programs to obtain updated information and training materials on maternal-perinatal health and health care. The emphasis will be on developing the technical foundation for health professional training in maternal-perinatal health, while at the same time orienting this information to the most appropriate and low-cost technologies. The team of master trainers will then be responsible for adapting and/or developing training materials in maternal-perinatal health for multidisciplinary health professionals. Approximately three months of T.A. will be provided by the Institutional Contractor for this activity.

Once the materials are in hand, the team will be responsible for, organizing and implementing a pilot training program for multidisciplinary teams of approximately four health professionals from each of four hospitals in two selected sub-regions, with T.A. from the Institutional Contractor. Due to the pilot nature of these initial courses, there will be a very strong evaluation component, including baseline data and possibly a parallel evaluation of a control hospital, also with T.A. by the Institutional Contractor. In this way, the course can be readjusted before replication to 45 additional hospitals.

The Project will provide T.A., and PL480 funds will support central level MoH supervision costs, to help the four multidisciplinary teams establish their institutions as model hospitals and local clinical training centers in maternal-perinatal health. Each model hospital will establish a system for local transportation and referral of emergency high-risk neonatal and obstetrical cases. T.A. for this activity will be provided through the Institutional Contractor or its local subcontractor. The Project will support the first two replica courses to be given by each of the four pilot model hospitals. The Project will also support a larger program for training-of-trainers at a maternal-perinatal master training center in Lima. As many as 45 hospitals will be selected by the MoH to participate in this activity.

Each participating hospital will receive supervision support and T.A. to establish itself as a model hospital and local clinical training center in perinatal services; support will include basic

hospital equipment, supplies, and training. Project support will also be provided to each of these hospitals to give the first two replica courses in maternal-perinatal health in their home area. T.A. will be provided to each hospital by the team of master trainers in Lima, and if necessary, additional T.A. will come from the Institutional Contractor. Health center and health post personnel will also receive training in how to train and supervise community volunteers (health promoters, traditional birth attendants, and other community members) in maternal-perinatal health.

Community health workers. Training and supervision of community health workers is key to prevention, early identification, treatment and referral of severe cases, especially where there is a high risk of infant and maternal mortality and low coverage of formal health services. Therefore, community health worker training in this Project will address the same technical areas as those for health personnel.

In general, training for community health workers will be skill-oriented and participatory, featuring real life situations and role-playing. Promoters will learn how to teach community members in a similar participatory fashion. In all possible cases, community health workers will be provided with appropriate teaching materials, such as simple manuals, flipcharts, and promotional posters. Such materials will be developed through the Project 2000 IEC component, which draws on formative research in communities on beliefs and practices regarding health and disease.

Wherever possible, community members who have received previous training as health promoters or volunteers will be selected for continued training and supervision under this Project. Also, the model of the community oral rehydration unit ("URO comunal"), which has been successfully implemented by the MoH in selected areas of the country, will be supported. The Project will build on currently existing community ORUs and add new ones. An additional emphasis will be placed on community-level treatment of ARI and pneumonia, including education of families and case referral. This will entail intensive continued training of community ORU volunteers in ARI and pneumonia and establishment of a logistics system to keep them supplied with basic ARI medicines.

Community health workers will receive training in the identification and referral of pregnant women for prenatal care, identification of high-risk pregnancy, distribution of iron and folate tablets to pregnant women, basic health and nutrition education related to pregnancy and childbirth, newborn care, promotion of professional attendance at childbirth, early and exclusive breastfeeding, and tetanus toxoid immunization for

women. They will be encouraged to coordinate maternal health activities with traditional birth attendants who work in the same communities. Community health workers will also be trained to manage common breastfeeding problems, promote appropriate weaning practices, monitor children's growth, counsel families, and promote full immunization for infants before the age of one year.

The Project will support the participation of community health workers at two-day training sessions on a monthly basis for the first year, and four times a year for each following year. The MoH will assume these costs gradually throughout the life of the Project. Health promotor training and supervision will be the responsibility of the health post staff, with participation from health center staff and other more experienced health promoters. At least one health center staff member will travel to each health post to provide assistance during each health promotor training session. In certain areas of difficult access to formal health services, local NGOs may be recruited to provide health promotor training and supervision.

Traditional birth attendants. TBAs play a very important role in maternal and perinatal health in Peru; they attend 29 percent of deliveries. In rural areas this figure climbs to 47 percent. Even in urban areas, it is 17 percent. The MoH has not formally supported training programs for traditional birth attendants in the last ten years. But a 1984 evaluation of TBAs showed that trained TBAs provided improved quality of care compared to non-trained TBAs, and that women followed the advice of trained TBAs in self-care during pregnancy. The major problems were in recruitment, teaching methods, inadequate patient referral, limited acceptance of the TBA as a valuable resource in the community by health personnel, limited supervision, and lack of a simple information system for the TBA to use.

Other lessons have been learned from previous TBA training efforts in Peru. An official curriculum developed in 1979 was very complicated and not well-defined, resulting in too much emphasis on classroom lectures. MoH nurses and professional midwives lacked the necessary training skills. MoH norms stated that nurses were responsible for promotor training, and professional midwives ("obstetrices") were in charge of TBA training. This ruling caused many problems, since professional midwives tend to work in hospitals in urban, not rural, areas.

Several types of materials exist in Peru for training TBAs and community health workers, including simplified manuals and a training-of-trainers curriculum. These should be reviewed by the Institutional Contractor, updated if necessary, and utilized for professional and community health worker training under the current Project.

TBA training under Project 2000 will emphasize three areas:

- Identification of high risk pregnancies with a simple risk-scoring index and early recognition of birthing complications that require immediate attention and referral.

- Identification and modification of harmful traditional practices related to pregnancy, childbirth, and immediate care of the newborn. These will be identified from the qualitative formative research referred to earlier. At the same time, beneficial practices and non-harmful practices that have social or cultural importance in the community will be supported.

- Basic promotive and preventive care during pregnancy and lactation. This includes micronutrient supplementation, basic nutrition education for pregnancy and lactation, proper newborn care and weaning.

2. <u>Initiatives for Efficient Management</u>

The goal for training under this component is to develop MoH personnel's knowledge and skills in health services administration and epidemiology, so that the performance and efficiency of resource use at all MoH levels can improve. This training will support the GoP and MoH policy of decentralization by ensuring that personnel at decentralized levels of authority and responsibility have the technical skills to carry out administrative and management functions in an optimal manner. Types of personnel that need training to support quality management models include hospital and health center directors; regional and sub-regional directors, technical directors, and administrators; and central level MoH officials.

To this end, the Project will support training for pilot projects; quarterly coordination meetings; in-country, short-term training; out-of-country, short-term training; and out-of-country, long-term training, if the latter is deemed desirable by the MoH at the time of Project commencement.

The training for pilot projects will support the implementation of a new "Programming, Budgeting and Control System" at the central, sub-regional and local level. A training course will be developed for MoH officials at these levels. Twenty-four person-months of T.A. will be required to develop the system and to develop and conduct the training course and training materials. Approximately 60 MoH officials will be trained: 15 from the central level and 45 from sub-regional and selected local levels. A six-day training course will be implemented in Lima and selected Sub-regions, with 40 of the 60 participants coming from outside of Lima.

Second, in order to improve productive and allocative efficiency in two pilot sub-regions, a Management Improvement Model will be developed and tested. Fifty-two person-months of T.A. will be required to design the model. Once the model is developed, approximately 20 administrative and clinical personnel from each sub-region will receive training in the management systems in a six-day training course. Training will be followed by a one-month trial implementation and, thereafter, evaluation.

Third, pilot projects will be implemented to test a TQM approach within the Management Improvement Model (MIM) in two pilot health centers and related health posts within the sub-regions selected for the MIM activity. The TQM model and training course will be developed and conducted by one international expert (estimated 4 months of T.A.) and two local experts (12 person months of T.A.). The course will be repeated twice with approximately 15 participants in each course: one for each health center and related health posts.

Four times a year, a three-day gathering will be held for all sub-regional directors, hospital directors, and higher MoH officials. The purpose will be to follow up progress and achievements in the implementation of management. The meetings will also promote vertical and horizontal communication among managers of the MoH. Two months of T.A. will be required to help devise the first agenda, to train on techniques and to facilitate the four meetings during the first year.

In-service training will be provided on an ongoing basis in order to enhance MoH health managers' job performance at each of five hierarchical levels of the health system. In the first and second years of the project, personnel from sub-regions and the local level will be trained. In the third year and thereafter, all MoH health managers applying for a higher level managerial position will be required to receive appropriate in-service training.

Twelve person-months of T.A. will be required to conduct baseline studies, develop curricula and teaching materials, and implement the training during the first four years of the Project. Thereafter, the MoH will assume responsibility for implementation of the training. The School of Public Health (ENSAP) of the MoH will be incorporated into the training program during the first four years, so that it can gradually take over training operations, either directly through training at that institution or through agreements between ENSAP and other institutions. ENSAP will be the main coordinating entity for all training, as a means of promoting this integration and sustainability.

A number of specific courses will be developed to teach MoH officials and managers to operate all administrative and operational systems that will be developed through the MIM

activity. This training activity will take place only in the two sub-regions selected for the MIM project.

Six person-months of T.A. from training experts will be required to develop the exercises for the courses and to facilitate the first course. MoH officials from the two sub-regions will be trained for each of the systems developed. These officials should act as monitors for further training at those localities.

Approximately 50 well-selected MoH executives from all levels will receive short-term courses (6 to 8 weeks) outside Peru in hospital and health administration. This should generate impact in the short run by establishing a common language and understanding of the administrative field. These courses could be divided into two or three segments, using innovative approaches in long-distance teaching through written or electronic means. Or, a private firm could be sub-contracted to arrange tailor-made courses and observational visits for selected MoH executives to appropriate institutions in the U.S. or in third countries. These courses would include a diagnosis and analysis of alternative ways to attack Peru's health problems, in the hope of establishing common approaches and possible solutions.

Early in the Project, a final determination will be made on the desirability of out-of-country, long-term-training. From the MoH viewpoint, this type of training is problematic, because it requires the extended absence of several key personnel at a time when there are few human and financial resources to replace them. Further, if these key personnel do not continue for many years in the MoH once their training is completed, the investment and short-term sacrifice are lost. Consequently, it may be more rational to augment the other components of short-term, in-country and short-term, out-of-country training, using the resources that would otherwise be used for long-term, out-of-country training. A final determination on this modality will be made early in the life of the Project. If it is indeed adopted, fifteen candidates will receive out-of-country training at the Master's level, with specialization in maternal-child health, epidemiology or health services administration. Training should include strong exposure to advances made by underdeveloped countries, with similar characteristics to Peru, in addressing equity, efficiency and coverage through decentralization and an adequate public to private mix. This could be achieved by a joint training program between a U.S.-based university and one located in another Latin American country that has a strong curriculum in public health and health administration.

For all of the out-of-country training, a joint committee with representation from the MoH, the IC and A.I.D. will recruit, review and select the participants. The committee will establish specific criteria that target appropriate training candidates and

that can be applied transparently to evaluate and select the best awardees from among them.

E. Information, Education and Communications Plan

Project 2000 will feature information, education and communications (IEC) activities composed of seven parts: formative research and message development; national mass media; local-level communications; seminars and workshops; self-instructional training materials; a continuing education bulletin; and a communications campaign to promote user fees.

1. Formative Research and Message Development

Specific educational activities will be developed on the basis of formative, ethnographic research to support the effective implementation of the Project 2000 strategy for child and maternal health. These will be in the key areas of maternal-perinatal health, ARI and pneumonia, diarrheal diseases and cholera, breastfeeding, weaning, growth and development, and immunizations.

2. National Mass Media

The mass media will be used, especially television and radio, to broadcast educational messages with a focus on both maternal-perinatal health and ARI/pneumonia. The messages will be based on the findings of formative research in different parts of the country regarding beliefs and practices in health. All IEC will be coordinated through the Office of Communications of the MoH. The contractor and the MoH will coordinate message content with other IEC campaigns conducted throughout Peru, especially those that are A.I.D.-funded and those to be conducted under the Basic Health and Nutrition Project of the IBRD. For each of the major topics, a package will be produced. A typical package might include two television spots, two radio spots, one flipchart, two educational posters/calendars, and two photonovels.

3. Local-level Communications

The mass media activities described above will encourage a demand for health services by the population. To complement this, IEC activities at the local level will be directed towards preserving local traditional beliefs and practices that are beneficial to maternal and child health and modifying detrimental ones. Again, messages and materials will be developed primarily on the topics of maternal-perinatal health and ARI/pneumonia in children, and secondarily on the topics of diarrheal diseases in

children, cholera, exclusive breastfeeding, appropriate weaning, growth monitoring and immunizations.

In all these activities, the Institutional Contractor will subcontract a local institution(s) to carry out the ethnographic research, develop messages and materials, and field test them. The Institutional Contractor will then work with the MoH sub-regional communications offices to identify and contract local NGOs or local production companies to develop media spots and to design, test, print or produce, and distribute materials and messages. The MoH sub-regional communications personnel will participate in all research and materials development under the Project, as the counterparts of the contracted regional advisors.

4. National and Regional Seminars and Workshops

During the first two years of the Project, seminars and workshops may be held in Lima and then in the regions to raise public and professional awareness of maternal-perinatal health and ARI as major health problems in Peru. The press would be invited to attend so that newspaper and television coverage can be generated.

5. Self-instructional Training Materials

The central-level MoH Office of Communications will be provided with a video camera and supplies for the production of motivational and self-instructional training videos to support Project 2000 training for MoH personnel and community health workers. Videos will be produced with the collaboration of the technical divisions of the Directorate of Mothers and Children.

Local technical assistance will be subcontracted to develop/adapt manuals for health personnel and community-level health workers on the major health topics of the project. Whenever possible, manuals already developed in Peru or other countries will be utilized and/or adapted to the needs of the MoH and community personnel. A set of up to eight manuals each will be made available for health professionals and for community workers.

6. Continuing Education Bulletin

A quarterly bulletin will be produced and distributed to all health personnel trained under the Project, as well as other readers. The bulletin will feature recent international and Peruvian literature on child and maternal-perinatal health services and issues.

7. Communications Campaign to Promote User Fees

If a new user fee system is put in place under the Project, communications campaign will be developed to motivate public acceptance and understanding. Television and radio spots will be produced. Project 2000 will support the diffusion of those spots on mass media for the first two months the system is in place.

F. Monitoring Plan

1. Compliance with Child Survival Requirements

In part, because of the level of U.S. Congressional and Administration interest in the Child Survival Initiative and the additional reporting requirements related to the use of these funds, a careful monitoring and evaluation plan is essential. An A.I.D. Task Force on Child Survival was charged with developing a systematic monitoring and evaluation approach for all child survival projects worldwide. The Agency has developed a standardized reporting form that each Mission completes and sends to AID/W in October of each year.

Thus, AID/W requires that all child survival projects include a plan to monitor Project effectiveness and to collect information annually on selected impact indicators, as well as Project inputs and outputs, and to report this information to AID/W. The annual data collection and analyses carried out under the Project will be done in a way that conforms with these data needs. The Institutional Contractor will be responsible for ensuring that the information required to complete these annual reports is collected regularly and available for these annual reports.

2. A.I.D. and MoH Ongoing Monitoring

Aside from monitoring requirements related to child survival funds, ongoing monitoring of the Project will be conducted by A.I.D./Peru and the MoH. A monitoring plan will be specifically designed for Project 2000. At one level, the PSC Project Coordinator in the HPN Office will monitor the plans, implementation and progress of the Institutional Contractor and its interface with MoH counterparts and personnel throughout the health system. The PSC Project management specialist will likewise be the primary link to the IC in Project reporting, ensuring that all A.I.D. regulations and needs are met. At another level, the HPN Project Officer for Project 2000, who must hold an OE-funded position, will monitor Project implementation. This person will be supported in this activity by the other OE-funded staff of the HPN office, as well as by the members of the

Project committee, which is made up of OE-funded staff from HPN, CONT, EXO and PDP. Quarterly meetings of the Project Committee will provide regularly scheduled forums for monitoring and evaluation purposes. At still another level, the Project Director at the MoH will monitor IC performance from the MoH perspective, as well as the performance of MoH counterparts and personnel throughout the health system in working toward and achieving Project objectives.

Systems will be developed for accomplishing this monitoring in an effective and timely manner. A joint Project oversight board will likely be formed, consisting of the MoH Project Director and the A.I.D. Project Officer; the Chief of Party and Deputy Chief of Party will be responsible to this board, as will the A.I.D. HPN Project staff. This board differs from the Project committee cited above, which serves an internal A.I.D. management function. Further, each of the three Project components will be monitored independently as well as jointly, so that it can be seen how the parts, as well as the whole, contribute to Project objectives. Within the Strengthening Child and Maternal Health Services component, the various program areas will also be independently tracked against process and impact indicators. The HPN OE-funded staff will divide primary responsibility for the programmatic areas among themselves by particular areas of technical expertise.

Specifically, monitoring will be accomplished through the following mechanisms: periodic technical and financial reports; site visits; consultant (TDY) debriefings and reports; service statistics; community-level surveys and qualitative information gathering; internal MoH reporting and other information sources, such as from the HIS/MIS particular components or program areas; and the major external evaluations described below.

A quarterly report, jointly submitted by the Institutional Contractor and its MoH counterparts, will report on each of the three major components. The report, at a minimum, will consist of the following: financial activities, including the status of HCOLC and counterpart contributions, procurement activities, site visits and training programs and their impact. Major problem areas and their proposed solutions should also be discussed. Project 2000 committee members will evaluate and monitor the Project's development through these reports. Each committee member will be responsible for his/her own area of expertise, i.e., EXO will take a closer look at procurement and the Controller at financial matters.

3. Formal External Evaluations

Three Project evaluations are scheduled: the first after a period of approximately three years, the second after approximately five years and the third at the end of the Project. During each evaluation, Project progress will be measured based on indicators in the Logical Framework, problem areas detected and recommendations for adjustments and corrective measures. Sub-regional activities to establish model programs will be carefully evaluated and recommendations made as to whether or not the Project should expand these models to other communities. Each evaluation will require an estimated four weeks of effort by a team of experts in the various child survival intervention areas, as well as experts in health financing and quality management.

VIII. PROJECT ANALYSES

A. Technical Analysis

1. Maternal-perinatal Health, including Family Planning

With declining mortality attributable to vaccine-preventable diseases and diarrheas, conditions originating in the perinatal period are now the leading cause of death of infants. Therefore, care during pregnancy and childbirth is crucial to further gains in child and maternal health. Improvements in the coverage and quality of prenatal care in MoH facilities, especially health centers and posts, is key. In part, the specific improvements needed will be identified in the recommendations of project-supported studies on socio-cultural factors affecting maternal and perinatal health and health care use.

Second, to improve access to prenatal care, community health workers need to be trained in basic prenatal care and assessment of reproductive risk. Third, there is a large body of evidence that supports the importance of micronutrients (vitamin A, iron, folic acid, and B vitamins) in the development and protection of infants and pregnant women, as well as the feasibility of micronutrient supplementation.

The reduction of maternal and perinatal mortality primarily means the diagnosis and management of obstetrical emergencies. Thus, the Project promotes the training of health personnel, TBAs, community health workers and family members in management of obstetric emergencies. Toward this end, maternity homes for low risk deliveries will be established on a test basis within the community. These centers will offer a place within the community where women can bear their child safely. The Project also proposes to improve the reporting, investigation and analysis of maternal deaths, through a system of epidemiologic surveillance. This technology will be based on technical assistance and resources provided by the Project.

2. Acute Respiratory Infections (ARI)

Among all the illnesses classified as ARI, pneumonia is the one disease most dangerous to young children, and especially children under one. The Project therefore proposes to strengthen mechanisms for the proper diagnosis and immediate management of pneumonia, the key to which is early recognition of a certain pattern of rapid breathing. When pneumonia is present, treatment with the appropriate antibiotic should begin immediately. Thus, training of health providers, community health workers and families will focus on identification of

pneumonia. This focus is very feasible, since it substantially reduces the amount of information that needs to be taught regarding all other types of ARI, while targeting the critical illness in this category.

Although the case-fatality rate in cases of pneumonia without treatment is 15 percent, experience has shown that appropriately trained community health workers can reduce the rate to one percent. A pilot effort to redesign community programs is a feature of Project 2000.

Since the most dangerous characteristic of pneumonia is the inability to breathe, the Project recommends the purchase of nebulizers for use in health centers and health posts that have electricity and that are located in areas with a high incidence of pneumonia cases and deaths.

Further, a system for the investigation and analysis of infant deaths attributed to pneumonia will be developed through Project 2000. Currently, health facilities are recording deaths but are doing nothing with the information. The project will stimulate the epidemiological surveillance of infant mortality through active detection, investigation and analysis. The data on deaths will be used to educate both health personnel and the community.

3. Breastfeeding, Weaning, Growth and Development

Statistically speaking, acute malnutrition, defined as a deficit in weight-for-height of more than two standard deviations of the NCHS reference standard for growth, does not exist in Peru. In contrast, the deficit of height/age for Peruvian children under five is 37 percent, while that of weight/age is 11 percent. Thus, at least 26 percent of those who have a deficit in height have a normal weight for their age. All of this suggests that during the first several months of life children suffer a serious insult to growth.

The Project will concentrate on promotion of breastfeeding, weaning and monitoring of growth in children in the first years of life, when malnutrition can set in very rapidly. Concentration on infants and young children not only reduces the target population, but also produces a higher cost-benefit ratio, since prevention is less expensive than nutrition rehabilitation.

The other Project strategy in this sub-component is to emphasize growth monitoring rather than solely nutrition status. Before a child reaches a state of malnutrition, according to the growth chart, he/she may demonstrate a clear tendency of faltering growth. Thus, the Project focuses on corrective action when the child begins to falter from his/her own growth curve.

Because of polio vaccination, health services have a high contact with children under one. Following through with this first contact will not only help monitor growth, but will also help to complete the full vaccination of children and facilitate the provision of family planning to their parents.

Another feasible setting for growth monitoring are the "comedores nacionales" that the GoP intends to establish in the near future. By tying food supplementation to growth monitoring, the food can be viewed less as merely a hand-out and more as part of overall development efforts. Further, this strategy will help target the children most at risk, since they are the ones whose families seek food. Thus, the Project will supply growth monitoring equipment, materials and training to personnel of the "comedores nacionales", as well as to other health care facilities.

4. Immunizations

The equipment and materials proposed under this component are utilized in the worldwide Expanded Program on Immunizations (EPI) and have demonstrated their safety and effectiveness. Vaccines are obtained through PAHO, in accordance with international standards of quality. One of the most important elements of the program is maintenance of vaccine quality through the cold chain. In order to monitor vaccine efficacy, the Project proposes support for annual studies on the potency of the lots of vaccine. In-country labs have the capacity for conducting the required laboratory tests, making this a feasible activity, given funding support from this Project.

One of the new technologies to be introduced is a listed-census system to facilitate the registration of births, which can then be followed up through an alarm system. This will help ensure that a majority of children are vaccinated in the first year of life. The alarm system will allow "searches" during mini-campaigns for children in need of subsequent immunization doses. This can replace the door-to-door operations that are labor intensive and costly. The proposed technology is simple and highly cost-effective. Its design will require technical assistance, training, materials and travel expenses for the field visits, all resources anticipated in this Project.

To increase the usefulness of vaccines and so diminish losses, a system will be designed to standardize requests for vaccine supplies from health facilities. The T.A. and materials necessary for the system will be provided by the Project.

In summary, Project 2000 will continue with technologies already proven in Peru, while incorporating new ones that will help achieve greater and more sustainable coverage, making more efficient use of resources.

5. Diarrheal Disease Control

In recent years, women's knowledge and use of oral rehydration therapy have increased substantially, while diarrhea prevalence has correspondingly decreased. Consequently, the Project proposes to continue with the same technologies currently used by the National Program for Control of Diarrheal Diseases. These include the use of packaged ORS salts and homemade solutions, as well as motivation of families to give more liquids and feedings both during and after diarrhea episodes. The feasibility of these technologies has been broadly demonstrated.

The Project proposes, as one of the strategies to improve the availability of ORS, strengthening national production of ORS. A study to determine the feasibility of this increased production is anticipated. The feasibility of increasing the efficiency of national production of ORS is not yet clear and will depend on the results of a productivity and cost study currently under way at one private national laboratory. Eventually, during Project operation, the possibility of supporting improvements of all national private laboratories should be explored.

The technologies and methods proposed by the Project in the field of diarrhea disease control are completely feasible, inexpensive, efficient, and have a high rate of success. The favorable evidence is being demonstrated by changes in the epidemiologic pattern of diarrheal diseases in children in Peru.

6. Information and Administration

This component will improve the use of the information produced by the HIS/MIS system developed under the CSAP Project. In general, many MoH personnel have expressed the need to refine the printouts of the system and develop a way to link it with monitoring and evaluation activities, so that its information may be used to make management decisions.

In addition, the Active Epidemiologic Surveillance (VEA) and Field Epidemiology Training Program (FETP), which were supported under the CSAP Project, will support Project 2000 by conducting epidemiologic surveys and surveillance for monitoring and evaluation in the health sector. The probable success of this component is quite high, as the computer hardware is already in place and provision is made for any technical assistance that may be required.

7. Supervision

The lack of supervision is one of the most serious problems the health system faces. The Project proposes to develop a nation-

wide system of supervision for health facilities that will help ensure successful program implementation. Its feasibility will depend, on one hand, on the development of a good model and the availability of resources to carry it out (per diem, transportation, materials, etc.). On the other hand, the health system must determine the level or levels of supervisors, a determination that will be facilitated once the organization of ZONADIS and UBAS is completed. Also, health centers must take on the supervision of the health posts, so that the supervisory process is systematic and sufficiently frequent to achieve its goals. The widespread agreement on a need for an orderly and systematic supervisory system as a way of improving management and increasing effectiveness argues for the feasibility of this component.

8. Logistics

In this component, a three-pronged strategy is proposed. The first is the strengthening of the storage network at the departmental (UDES) level through the MoH and DIGEMID. At this time, this process is already under way, indicating its administrative feasibility. A good part of the funds destined to buy medicines for the regions will be pooled at the central level to decrease costs through economies of scale. This indicates that DIGEMID will manage a larger volume of supplies. A second strategy is to use an NGO for the distribution to the local level, with the guarantee that the key supplies will be received into the country and distributed on a consistent basis. Finally, a third possible strategy is to aid the local system to assure the distribution from the regions to the health facilities. The three strategies are compatible and complementary. There exists in Peru an NGO that has a successful history of distribution of contraceptives. These experiences should be used to benefit the new Project. Also, the UTES of Cuzco has developed, with the cooperation of the Italian government, the Local System of Medicines (SILOMED), which appears to function well. The new Project could look to this system for guidance.

9. Repair of Physical Facilities

One-time basic repairs will be funded for health centers and posts; these will consist of such activities as filling in holes and painting. No major renovations nor construction is included. Maintenance will be based on requests received from each facility. Further, community collaboration will be sought as a counterpart. The community, for example, might solicit materials and perform the maintenance themselves. The Project will provide such supplies as paint, cement and hardware.

10. Management and Health Financing Components

The financial and management components build on already existing MoH strategies and approaches, and, as such, have a proven track record and are clearly feasible. These include user fees and other cost-recovery schemes, better targeting of resources and use of lower-level facilities to provide basic services. The project is designed to improve on these means and methods by formalizing, rationalizing and systematizing the techniques. Some of the idiosyncratic cost-recovery schemes will be replicated, while the user-fee criteria will be standardized and generalized. In addition, some experimental approaches will be designed and implemented. Technical feasibility is not an issue.

From a political perspective, feasibility is less certain, but all indications at present are very positive. During the course of preparing this document, the major elements of the financial component of the Project were discussed with officials in the Ministry of Health, including the Director of the Planning Office, and the chiefs of that Office's three sub-directorates, the Vice Minister, and the Minister; the Ministry of Economy and Finance's Director General of the Public Budget; the Chairman of the Congressional Health Committee and his chief health analyst. All parties were overwhelmingly positive and supportive of the objectives and proposed approaches.

B. Economic Analysis

The financing and management components have been designed as enabling components of the project: they enable the MoH to improve its financial position so as to provide more and better health care, including child survival and maternal care services, as well as to sustain them after the completion of Project 2000.

The heart of the financial and management components of the project builds on already existing MoH strategies and approaches, and, as such, has a proven track record, is clearly feasible, and entails virtually no incremental costs[6]. The strategies and approaches -- user fees and other cost recovery schemes, greater use of lower level health care facilities and the targeting of resources -- have already been tried, in one form or another, in Peru, and have proven successful. By building on these

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[6]This statement is qualified because some of the new, other than standard user fee, cost recovery schemes that will be introduced are likely to have some increased incremental costs. The evaluation and operations research studies sub-component of the financial component of Project 2000, however, is designed to ensure that these new schemes are net resource generators. Thus, while they may entail additional incremental costs, these costs will be more than offset by the revenues they produce, resulting in a net reduction in operating costs.

experiences, the Project strategy entails a low-risk, high payoff, cost-effective approach to effective resource enhancement: striving to increase the absolute level of resources available to the MoH, while improving the effectiveness and the efficiency with which it uses its resources.

From a recurrent cost perspective, because they consist of one-time changes in administrative structures, one-time changes in the design, scope and activities of existing personnel, positions and systems, and a variety of one-time training activities, once the financial component's activities are institutionalized (which is a part of the Project's activities) they will entail only minor incremental costs. Moreover, those incremental costs should be more than offset by the additional revenues these activities will generate.

It is estimated that the development and adoption of a rationalized, national Ministry of Health user fee-system will result in an increase in MoH annual "ingresos propios" from its current 33 million soles (which is the sum of the MoH and regions' "ingresos propios" in 1992) to 66 million soles (valued in 1993 soles) by 1998.[7] This amounts to an increase of 33 million soles, or just over US $17 million (in June 1993 values). Ignoring the anticipated annual increases in user-fee revenues expected as a result of the Project's user fee activities prior to 1998, and focussing on just the three last years of Project 2000, this would result in a total increase of US $51 million, more than fully offsetting the US $30 million USAID direct cost of the Project. Indeed, not only would this cover the sum of the direct costs of the Project, it would even cover the US $22 million indirect costs of the Project, which consist of the PL480 portion of support for counterpart funding. Even if user-fee revenues increased by just 60 percent starting in 1998 (rather than the 100 percent figure assumed here), Project 2000's US $30 million, derived from A.I.D. funds, would still be fully covered by its anticipated impact on user-fee generation in just the final three years of the Project.

These expected changes in MoH revenue generation do not even take into account the additional net revenues that are expected to be generated by other than standard user-fee cost recovery efforts (e.g., private wards in MoH hospitals), nor the reductions in costs that are expected to be generated by improved efficiency,

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[7] This number is derived using certain assumptions. The first is that the price paid for health care is inelastic when dealing with certain income groups. The second assumption is that the MoH exempts 40% of its clientele due to inability to pay. With this substantial protection of the most vulnerable segments of the population from the most adverse aspects of an MoH price hike, a "best guess" would be that the MoH can double or even triple it very low level of general fees, thus doubling or tripling the amount collected.

nor the improved resource mobilization expected from the Ministry's improved technical standing with the Ministry of Economy and Financing.

Moreover, the recurrent costs of the primary component of Project 2000, the delivery of more and higher quality child and maternal health, are relatively small. The vast bulk of the inputs into this component of the Project consist of a comprehensive one-time training program package that is designed to serve as a temporary stopgap measure, while the curricula of already existing training programs are reformed to incorporate these same elements. Once this one-time training and curricula reform are completed, there will be virtually no additional costs relative to those currently incurred by these programs and institutions.

The remainder of the inputs into this component of the Project consists of commodities. Over the life of the Project, these service delivery-related commodities annually average less than US $700,000. A.I.D. resources to pay for these commodities will be gradually phased out, and MoH resources phased in, so that the MoH will assume responsibility for these commodities prior to the end of the Project. These constitute the recurrent cost legacy of Project 2000 that the MoH will have to be able to cover to sustain Project 2000 activities. If the increase in user fees is a mere 5 percent, rather than the 100 percent increase anticipated by 1998, Project 2000 will still be a worthwhile investment: its activities will still be able to annually generate sufficient additional revenues to more than pay for the incremental commodities costs of US $700,000.

C. Financial Analysis

A rigorous, comparative financial analysis was not done specifically for this Project. This is because numerous studies have demonstrated that the types of primary health care interventions featured in Project 2000 are the most efficient and effective ways presently known to reduce mortality and morbidity and to improve nutrition. The interventions under Project 2000 are ones endorsed by A.I.D. sectoral policies, as well as by the World Health Organization, the United Nations Children's Fund and other major organizations dedicated to health and nutrition. Further, worldwide experience in other A.I.D. projects also bears witness that these are cost-effective interventions.

D. Social Soundness Analysis

Project 2000 is designed to strengthen the quality of health care delivery in MoH facilities and in communities, including promoting a demand for services through social communications, improving management skills and testing new management models,

and improving health financing mechanisms. This section concerns the social soundness of the project, taking into consideration the socio-cultural characteristics of the population and an evaluation of the population's needs and desires for health care. Part of this analysis is based on a rapid ethnographic assessment that was conducted in 1991 in three areas of Peru: urban and rural Puno, urban and rural Arequipa, and urban Chiclayo. Key informants and a random sample of women with young children were interviewed in each site to understand their perceptions about health and health care needs, use of health services, and attitudes toward paying for services.

1. Socio-cultural Context

Although rich in history and natural resources, the severe economic crises in Peru in the past two decades, combined with terrorism, have wreaked havoc on social and economic development and have severely worsened income distribution. International recession, the mismanaged economic policies of a succession of governments and recurring natural disasters have all had severe effects on agricultural production. The Peruvians most negatively affected have been rural people who rely on agriculture for subsistence. This has caused a greatly stepped-up rural to urban migration; while in 1940 Peru was two-thirds rural, today it is only one-fourth rural.

Rural areas of Peru have long been relatively abandoned by government services. Access is difficult, and rural areas have not been politically important. Incentives have been lacking for qualified personnel and their families to settle and work there, away from urban amenities. The lack of good education for the rural population, in addition to poor lines of communication with urban centers, has kept those populations from becoming incorporated into the mainstream culture. Women have been especially isolated from education. At the same time, health facilities that do exist are often underutilized, either because of accessibility in cost and/or distance or social distance between patient and health care provider. These factors, added to the major factor of poverty, have contributed to the high rates of infant, young child and maternal morbidity and mortality in rural areas.

Even the poorest peri-urban areas are better off than rural ones because of better access to services. These urban settlements, known as "pueblos jóvenes", surround larger urban areas and have grown exponentially in past decades, populated primarily by people who have migrated from rural or less urban areas. Also, the poor from inner city "tugurios" also settle in "pueblos jóvenes", seeking to build a house on their own plot of land.

Grassroots community organizations have been flourishing for many years in periurban areas and provide excellent means to reach community members with health information and education. Community kitchens, which are a major focal point for many communities, have emerged as a response to the economic crisis. Their numbers have been increasing since the strict structural adjustment measures were put into place by the current government. The "Vaso de Leche" program, which was started by the city of Lima and has now spread to other municipalities, provides dry milk powder to organized groups of women ("Vaso de Leche" committees), who take turns preparing the milk and distributing one glass per day to all children and pregnant and lactating women in their communities. Although the nutritional benefit may be small, this program has encouraged women to organize themselves in the community. This can help them to solicit other benefits and helps channel resources to the community. Rural communities typically have some type of organization that is dominated by men, but many also have mothers' clubs or other such groups.

2. Beneficiary Populations

The direct beneficiary population of the Project consists of women of childbearing age and children under age three who live in selected areas of the country where health services are currently severely underdeveloped and where the highest rates of infant, young child and maternal morbidity and mortality exist. Indirectly, the beneficiary population will include other family members, neighbors and friends of the targeted women and children. They will benefit from improvements in the quality and efficiency of health services delivery, from improved access to those services and from the health information provided to general audiences.

The health needs identified in the rapid ethnographic assessment correlate closely with epidemiologic data on disease and coincide with the health services to be strengthened under Project 2000. For example, women reported respiratory illness as their first child health priority, followed by diarrheal illness. Nutrition was a primary concern of low-income women. Vaccinations and growth monitoring were also mentioned, albeit less frequently. Regarding their own health, women identified family planning as a primary need, as well as nutrition, care during pregnancy and delivery, gynecological diseases and urinary tract infections, which are referred to obliquely as "kidney problems." Women are concerned about their mental health, mentioning as problems nervousness, headaches and fatigue.

3. Participation

The Project was designed collaboratively with the MoH central level, which identified the inputs needed to complement financing for implementation of national programs in maternal and child health. A series of planning meetings was held with technical officers of the MoH. Further, the draft Project description was circulated for review to technical offices and senior levels of the MoH. Comments and suggestions from that review have been incorporated into the present document. Coordination meetings were held with the other major donor agencies in Peru that support the health sector, including PAHO, the World Bank, the IDB, UNDP, FAO, and UNICEF.

4. Socio-cultural Feasibility

This Project is socially feasible for two reasons. First, people recognize quality in health care, look for it, and are willing to pay for it. Second, many people consider that their health needs are not well met and that health services should be improved. The services to be offered under the Project are highly acceptable to potential beneficiaries and MoH health care providers, with a few exceptions in the maternal health services. That level of acceptability varies by residence and level of education, among other factors.

Maternal-perinatal health. The generally low level of acceptance of maternal health services in the country, especially among rural women and those with little education, is reflected in utilization rates. One-third of women with children under five had no prenatal care in their last pregnancy; this figure is 45 percent for rural women and 37 percent for women with no education.

Institutional childbirth is even less acceptable, with only one-half of women bearing their children in a health facility. While 65 percent of urban women do so, only 15 percent of rural women and 13 percent of those with no education bear children in health facilities. Reasons for such low utilization include cost; hospital requirements that disqualify women who have not done prenatal care there; distance; the perception that hospitals are for the ill, while childbirth is a normal event; and the desire to comply with cultural rites that are not permitted with hospital delivery (e.g., special burial of the placenta).

The Project will promote hospital deliveries, especially for high-risk pregnancies and obstetrical emergencies. It will also provide training for TBAs and other community members, to improve their practices for home deliveries and their health education to women.

Family planning. Knowledge, attitudes, and practices regarding fertility correlate strongly with residence. The total fertility rate of 2.8 among urban women contrasts markedly with that of 6.2 among rural women. Four of five women in union have used a family planning method at least once. Use of modern methods has increased steadily, from 11 percent in 1978 to 33 percent today. An additional 20 percent of women have an unsatisfied demand for family planning services.

In general, health care providers are supportive of family planning, but inadequate logistics systems impede quality service provision. Family planning is now a widely accepted concept in Peru and enjoys strong political support. Peruvian President Alberto Fujimori has been an outspoken supporter, making family planning a priority. The Church continues to resist lending its support to family planning, but does not stand in the way of programs.

Acute respiratory infections. As the major cause of child morbidity and mortality, and the second cause of infant mortality, ARI is recognized by women as a priority health care need. It is the primary reason for children's outpatient visits. Treatment of pneumonia clearly reduces ARI mortality, but the definitive solution to ARI deaths is prevention.

Public education campaigns have promoted the importance of early home treatment of the first stage of ARI so that it does not "progress" to the second stage. Antibiotics are a commonly used treatment for many illnesses and have been readily accepted and even sought by families. It has been recognized recently, however, that this disease progression strategy and generalized use of antibiotics are erroneous. The early identification (through respiratory frequency) and immediate treatment of pneumonia, therefore, has become the focus of new ARI strategies, and the need is now to modify the messages given to health care providers and families. There may be resistance on the part of health care providers and community members to accept as true a different strategy than the previous erroneous one that they recently learned through the same communication channels.

Exclusive breastfeeding, weaning, and growth monitoring. Nearly all Peruvian women believe that breastmilk is the best food for their infants. Urban mothers plan to breastfeed, "if they can", for 6 to 12 months. Many feel that the quality or value of breast-milk deteriorates after 6 months. Similarly, a common misperception of health care providers is that breastfeeding should be discontinued after six months. This is a misinterpretation of the recommendation to breastfeed exclusively for six months. Rural mothers consider breastfeeding more natural and appropriate for a longer period of time.

But problems in breastfeeding remain. Even before delivery, some women are already anticipating not being able to produce sufficient milk and plan to supplement. This fear is reinforced by family and even health personnel. In some cases, women think that breastmilk production is intimately linked to what they ingest. Emphasis on ingesting adequate liquids and special foods detracts from the real means of increasing production, which is frequent suckling of the breast. Further, colostrum is not universally recognized as necessary or even good for newborns, although perceptions vary around the country. Health personnel in urban areas are no better informed about colostrum and do not necessarily promote its consumption.

Growth monitoring is the best way to know if children are consuming sufficient breastmilk in the first six months, and if their weaning foods are adequate after that age. This is a sound intervention, although its practice is not as frequent as it should be, nor is the interpretation of the information and counseling typically of high quality. Family members are unlikely to receive recommendations on health and nutrition. Growth monitoring is an activity for which nurses have taken a strong leadership role in Peru. Most of the large hospitals in Peru have a growth and development clinic. But there is a fair amount of resistance by physicians to allow nurses to diagnose poor growth. The resistance becomes stronger as levels of less-trained personnel are included in growth monitoring. In general, all levels, including physicians, need further training in correct measuring techniques, interpretation of growth charts, and counseling of family members.

Diarrheal disease. Families and health care workers are increasingly accepting oral rehydration therapy as first line treatment for diarrheal diseases in children. Some 20 percent of families use oral rehydration salts (ORS), and another 11 percent use home solutions. ORT is now a well-known treatment for diarrhea in Peru: 72 percent of families know about ORS and 38 percent have used ORS at least once. Nevertheless, it is necessary to increase diffusion in rural areas, among younger mothers, and among those with lower levels of education.

The first mass media campaign on diarrheal diseases was in 1985. Messages focused on recognition of dehydration and the proper mixing of ORS. The program had a major setback, however, in 1986, when poorly manufactured ORS salts were responsible for four child deaths. This caused a backlash of opinion among families and health personnel who were just beginning to accept ORT. The backlash was countered with public education and a training program for physician-nurse teams from hospitals throughout the country. The recent significant increase in use of ORS suggests that families' acceptance of ORS will continue to improve.

The 1991 cholera epidemic in Peru was the likely stimulus for improving the acceptance of ORS. The epidemic sparked intensive education efforts on prevention and treatment of acute diarrhea in both adults and children, with emphasis on immediate home treatment with ORS. Health personnel were under MoH orders to provide ORS as primary treatment for all but the most severe cholera cases, which were initially treated with IV fluids. Many physicians who had doubted ORS became converted.

Two major challenges still face diarrhea programs in Peru. The first is the need to reduce the inappropriate use of pharmaceuticals to treat diarrhea. Presently, pharmaceuticals are used in 3 of every 5 episodes.

The second challenge is to train health personnel in the dietary management of diarrhea, and to reach families with similar messages. Current practices include the promotion of "bland diets", including special soups that may fulfill fluid requirements during diarrhea but do not meet the energy needs of the child. Most physicians do not think to mention dietary aspects while prescribing treatment for diarrhea. Post-illness catch-up growth made possible by extra nutritional intake is not a concept generally known by either health providers or mothers.

Immunization. Immunizations are well-accepted in Peru, as reflected by the good rates of coverage of at least the first dose of most childhood vaccines. More than 9 out of every 10 children under 2 have received the first dose of polio and DPT vaccine. However, coverage of later doses falls to about 7 of every 10 children. Either families are not well-informed of childhood vaccination needs or there is a problem in the health care system. Also, many health personnel may still hold to previous concepts of contraindications to immunizations (e.g., that vaccines should not be given if the child has a cold or fever). These problems suggest the need to continue technical training on immunizations as well as to try new methods for identifying and following-up infants in the community.

An evaluation of the 1990 Vaccination Campaign in Puno showed that the highest coverage was obtained by a house-to-house strategy, rather than by the Vaccination Day campaign. The principal conclusion was that it was feasible to significantly increase coverage by making routine vaccination services more available. Illiteracy and rural residence, frequently identified as correlates of low coverage, were not obstacles when appropriate strategies were used.

5. Impact

The Project will develop a replicable model of health care delivery in rural areas. The social science research to be

undertaken will guide the development of specific educational activities and training for health professionals and community health workers. The technical and management training and educational activities, the equipment purchased, and especially the new health service, management, and financing models developed through this Project will make a lasting contribution to development of the health sector in Peru.

6. Issues

There is currently a dearth of good research on the beliefs and practices of people living in the areas of greatest need -- isolated rural areas and recently settled periurban areas. This lack of research has limited the specification of the Project Paper. However, Project 2000 should begin to fill this void through the studies and operations research it will support.

Lack of health personnel in MoH facilities may present a problem in some Project areas. Poor rural areas, especially where terrorism has been a problem, are most likely to have unstaffed health facilities. The World Bank project may place in these facilities nurses who have graduated from professional nursing education programs, but have not completed their required service in a rural area. Project 2000 might consider exploring this option if the need arises. Further, the MoH is currently developing a policy for contracting PVOs and other non-governmental organizations as service delivery agents. This provides a second option.

In the past, political selection of training candidates has sometimes been a problem. New methods of candidate selection need to be found so that the selection process is conducted competitively and based on specific criteria. The joint committee that will oversee participant selection for overseas training should help in this regard.

E. Institutional/Administrative Analysis

This analysis is based on political, social, administrative and technical events of the last several years that have had a significant impact on the ability of the MoH to operate efficiently. The history of previous projects has helped assess the operational and institutional capacity to attain this Project's objectives.

Project 2000 continues a longstanding collaborative effort between USAID and the MoH to improve the health of Peruvians, especially women and children. Previous USAID projects are 527-0219, 527-0230, 527-0221, and 527-0285. These projects have sought to strengthen the efficiency, efficacy, quality, and

equity of health services throughout the country, with special emphasis on the health of children. This new Project continues on this course. Since many of its activities will be carried out on a national level, its operation will be linked with the entire structure of the MoH. Other activities will be modelled at the regional level as pilot programs, to perhaps be replicated nationally later on.

The success of this Project will depend on both technical and administrative assistance. Although the Project resources are essential, they must fit in with the administrative framework in which they operate. This section analyzes the situation in the MoH.

1. Organization of the MoH

The MoH has spent the last several years in a permanent state of reorganization, reflecting the larger sphere of the Peruvian government. The populist and sectarian policies within the country and the country's subsequent financial isolation from the international arena led it into a debilitating institutional and financial crisis. Presently, Peru is recuperating from dramatic hyperinflation that caused a significant decline in purchasing power.

The decentralization process was strongly disrupted by the so-called "regionalization process", a major reform instituted by Alan Garcia. Regional units became virtually independent, with MoH central level authority sharply reduced. This process occurred in a disorderly and improvised manner. It created disruptions of such a magnitude that the MoH almost totally lost its ability to direct and manage health care policies and services within the country. A large part of the regions' budgets are directly assigned by the Ministry of Economy and Finance (MEF), without participation from the MoH, and without mechanisms to ensure that the money is used according to the priorities and policies of the health sector. Decentralization is really a two-way process: as the periphery assumes control of a process or function, the center should have mechanisms to ensure that these processes or functions are carried out. Therefore, decentralization must not be interpreted as dismemberment of the system, but rather as a mechanism to improve the efficiency of the system as a whole.

Ministerial Resolution No. 00020 93-SA/DM of February 5, 1993, has defined the lines of reorganization of the MoH and the future structure of the regions and sub-regions. More recently, in early May, the Democratic Constitutional Congress (CCD) preliminarily voted on the draft of a new constitution that would rescind regionalization and return political organization to the former scheme of departments. This dynamic state of affairs will affect the functioning of the MoH. The process of reorganization

will thus take time and adaptive effort in such a politically conflictive and uncertain atmosphere. Moreover, continued financial restrictions, reduction of personnel and very low salaries continue to burden the public health sector.

MoH facilities outside Lima were decentralized in 1986. To this effect, Departmental Health Units (UDES) were created, to be responsible for managing public sector health care services in their corresponding geographic areas. Below this level came Territorial Health Units (UTES), which often correspond to provinces. The same 100 UTES are composed of peripheral services (primary and ambulatory care) and support hospitals. These units receive direct budget allocations from the MEF, but have to report to the MoH central level on health policy, norms, procedures, and operational aspects.

The position of Minister is the highest political post in the MoH. Coordination of the offices in charge of health programs is the responsibility of the Vice Minister. Under the Vice Minister is the General Directorate of Human Health, which in turn is in charge of the General Directorate of Integrated Health Programs. The Director of Mother-Child Programs is responsible to that office, and in turn is directly in charge of the technical offices for maternal and child health programs: immunizations, maternal/perinatal health, diarrheal disease control, acute respiratory infections, growth and development, and family planning. These programs are the focus of activities that will be supported by this Project. On the other hand, there is the Office of Planning, where the budgetary process occurs, and the Offices of Statistics, Communications, Epidemiology, and DIGEMID, with which the Project will have continuous contact, because of the nature of the proposed activities. At the political level, regular contact should be maintained with the Office of Investment, Financing and External Cooperation, which coordinates the MoH's activities with outside cooperative agencies.

The operational capacity of these central offices has diminished during the past several years, due to a high turnover rate and a substantial reduction in technical personnel as well as in operating budget. Personnel have been reduced from 70,552 to 28,671; and, at the central level, there remain only 730 technical people. The central office is thus less able to program, supervise and support regional health offices. Nevertheless, the reactions of MoH staff to the proposals and requirements of this Project were extremely positive and appropriate. This same attitude was also apparent in the field, indicating that MoH staff are serious about their responsibilities, despite the instability. This is a favorable environment for the implementation of the Project.

A large part of the Project activities will be carried out at what the MoH is now calling the sub-regions. Programming,

implementation, monitoring and evaluation are carried out at this level. Thus, a good deal of Project resources should be directed to this level of the health care system. Recently, the concept of ZONADIS (Zones of Integrated Health Development) has been introduced. This is based on the concept of "local health systems" (SILOS) promoted by PAHO. However, the ZONADIS concept has been interpreted in different ways. Some regions are managing it as a point of coordination to bring together health services, the community, and other involved organizations, such as the church and NGOs, to discuss and solve health problems. In other regions, ZONADIS are true administrative entities that substitute for the UTES, albeit on a smaller scale. Eventually, they could become a combination of both interpretations. The Project is likely to focus its decentralization activities at the ZONADIS level, if that indeed emerges as the MoH's basic unit.

There are two more organizational concepts that do not seem to be well defined, but may become more important as the new decentralization scheme becomes clear. One of them is the "Basic Health Units" (UBAS) that supposedly are, or will be, a sub-division of the UTES, having as its head a hospital or health center. The other is the "Basic Health Module" (MBS), which is essentially a grouping of one health center and various health posts within a geographic area of responsibility. These organizational units are likely also to become key in decentralization activities.

2. Planning and Monitoring in the MoH

Because of these many organizational changes, the central MoH's ability to carry out Project activities has been weakened. The organization of the regional governments, which gave the decision-making to the Secretary of Social Affairs, weakened the administrative capacity of the UDES. However, some activities, such as the Expanded Program on Immunizations, which substantially increased national immunization coverage, have achieved a great level of coordination. One can now see a rekindling of the processes of coordination, programming, and monitoring between the central level of the MoH and its peripheral units.

The DIGEMID is in the process of strengthening its organization and management of supplies by rehabilitating its network of regional warehouses, developing inventory systems, training, and purchasing supplies in bulk to obtain the best prices. Presently, this office is only handling 5 percent of the resources in its area of responsibility.

Project 2000 will be managed through an Institutional Contractor that will be in charge of technical assistance, studies, and other specific actions. Keeping in mind the organization of the

central MoH, the basic plans of operation will be developed in conjunction with the appropriate MoH staff in charge of each of the particular programs. Jointly, and with the collaboration of regional technical assistance, the plans will be carried out in the peripheral areas. Some activities on a national level, such as the information, education, and communications campaign, will be developed by the respective national offices. The local level has the final responsibility to carry out project activities. It will be in charge of supervision, monitoring and evaluation. For this task, the local level must be supplied with the appropriate administrative training, as is planned. It should, during the life of the Project, develop the mechanisms and systems to achieve a systemic process of planning, operation and analysis to sustain the functions of the program.

3. Personnel

The Peruvian health care system is biased towards hospitals. In the Cusco UDES, for example, the hospital capacity is approximately 900 beds -- not including the IPSS hospital. However, occupancy rates do not exceed 30 percent. This means that on average 600 beds are always unoccupied in a region where infant and maternal mortality is the highest in the country. Because these empty beds still demand a significant number of employees, the over-availability of hospitals seriously affects the assignment of personnel to peripheral health facilities. Scarce health resources would be better used closer to where the infants are dying: the rural and marginal urban areas. At this lower level, nurse auxiliaries and health technicians in health posts, and nurses, midwives, and physicians in health centers are the key personnel to the success of the Project. The achievement of community development and the capability of the community to act appropriately and conscientiously where health matters are concerned will depend on these personnel. This group often works in an atmosphere with serious restrictions, little supervision, lack of training and the absence of support from other levels. Their facilities are badly equipped and maintained in relation to the enormous task that they are assigned. Therefore, the inputs of this Project will support them in improving their work.

4. Training and Communication

Apparently, the MoH has the capacity to carry out some training for its regional personnel. However, the lack of personnel and the attrition of trained personnel have seriously diminished this capacity. With the CSAP Project, A.I.D. has been helping develop human resources in clinical management of diarrhea, ARI, breastfeeding and weaning. This type of training will continue in selected regions for health personnel in peripheral hospitals, health centers, health posts and community health workers. This

is an indispensable condition for the success of the project. The contractor should pay special attention to strengthening the most peripheral health facilities, making sure that resources do not become, again, concentrated in the more sophisticated facilities without considering the entire network of services.

The Institutional Contractor should also coordinate training activities through the School of Public Health (ENSAP), an institution dependent on the MoH, and strengthen the apparently underutilized resources of that institution. The most likely participation of ENSAP, in addition to a coordinating role, will be for the in-service training in public health administration and management for MoH functionaries at all levels, to be developed under the management improvement component of the Project. The persons selected for long-term, out-of-country training at the Master's degree level, if this component is adapted, could be incorporated into ENSAP following their training, in order to develop that institution and transfer their knowledge. The commitment to continued service to the MoH that will be a requirement of candidate selection should facilitate this institutionalization. Eventually, there should be a strategy to rotate ENSAP professors or maintain links with actual management practice in the MoH in order to keep ENSAP teaching up-to-date and practical.

The MoH has a limited capacity to develop information, education and communications campaigns. The Project will help in the development of this capacity, so that the MoH will be able to participate in basic activities at both the central and regional levels. This could be done following the model developed by HEALTHCOM, which has been introduced to the MoH in the past year. To the extent possible, however, major studies and campaign design should be subcontracted to local firms with appropriate expertise.

5. Purchasing and Distribution (Logistics)

The list of commodities for this Project was based on information given by relevant MoH personnel. It is evident that the programs have identified what their needs are and, in the future, should be closely involved in the development of specifications. As happens in bureaucracies, simple purchases can be extremely complicated -- to the point that the system is overly slow. Most of the Project commodities that draw on grant funds will be purchased through USAID and/or the Institutional Contractor.

The MoH has had serious problems with the delivery of supplies to the UPS (Unidades Productores de Servicios). Presently, only 5 percent of the supplies required are channeled through the MoH. For example, contraceptives and food assistance are distributed through an NGO. In some areas, local entities have created

revolving funds that are almost self-financing (such as SILOMED in Cuzco). Because of the low capacity of the MoH in this area, the Project should seek strategies to strengthen the MoH system. Presently, the system is in the process of being strengthened through DIGEMID.

6. Absorptive Capacity of the MoH

Granted that the three large health projects (Project 2000, SHSP and BHNP) may present implementation challenges to both the MoH and the three donors, perhaps the major problem in recent years in the health sector has been non-functioning or sub-functioning health service outlets that have been in that state because of lack of basic commodities and personnel. In this respect, the considerable donor inputs to health service delivery should be absorbed well. Further, it should be noted that none of the planned activities represents a new vertical program. All of them relate to ongoing MoH programs, whether in immunization, diarrheal disease, respiratory infections or other areas. Thus, infrastructure is in place to absorb them. Third, the recent change in Minister of Health, and thus senior staff at the Ministry, offers a timely opportunity at the MoH to rethink and reorient policies and programs. Though Project 2000 was designed during the administration of the previous Minister, it was designed to move in some directions that are perhaps more consonant with the new Minister's orientation, particularly in the areas of decentralization, privatization, nutrition and community-based preventive care. In sum, the confluence of a new administration in health and three new health projects makes this an exciting time for health in Peru. That excitement and energy to move in new directions will only enhance the MoH absorptive capacity.

7. Institutional Technical Assistance

USAID/Peru has to be able to ensure that all of its grantee institutions adhere to standard accounting practices that allow appropriate monitoring of funds. Thus, the Project Agreement contains a condition precedent requiring an explicit commitment on behalf of the GoP to correct any institutional weaknesses in its financial management. A.I.D. has been analyzing the possibility of financing a technical assistance contract to support the MoH in the design of an administrative and accounting system compatible with A.I.D. norms and regulations, thus ensuring transparency of accounts and facilitating audit requirements. Under such a contract, key Ministry personnel that handle A.I.D. funds would receive appropriate training. A letter from the Ministry of Health confirming its interest in this type of assistance would constitute such an explicit commitment. That letter will be forthcoming in the immediate future.

F. Women In Development

Peruvians with lower incomes will be beneficiaries of the Project. As with most health and family planning projects, women will enjoy Project benefits. Under the main component of child and maternal health services, the priority area of emphasis will be on maternal-perinatal health. This will include improved health services and education of women during pregnancy, delivery, and the postpartum period.

The Project 2000 training component for child and maternal health services will train multidisciplinary teams of health professionals that will include women in greatest numbers, since most non-physician health workers in Peru are women. This includes the categories of nurses, midwives, auxiliary nurses, health technicians, community health workers and traditional birth attendants.

G. Initial Environmental Examination

The Initial Environmental Examination (IEE) recommends a categorical exclusion from the requirement to carry out an environmental assessment. This determination was made based on the absence of any activities in the Project that would have a direct impact on the environment. The IEE makes reference to Section 216.2, Paragraphs c(2)(i) and c(2)(iii), which allow a waiver of the requirement for further environmental review for analyses, studies, academic or research workshops and meetings, and for programs involving education, technical assistance, or training -- to the extent that they do not directly affect the environment (such as construction of facilities, etc.). The IEE recommendation was made by the Mission Environmental Officer on April 14, 1993, and the Mission received concurrence from Washington on August 9, 1993.

Volume II

Annexes to

Project 2000 Project Paper

(527-0366)

Lima, Perú
September 1993

134

List of Annexes

1. Host Country Request for Assistance

2. Logical Framework

3. Estimated A.I.D. Detailed Budget by Components, Line Items, Project Year and Funding Source

4. Waiver to Fully Fund International Travel Costs for Participant Training

5. Waiver of Requirements regarding Cold Chain Commodity Source/Origin and Nationality of Ocean Transportation Services

6. Waiver of Full and Open Competition for Procurement of Cold Chain Equipment

7. Cable Approving Project 527-0366 New Project Description (NPD)

8. Memo Approving Project 527-0366 Project Implementation Document (PID)

9. Cable Approving a Categorical Exclusion from an Initial Environmental Evaluation for Project 527-0366

10. Congressional and Technical Notifications for Project 527-0366

11. Statutory Checklists
    - 5 C(1): Country Checklist
    - 5 C(2): Assistance Checklist

12. Illustrative List of Commodities

13. Suggested Field Studies, Ethnographic Research and Operations Research

14. Contributors to the Project Paper

15. Bibliography

135

Annex 1

Host Country Request for Assistance

136

MINISTERIO DE SALUD

"AÑO DE LA MODERNIZACION EDUCATIVA"

93 JUL 30 PM 7:47
USAID/LIMA

Lima, 26 de Julio de 1993

SA-DM Nº 184 -93

Sr.
GEORGE A. WACHTENHEIM
Director
Agencia para el Desarrollo
Internacional (AID)
Presente.-

De mi consideración:

Tengo el agrado de dirigirme a Usted, en referencia al Proyecto 2000 cuyo objetivo es contribuir al fortalecimiento de los programas de salud materno infantil mediante el desarrollo de tres componentes: 1)fortalecimiento de los programas de salud materno-perinatal, incluida la planificación familiar, 2) las iniciativas para un eficiente manejo gerencial de los servicios de salud y 3) el financiamiento de los servicios de salud.

Sobre el particular, manifiesto a Ud. el interés del Ministerio de Salud en la obtención de apoyo para el mencionado proyecto que será ejecutado por el Ministerio de Salud, lo cual demanda un monto de donación de aproximadamente US $ 30'000,000 para un periodo de siete años.

Agradeciendo anteladamente la atención que brinde a la presente, hago propicia la ocasión para reiterar a Ud. los sentimientos de mi especial consideración y estima.

Atentamente,

Dr. VICTOR PAREDES GUERRA
Ministro de Salud

ACTION HN/PS
INFO HN
Cord
C
CO

Annex 2

Logical Framework

LOGICAL FRAMEWORK

Name and No. of Project: PROJECT 2000 (AID 527-0366)

Peru
1994-2000

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS[1]
Program or Sector Goal: The broader objective to which this Project contributes: **Improve the health and nutrition status of young children and women of childbearing age.**	**Measures of Goal Achievement:** 1. Infant mortality will decrease from 55 in 1991-92 to 40. 1.1. Infant mortality due to conditions originating in the perinatal period will decrease from 30 in 1991-92 to 25. 1.2. Infant mortality due to ARI will decrease from 16.5 deaths in 1991-92 to 12. 1.3. Infant mortality due to diarrheal disease will decrease from 6 in 1991-92 to 4.	Encuesta Demográfica y de Salud Familiar (ENDES) 1996 and 2000.	That social conditions and terrorism permit the implementation of proposed interventions. That the GOP ensures financing in the future of activities developed through the Project. That AID ensures financing for ENDES surveys. That there is no impediment on the part of USG to finance the Project.
	2. Under five mortality will decrease from 78 in 1991-92 to 60.	ENDES 1996 and 2000	That the Institutional Contractor is permitted to begin work in a timely manner.
	3. Maternal mortality will decrease from 303 in 1991 to 200.	National Survey of Women of Reproductive Age and Maternal Mortality in 1994-95 and 2000.	That appropriate expatriate experts are allowed into Peru to begin the Project in a timely manner.
	4. Total fertility will decrease from 3.5 in 1991-92 to 3.0.	ENDES 1996 and 2000	
	5. The proportion of children under 5 with chronic malnutrition will decrease from 37% in 1991-92 to 25%.	ENDES 1996 and 2000	
	6. The morbidity rate of measles will decrease from 101 to less than 20, neonatal tetanus from 19 to less than 8, and morbidity from polio will be maintained at 0.	Active Epidemiologic Surveillance system of the MoH.	

[1] These assumptions apply throughout the Logical Framework

Project Purpose: Increase utilization of priority maternal and child health interventions.	End of Project Status (EOPS) - Conditions that will Indicate Purpose Has Been Achieved.		
	Maternal-Perinatal Health, Including Family Planning		That social conditions and terrorism permit the implementation of proposed interventions in rural and periurban areas.
	1. The proportion of pregnant women receiving prenatal care will increase from 68% in 1991-92 to 80%.	ENDES 1996 and 2000.	That GOP and AID financing occur as called for in the PP design.
	2. The proportion of births attended by qualified personnel will increase from 52% in 1991-92 to 67%.	ENDES 1996 and 2000.	That the Institutional Contractor is able to begin work in a timely manner.
	3. The prevalence of modern contraceptives will increase from 33% in 1991-92 to 40%.	ENDES 1996 and 2000.	That GOP policies support family planning.
	4. Total contraceptive prevalence will increase from 59% in 1991-92 to 67%.		
	Acute Respiratory Infections (ARI)		That appropriate international and local expertise are made available.
	5. The proportion of children under 5 with pneumonia who receive care at a health facility will increase from 48% in 1991-92 to 67%.	ENDES 1996 and 2000.	
	Breastfeeding, Weaning, and Growth Monitoring		
	6. The average duration of exclusive breastfeeding will increase from 2.2 months in 1991-92 to 3 months.	ENDES 1996 and 2000.	1.5. Present status method used to calculate average duration.
	7. The proportion of children aged 6-9 months who receive two portions of appropriate weaning foods in addition to breastmilk will increase from 62% in 1991-92 to 75%.	ENDES 1996 and 2000.	
	8. The proportion of infants under 12 mos. who receive at least 5 growth and development check-ups will stand at 75%.	ENDES 1996 and 2000.	1.7. New questions added to ENDES household questionnaire.

	Immunizations		
	9. Coverage of measles, BCG, and 3 doses of polio and DPT vaccine in children 12-23 months of age will increase from 51, 88, 60, and 59% in 1991-92 to an average of 75%.	ENDES 1996 and 2000.	
	10. Coverage of women of fertile age with 2 doses of tetanus toxoid will increase in high-risk areas from 20% in 1991-92 to 60%.	ENDES 1996 and 2000.	
	Diarrheal Disease Control		
	11. The proportion of women with children under 5 who used ORT in the most recent episode of diarrhea will increase from 31% in 1991-92 to 50%.	ENDES 1996 and 2000.	

Outputs: Maternal-Perinatal Health, Including Family Planning			
1. Pregnant women have adequate access to prenatal care.	1.1. First prenatal visit will occur on average before the fourth month of pregnancy.	ENDES 1996 and 2000.	
	1.2. Rural women will receive on average 3 prenatal visits.	ENDES 1996 and 2000.	
2. Health facilities and communities have adequate resources to provide quality prenatal care.	2.1. 40% of health facilities will have personnel trained to provide appropriate prenatal care (including the risk approach) in 1996; 60% in 2000.	Sample survey of health personnel Knowledge, Attitudes, and Practices (KAP).	
	2.2. 50% of participating traditional birth attendants (TBA) will be able to apply a simple risk assessment instrument in the community by 1996; 75% by 2000.	Sample survey of TBA KAP.	
	2.3. 20% of health facilities will have necessary equipment for prenatal care (weight scales, tape measures, etc.).	MoH inventory of health facilities and equipment.	
	2.4. 50% of health facilities and 67% of participating TBAs will have necessary supplies for prenatal care (micronutrients: vit. A, folic acid, iron, iodine).	Sample survey of health facilities and TBA.	
3. Health facilities have adequate resources to attend obstetrical emergencies.	3.1. 33% of hospitals and health centers will have trained personnel for obstetric emergencies in 1996, and 67% in 2000.	Sample survey of health personnel.	
	3.2. 50% of hospitals and health centers will have basic equipment and supplies for obstetrical emergencies.	MoH inventory of health facilities and equipment.	

142

4. Health facilities have strengthened reporting and analysis of maternal and perinatal deaths, epidemiologic surveillance and discussion with the community.	4.1. 20% of Basic Health Units will do epidemiologic surveillance of maternal and perinatal deaths and will discuss them with the community and TBAs by 1996, 40% by 2000.	MoH Active Epidemiologic Surveillance (VEA) system.	4.1. Basic Health Units (UBAS) continue to be an administrative unit of the MoH.
5. The quality of voluntary family planning services improves.	5.1. 33% of hospitals and health centers will have personnel trained in family planning counselling in 1996, and 67% in 2000.	Sample survey of MoH health personnel.	
	5.2. 80% of health facilities will have family planning equipment and supplies needed to satisfy the demand.	MoH inventory of health facilities and equipment.	
	5.3. 30% of health facilities that provide surgical sterilization will be better equipped.	MoH inventory of health facilities and equipment.	
Outputs: ARI and Pneumonia			
6. Early identification and diagnosis, and early treatment of children with pneumonia improve.	6.1. 67% of ARI cases seen in health facilities will receive appropriate case management.	Sample survey of health facilities.	
	6.2. 40% of mothers will recognize signs of pneumonia (rapid respiration, etc.) in 1996. 67% in 2000.	ENDES 1996 and 2000. KAP studies.	
7. Quality of services for treatment of pneumonia in children improves.	7.1. 33% of health facilities will have personnel trained in ARI case management in 1996, and 67% in 2000.	Sample survey of health personnel.	
	7.2. 67% of health facilities will have medicines, supplies, and basic equipment for appropriate and immediate treatment of pneumonia and its complications in 1996; 80% in 2000.	MoH inventory of health facilities and equipment.	

Outputs: Breastfeeding, Weaning, and Growth Monitoring			
8. Hospital practices that support the establishment of exclusive breastfeeding improve.	8.1. 80% of births in MoH hospitals will have post-partum rooming-in.	Sample survey of MoH health facilities	
	8.2. The proportion of newborns breastfed in he first hour after birth will increase to 0% in 1996, 67% in 2000, from 20% in 1991-92.	Sample survey of MoH health facilities	
9. Knowledge and practice of infant feeding (including exclusive breastfeeding management, proper weaning, and appropriate feeding during and after illness episodes) improve.	9.1. 33% of health facilities will have personnel trained in how to promote appropriate infant feeding in 1996, 67% in 2000.	Sample survey for evaluation of MoH health personnel.	
	9.2. 50% of participating TBAs will have strengthened knowledge about infant feeding in 1996, and 80% in 2000.	Sample survey of TBA	
	9.3. 50% of mothers will know more about proper infant feeding in 1996, 80% in 2000.	ENDES 1996 and 2000	
10. Quality of care for monitoring growth and development of children, especially those under age two, improves.	10.1. At least 10 demonstration centers in health centers and posts will implement a new model for monitoring of growth and development.	Supervision visits	
	10.2. 20% of health facilities will have material and equipment for monitoring growth and development.	MoH inventory of health facilities and equipment	
	10.3. 50% of infants under age one will have at least 5 growth monitoring visits in their first year.	Sample survey of health facilities.	
11. Growth-monitoring based in the community is strengthened or developed.	11.1. At least 10 communities will implement a new model for monitoring of growth in the community.	Supervision visits	

Outputs: Immunizations			
12. Children complete their vaccination series by age one year.	12.1. 80% of children will have reached their first birthday with complete immunizations, increased from 58% in 1991-92.	ENDES 1996 and 2000	
13. Vaccine potency is maintained.	13.1. 80% of the cold chain will function optimally at any one moment.	Sample survey of health facilities.	
14. Coverage of tetanus toxoid immunization among women of fertile age living in high risk areas for neonatal tetanus increases.	14.1. 80% of women in prenatal care will receive at least two doses of tetanus toxoid in high risk areas.	ENDES 1996 and 2000	
	14.2. 40% of women of fertile age under 25 years of age and without children will have two doses of tetanus toxoid in high risk areas in 1996, and 67% in 2000.	ENDES 1996 and 2000	
Outputs: Diarrheal Disease Control			
15. Availability of oral rehydration salts improves.	15.1. 80% of health facilities will have ORS packets available.	Sample survey of health facilities and equipment.	
16. Knowledge and use of oral rehydration is improved, especially in rural areas.	16.1. 80% of mothers of children under age 5 will have heard about ORS in 1996, 85% in 2000, increased from 72% in 1991-92.	ENDES 1996 and 2000	
	16.2. 80% of severe diarrhea cases will be seen at health facilities and will be treated with ORS.	ENDES 1996 and 2000	
	16.3. 25% of diarrhea episodes in children under age five will be treated with pharmaceuticals, reduced from 60% in 1991.	ENDES 1996 and 2000	
17. Mothers are knowledgeable about basic measures to prevent diarrhea.	17.1. 75% of mothers will know basic measures to prevent diarrhea.	ENDES 1996 and 2000	

Outputs: Information 18. Utilization of health information produced in the sector for decision-making is improved.	18.1. 80% of local health units will be able to calculate and utilize selected indicators using the HIS/MIS system. 18.2. In at least one local health unit, a model for monitoring and evaluation for decision-making according to each level (health post, health center, UBAS, and UTES) will be implemented and evaluated.		
Outputs: Supervision 19. Supervision of MoH health facilities is strengthened.	19.1. In at least one local health unit, a supervision system (that includes a subsystem of monitoring and quality control) of MoH health facilities, especially health center and health posts, will be implemented and evaluated. 19.2. 67% of health facilities will receive at least 3 supervisory visits per year to monitor quality of care for interventions in MP, ARI, EBF, W, GM, IMM, and DDC (*).		
Outputs: Logistics 20. Logistics system for medicines and other supplies in health services is improved.	20.1. 50% of hospitals, health centers, health posts, and UROCs (**) will have some stock of each medicine appropriate to that level.	Sample survey of health facilities and equipment.	
Outputs: Physical Repairs 21. The physical state of repair of health centers and health posts is improved.	21.1. 200 health centers and health posts will have basic repairs done.		

(*) MP= Maternal-Perinatal Health, ARI= Acute Respiratory Infections, EBF= Exclusive Breastfeeding, W= Weaning, GM= Growth Monitoring, IMM= Immunizations, DDC= Diarrheal Disease Control.
(**) UROC= Community Oral Rehydration Unit.

146

Outputs: Management			
22. MoH increases efficiency of planning for use of resources.	22.1 Budget categories will be rationalized.	MoH budgets, compared with 1993 budget.	
	22.2 A decentralized budget allocation formula will be adopted at central level.	MoH budget documents.	
	22.3 Annual workplans will be designed and budgets developed at sub-national and lower levels.	Sub-national and lower level workplans and budgets.	
	22.4 A revised cost accounting system will be used to report expenditures.	Expenditure reports.	
23. Less costly facilities are used more for service provision.	23.1 75% of ambulatory services will be provided at health centers and posts, increased from 62% in 1991.	HIS/MIS reports.	
	23.2 90% of health centers will be functioning, increased from 76% in 1990.	Project evaluation; supervisory visits, MoH reports.	
	23.3 98% of health posts continue to function, maintaining the 1990 levels.	Project evaluation; supervisory visits, MoH reports.	

Outputs: Financing			
24. Increased GOP resources are mobilized for priority child survival and maternal care programs.	24.1 More than 55% of MoH services will be MCH, increased from 48% in 1990;	MoH reports, based on HIS/MIS	
	24.2 A increased % of MoH spending of GOP (including PL-480) funds will be in the neediest 25% of departments.	MoH expenditure reports.	
	24.3 Increased amounts of GOP funds will be spent by MoH for health centers and posts.	MoH expenditure reports.	Peruvian economy remains relatively stable.
25. Increased cost recovery us achieved.	25.1 A national fee collection system will be designed, implemented, and functioning, collecting S/. 66 million or more, compared to S/. 33 million in 1993.	MoH records	
Inputs:			
1.1 Train MoH health care providers.	Please see budget notes for details on level of effort in all areas of training and IEC.	Sample survey of health personnel.	
1.2 Train community health promoters and TBAs.			
1.3 Educate women concerning family planning, birth spacing, pre-natal care.		ENDES 1996 & 2000.	
2.1 Supply facilities with necessary: equipment, materials, manuals, MoH norms.	Please see budget notes for details on specific equipment and quantities.	MoH inventory of facilities and equipment.	
2.2 Supply common antibiotics for RTI, iron and folic tablets.		Procurement and distribution records.	
2.3 Supply tetanus toxoid vaccine.		Procurement records/Inspection of health facilities.	
2.4 Supply materials to renovate/maintain physical infrastructure.		Sample survey of health personnel.	
3.1 Train MoH and community health workers to identify high-risk births.		Procurement and distribution records.	
3.2 Supply hospitals and clinics with appropriate equipment for obstetrical emergencies.			

4.1 Train health personnel to lead discussions concerning infant deaths.		Supervisory visits to field.	
4.2 Educate and encourage women and other caregivers to communicate about infant deaths.		Supervisory visits to field.	
4.3 Carry out a survey on perinatal mortality.		Project documents and reports.	
5.1 Train hospital, clinic and community health workers in FP counselling.		Sample survey of health personnel.	
5.2 Supply health facilities with FP equipment and supplies.		Procurement and distribution records.	
6.1 Educate and train health personnel to improve case management of ARI.		Sample survey of health personnel.	
6.2 Educate community to detect symptoms and early signs of ARI.		ENDES 1996 & 2000.	
6.3 Support mass media campaigns concerning ARI.		Project records and reports.	
6.4 Provide short-term technical assistance for ethnographic studies about ARI.		Sample survey of health personnel.	
7.1 Educate caregivers concerning the correct use of antibiotics.		Sample survey of health personnel.	
7.2 Supply health facilities with appropriate medicines, supplies and equipment.		Site visits.	
8.1 Promote the practice of "rooming in" in hospitals.		Sample survey of health personnel/site visits.	
8.2 Educate hospital caregivers about the benefits of exclusive breastfeeding.		Sample survey of health personnel/site visits.	
9.0 Educate women, TBAs and other caregivers about breastfeeding and weaning.		ENDES 1996 and 2000.	

149

10.0 Design and implement new model for growth monitoring centers.		Project documents and reports.	
10.1 Supply health facilities with growth monitoring equipment.		Procurement and distribution records/site visits.	
11.1 Design and test model for community growth monitoring sessions.		Project documents and reports.	
11.2 Add growth-monitoring component to food programs.		Project documents/site visits.	
11.3 Train health care providers in growth monitoring techniques/promotion.		Sample survey of health personnel.	
12.1 Design and implement system for newborn registration and follow-up.		Project documents and reports.	
13.1 Update training for personnel on maintenance of cold-chain equipment.		Sample survey of health personnel.	
13.2 Supply additional cold chain equipment.		Procurement and distribution documents.	
14.1 Educate women and caregivers about tetanus toxoid.		ENDES 1996 & 2000.	
14.2 Supply syringes for tetanus toxoid vaccine to health care facilities.		Procurement records.	
15.1 Finance the procurement of oral rehydration salts.		Procurement records.	
15.2 Conduct feasibility study for the national production of ORS.		Project documents and reports.	
16.1 Educate caregivers about ORS.		Sample survey of caregivers.	
17.1 Educate mothers and other caregivers about ways to prevent diarrhea.		ENDES 1996 and 2000.	
18.1 Train appropriate facility personnel about HIS/MIS system.		Survey of personnel/site visits.	
18.2 Establish a model for monitoring and evaluation for decision-making.		Project documents and reports.	

152

19.1 Establish supervisory system of MoH facilities.		Project documents and reports.	
19.2 Finance supervisory visits of health facilities throughout the MoH system.		Project documents and reports.	
20.1 Strengthen departmental storage network for medicines and supplies.		Project documents/site visits.	
20.2 Strengthen distribution system.		Site visits.	
21.1 Supply basic maintenance materials for facility renovation.		Site visits.	
Management Inputs:			
22.1 Supply technical assistance to rationalize budget categories.		Project documents and reports.	
22.2 Promote dialogue about decentralized budget allocation.		Project documents and reports.	
22.3 Supply technical assistance to revise accounting system so that it is based on costs.		Project documents and reports.	
23.1 Reallocate resources to clinics and posts.		Project documents/site visits.	
23.2 Increase the number of operating health centers.		Project documents/site visits.	
23.3 Supply technical assistance to design and implement decentralized management improvement model.		Project documents and reports.	
23.4 Supply technical assistance to design and implement total quality management model.		Project documents and reports.	
Financing:			
24.1 Provide resources to carry out studies for the basis of a national user fee system.		Project documents and reports.	

151

25.1 Assess existing cost recovery schemes.		Project documents and reports.	
25.2 Provide technical assistance to design and implement pilot projects and perform operations research on new cost recovery schemes.		Project documents and reports.	

Annex 3

Estimated A.I.D. Detailed Budget

by Components, Line Items,

Project Years and Funding Source

(P2000v1.WK1)

ESTIMATE DETAILED AID PROJECT BUDGET BY PROJECT COMPONENT, LINE ITEM AND PROJECT YEAR

(US $'000)

CATEGORY/line item	PY 1 1994	PY 2 1995	PY 3 1996	PY 4 1997	PY 5 1998	PY 6 1999	PY 7 2000	TOTAL	FX	LC
A) Strengthening MACH Health programs	0.00	3,263.00	2,575.00	2,553.00	2,158.00	2,064.00	1,458.00	14,071.00	5,712.00	8,359.00
1. Priority Health Programs	0.00	1,388.00	983.00	837.00	692.00	680.00	584.00	5,174.00	4,001.00	1,173.00
a) Maternal-Perinatal Health including FP	0.00	669.00	363.00	333.00	198.00	191.00	87.00	1,841.00	1,187.00	654.00
(1) Prenatal Care	0.00	258.00	246.00	222.00	156.00	149.00	49.00	1,080.00	1,000.00	80.00
- Equipment & Materials	0.00	28.00	36.00	12.00	11.00	4.00	4.00	95.00	95.00	0.00
- Pharmaceuticals	0.00	100.00	100.00	100.00	100.00	100.00	0.00	500.00	500.00	0.00
- Micronutrients	0.00	90.00	90.00	90.00	45.00	45.00	45.00	405.00	405.00	0.00
- Operational Research	0.00	40.00	20.00	20.00	0.00	0.00	0.00	80.00	0.00	80.00
(2) Birth-Related Health	0.00	392.00	98.00	92.00	28.00	28.00	24.00	662.00	88.00	574.00
- Equipment & Materials	0.00	18.00	14.00	8.00	4.00	4.00	0.00	48.00	48.00	0.00
- Operational Research	0.00	60.00	60.00	60.00	0.00	0.00	0.00	180.00	0.00	180.00
- Surveillance Maternal/perinatal Deaths	0.00	24.00	24.00	24.00	24.00	24.00	24.00	144.00	0.00	144.00
- Surveys maternal/perinatal mortality	0.00	250.00	0.00	0.00	0.00	0.00	0.00	250.00	0.00	250.00
- Short Term Technical Assistance	0.00	40.00	0.00	0.00	0.00	0.00	0.00	40.00	40.00	0.00
(3) Family Planning	0.00	19.00	19.00	19.00	14.00	14.00	14.00	99.00	99.00	0.00
- Equipment & Materials	0.00	19.00	19.00	19.00	14.00	14.00	14.00	99.00	99.00	0.00
b) Acute Respiratory Infections	0.00	303.00	269.00	234.00	238.00	256.00	292.00	1,593.00	1,196.00	397.00
- Equipment & Materials	0.00	23.00	20.00	18.00	18.00	10.00	10.00	99.00	99.00	0.00
- Pharmaceuticals and micronutrients	0.00	146.00	142.00	162.00	167.00	192.00	228.00	1,037.00	1,037.00	0.00
- Operational Research	0.00	40.00	33.00	0.00	0.00	0.00	0.00	73.00	0.00	73.00
- Surveillance ARI infants mortality	0.00	24.00	24.00	24.00	24.00	24.00	24.00	144.00	0.00	144.00
- Surveys antibiotic resistance	0.00	30.00	30.00	30.00	30.00	30.00	30.00	180.00	0.00	180.00
- Short Term Technical Assistance	0.00	40.00	20.00	0.00	0.00	0.00	0.00	60.00	60.00	0.00
c) Breast Feeding/Weaning/Growth Monitoring	0.00	84.00	74.00	50.00	35.00	35.00	35.00	313.00	283.00	30.00
- Equipment & Materials	0.00	44.00	44.00	50.00	35.00	35.00	35.00	243.00	243.00	0.00
- Operational Research	0.00	20.00	10.00	0.00	0.00	0.00	0.00	30.00	0.00	30.00
- Short Term Technical Assistance	0.00	20.00	20.00	0.00	0.00	0.00	0.00	40.00	40.00	0.00
d) Vaccine Preventable Diseases	0.00	185.00	170.00	145.00	145.00	133.00	170.00	948.00	880.00	68.00
- Cold Chain Equipment	0.00	78.00	83.00	78.00	78.00	78.00	115.00	510.00	510.00	0.00
- Materials & Supplies (TT)	0.00	55.00	55.00	55.00	55.00	55.00	55.00	330.00	330.00	0.00
- Operational Research	0.00	12.00	12.00	12.00	12.00	0.00	0.00	48.00	0.00	48.00
- Models and systems Design	0.00	20.00	0.00	0.00	0.00	0.00	0.00	20.00	0.00	20.00
- Vaccine potency testing	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Short Term Technical Assistance	0.00	20.00	20.00	0.00	0.00	0.00	0.00	40.00	40.00	0.00
e) Acute Diarrheal Diseases	0.00	147.00	107.00	75.00	75.00	75.00	0.00	479.00	455.00	24.00
- Materials & Supplies (ORS)	0.00	75.00	75.00	75.00	75.00	75.00	0.00	375.00	375.00	0.00
- Operational Research	0.00	12.00	12.00	0.00	0.00	0.00	0.00	24.00	[illegible] 00	24.00
- Short Term Technical Assistance	0.00	60.00	20.00	0.00	0.00	0.00	0.00	80.00	80.00	0.00
2. Clinical Training	0.00	776.00	732.00	921.00	851.00	871.00	771.00	4,922.00	30.00	4,892.00
a) MPH - including FP	0.00	360.00	316.00	505.00	435.00	455.00	365.00	2,456.00	30.00	2,426.00
* Subcontract	0.00	260.00	260.00	280.00	280.00	300.00	230.00	1,610.00	0.00	1,610.00
* Institutional	0.00	100.00	56.00	155.00	85.00	85.00	85.00	566.00	30.00	536.00
- Training of Trainers overseas	0.00	30.00	0.00	0.00	0.00	0.00	0.00	30.00	30.00	0.00
- Pilot clinical management	0.00	10.00	0.00	0.00	0.00	0.00	0.00	10.00	0.00	10.00
- Pilot replica training	0.00	60.00	0.00	0.00	0.00	0.00	0.00	60.00	0.00	60.00
- Training of Trainers	0.00	0.00	56.00	70.00	0.00	0.00	0.00	126.00	0.00	126.00
- Model hospitals	0.00	0.00	0.00	85.00	85.00	85.00	85.00	340.00	0.00	340.00
* Community	0.00	0.00	0.00	70.00	70.00	70.00	70.00	280.00	0.00	280.00
- Health Promotor	0.00	0.00	0.00	38.00	38.00	38.00	38.00	152.00	0.00	152.00
- Traditional Birth Attendance	0.00	0.00	0.00	32.00	32.00	32.00	32.00	128.00	0.00	128.00
b) ARI/DDC	0.00	280.00	280.00	280.00	280.00	280.00	250.00	1,650.00	0.00	1,650.00
* Subcontract	0.00	144.00	144.00	144.00	144.00	144.00	114.00	834.00	0.00	834.00
* Training (Institutional)	0.00	98.00	98.00	98.00	98.00	98.00	98.00	588.00	0.00	588.00
- Model hospitals	0.00	98.00	98.00	98.00	98.00	98.00	98.00	588.00	0.00	588.00
* Training (Community)	0.00	38.00	38.00	38.00	38.00	38.00	38.00	228.00	0.00	228.00
- Health Promotor	0.00	38.00	38.00	38.00	38.00	38.00	38.00	228.00	0.00	228.00
c) EBF/W/GM - I	0.00	136.00	136.00	136.00	136.00	136.00	136.00	816.00	0.00	816.00
* Training (Institutional)	0.00	98.00	98.00	98.00	98.00	98.00	98.00	588.00	0.00	588.00
- Model hospitals	0.00	98.00	98.00	98.00	98.00	98.00	98.00	588.00	0.00	588.00
* Training (Community)	0.00	38.00	38.00	38.00	38.00	38.00	38.00	228.00	0.00	228.00
- Health Promotor	0.00	38.00	38.00	38.00	38.00	38.00	38.00	228.00	0.00	228.00

154

154

(AIDMOHLWK1)

ESTIMATE DETAILED AID PROJECT BUDGET BY PROJECT COMPONENT, LINE ITEM AND PROJECT YEAR

(US $'000)

CATEGORY/line item	PY 1 1994	PY 2 1995	PY 3 1996	PY 4 1997	PY 5 1998	PY 6 1999	PY 7 2000	TOTAL	FX	LC
3. Information, Education, and Communications	0.00	577.00	502.00	477.00	371.00	371.00	21.00	2,319.00	1,049.00	1,270.00
- Equipment & Materials	0.00	7.00	32.00	7.00	1.00	1.00	1.00	49.00	49.00	0.00
- KAP/ etnographic studies	0.00	100.00	100.00	100.00	0.00	0.00	0.00	300.00	0.00	300.00
- National-level mass-media campaign	0.00	200.00	200.00	200.00	200.00	200.00	0.00	1,000.00	1,000.00	0.00
- Local-level mass-media campaign	0.00	150.00	150.00	150.00	150.00	150.00	0.00	750.00	0.00	750.00
- National-Seminars	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Regional-Seminars	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Training materials & manuals	0.00	100.00	0.00	0.00	0.00	0.00	0.00	100.00	0.00	100.00
- Educational bulletins	0.00	20.00	20.00	20.00	20.00	20.00	20.00	120.00	0.00	120.00
a) Maternal-Perinatal Health including FP	0.00	154.00	134.00	134.00	134.00	134.00	4.00	694.00	500.00	194.00
- National-level mass-media campaign	0.00	100.00	100.00	100.00	100.00	100.00	0.00	500.00	500.00	0.00
- Local-level mass-media campaign	0.00	30.00	30.00	30.00	30.00	30.00	0.00	150.00	0.00	150.00
- National-Seminars	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Regional-Seminars	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Training materials & manuals	0.00	20.00	0.00	0.00	0.00	0.00	0.00	20.00	0.00	20.00
- Educational bulletins	0.00	4.00	4.00	4.00	4.00	4.00	4.00	24.00	0.00	24.00
b) Acute Respiratory Infections	0.00	154.00	134.00	134.00	134.00	134.00	4.00	694.00	500.00	194.00
- National-level mass-media campaign	0.00	100.00	100.00	100.00	100.00	100.00	0.00	500.00	500.00	0.00
- Local-level mass-media campaign	0.00	30.00	30.00	30.00	30.00	30.00	0.00	150.00	0.00	150.00
- National-Seminars	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Regional-Seminars	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Training materials & manuals	0.00	20.00	0.00	0.00	0.00	0.00	0.00	20.00	0.00	20.00
- Educational bulletins	0.00	4.00	4.00	4.00	4.00	4.00	4.00	24.00	0.00	24.00
c) Breast Feeding/Weaning/Growth Monitoring	0.00	54.00	34.00	34.00	34.00	34.00	4.00	194.00	0.00	194.00
- National-level mass-media campaign	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Local-level mass-media campaign	0.00	30.00	30.00	30.00	30.00	30.00	0.00	150.00	0.00	150.00
- National-Seminars	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Regional-Seminars	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Training materials & manuals	0.00	20.00	0.00	0.00	0.00	0.00	0.00	20.00	0.00	20.00
- Educational bulletins	0.00	4.00	4.00	4.00	4.00	4.00	4.00	24.00	0.00	24.00
d) Vaccine Preventable Diseases	0.00	54.00	34.00	34.00	34.00	34.00	4.00	194.00	0.00	194.00
- National-level mass-media campaign	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Local-level mass-media campaign	0.00	30.00	30.00	30.00	30.00	30.00	0.00	150.00	0.00	150.00
- National-Seminars	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Regional-Seminars	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Training materials & manuals	0.00	20.00	0.00	0.00	0.00	0.00	0.00	20.00	0.00	20.00
- Educational bulletins	0.00	4.00	4.00	4.00	4.00	4.00	4.00	24.00	0.00	24.00
e) Acute Diarrheal Diseases	0.00	54.00	34.00	34.00	34.00	34.00	4.00	194.00	0.00	194.00
- National-level mass-media campaign	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Local-level mass-media campaign	0.00	30.00	30.00	30.00	30.00	30.00	0.00	150.00	0.00	150.00
- National-Seminars	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Regional-Seminars	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Training materials & manuals	0.00	20.00	0.00	0.00	0.00	0.00	0.00	20.00	0.00	20.00
- Educational bulletins	0.00	4.00	4.00	4.00	4.00	4.00	4.00	24.00	0.00	24.00
4.Support System	0.00	522.00	358.00	318.00	244.00	132.00	82.00	1,656.00	632.00	1,024.00
a) Information and Managment System	0.00	154.00	94.00	94.00	114.00	2.00	2.00	460.00	90.00	370.00
- Equipment & Materials	0.00	14.00	14.00	14.00	4.00	2.00	2.00	50.00	50.00	0.00
- Short Term Technical Assistance	0.00	40.00	0.00	0.00	0.00	0.00	0.00	40.00	40.00	0.00
- Training	0.00	80.00	80.00	80.00	80.00	0.00	0.00	320.00	0.00	320.00
- Training materials & manuals	0.00	20.00	0.00	0.00	30.00	0.00	0.00	50.00	0.00	50.00
b) Supervisory System	0.00	168.00	118.00	94.00	0.00	0.00	0.00	380.00	292.00	88.00
- Vehicles	0.00	84.00	84.00	84.00	0.00	0.00	0.00	252.00	252.00	0.00
- Travel/per diem	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Training	0.00	24.00	24.00	0.00	0.00	0.00	0.00	48.00	0.00	48.00
- Follow-up	0.00	20.00	10.00	10.00	0.00	0.00	0.00	40.00	0.00	40.00
- Short Term Technical Assistance	0.00	40.00	0.00	0.00	0.00	0.00	0.00	40.00	40.00	0.00
c) Logistic System	0.00	200.00	146.00	130.00	130.00	130.00	80.00	816.00	250.00	566.00
- Equipment & Materials	0.00	46.00	44.00	40.00	40.00	40.00	0.00	210.00	210.00	0.00
- Warehouse Renovation	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- NGO distribution contract	0.00	50.00	50.00	50.00	50.00	50.00	50.00	300.00	0.00	300.00
- SILOMED Replication	0.00	30.00	30.00	30.00	30.00	30.00	30.00	180.00	0.00	180.00
- Training	0.00	24.00	12.00	0.00	0.00	0.00	0.00	36.00	0.00	36.00
- Follow-up	0.00	10.00	10.00	10.00	10.00	10.00	0.00	50.00	0.00	50.00
- Short Term Technical Assistance	0.00	40.00	0.00	0.00	0.00	0.00	0.00	40.00	40.00	0.00
d) Infrastructure Repair	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Basic Maintenance Materials	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

135

(AIDMOHLWE1)

ESTIMATE DETAILED AID PROJECT BUDGET BY PROJECT COMPONENT, LINE ITEM AND PROJECT YEAR

(US $'000)

CATEGORY/line item	PY 1 1994	PY 2 1995	PY 3 1996	PY 4 1997	PY 5 1998	PY 6 1999	PY 7 2000	TOTAL	FX	LC
B. Initiative for Efficient Management	0.00	900.00	960.00	520.00	400.00	220.00	70.00	3,080.00	2,050.00	1,030.00
a) Cost-Based Programming and Budgeting	0.00	320.00	290.00	10.00	10.00	10.00	10.00	650.00	560.00	90.00
- Training	0.00	30.00	0.00	0.00	0.00	0.00	0.00	30.00	0.00	30.00
- Follow-up	0.00	10.00	10.00	10.00	10.00	10.00	10.00	60.00	0.00	60.00
- Short Term Technical Assistance	0.00	280.00	280.00	0.00	0.00	0.00	0.00	560.00	560.00	0.00
b) Decentralized Management Improvement Model	0.00	90.00	70.00	10.00	10.00	0.00	0.00	180.00	120.00	60.00
- Training	0.00	20.00	0.00	0.00	0.00	0.00	0.00	20.00	0.00	20.00
- Follow-up	0.00	10.00	10.00	10.00	10.00	0.00	0.00	40.00	0.00	40.00
- Short Term Technical Assistance	0.00	60.00	60.00	0.00	0.00	0.00	0.00	120.00	120.00	0.00
c) Total Quality Management Model	0.00	150.00	110.00	10.00	10.00	0.00	0.00	280.00	200.00	80.00
- Training	0.00	20.00	0.00	0.00	0.00	0.00	0.00	20.00	0.00	20.00
- Training materials & manuals	0.00	20.00	0.00	0.00	0.00	0.00	0.00	20.00	0.00	20.00
- Follow-up	0.00	10.00	10.00	10.00	10.00	0.00	0.00	40.00	0.00	40.00
- Short Term Technical Assistance	0.00	100.00	100.00	0.00	0.00	0.00	0.00	200.00	200.00	0.00
d) Coordination and Evaluation Meetings	0.00	60.00	60.00	60.00	60.00	60.00	60.00	360.00	0.00	360.00
e) Management training	0.00	280.00	430.00	430.00	310.00	160.00	0.00	1,610.00	1,170.00	440.00
- Out-of-Country Long Term Training (15)	0.00	120.00	240.00	240.00	120.00	0.00	0.00	720.00	720.00	0.00
- Out-of-Country Short Term Training (50)	0.00	90.00	90.00	90.00	90.00	90.00	0.00	450.00	450.00	0.00
- In-Service Training (42)	0.00	70.00	100.00	100.00	100.00	70.00	0.00	440.00	0.00	440.00
C. Health Care Financing	325.00	220.00	180.00	180.00	180.00	0.00	0.00	1,085.00	485.00	600.00
a) Resource mobilization	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
b) Cost Recovery	325.00	220.00	180.00	180.00	180.00	0.00	0.00	1,085.00	485.00	600.00
- Demand Study	325.00	0.00	0.00	0.00	0.00	0.00	0.00	325.00	325.00	0.00
- Development of MOH Fee Structure	0.00	100.00	0.00	0.00	0.00	0.00	0.00	100.00	100.00	0.00
- Evaluation/operational research	0.00	120.00	180.00	180.00	180.00	0.00	0.00	660.00	60.00	600.00
D. Project Administration Support	277.00	1,740.00	2,018.00	1,956.00	2,128.00	1,882.00	1,763.00	11,764.00	10,504.00	1,260.00
a) Institutional Contractor	207.00	1,516.00	1,691.00	1,725.00	1,793.00	1,643.00	1,419.00	9,994.00	9,994.00	0.00
- Personnel	207.00	1,061.00	1,429.00	1,454.00	1,512.00	1,352.00	1,185.00	8,200.00	8,200.00	0.00
- Office Support Cost	0.00	455.00	262.00	271.00	281.00	291.00	234.00	1,794.00	1,794.00	0.00
b) AID management support	70.00	174.00	177.00	181.00	185.00	189.00	194.00	1,170.00	0.00	1,170.00
c) Evaluations	0.00	0.00	100.00	0.00	100.00	0.00	100.00	300.00	300.00	0.00
d) Financial Review	0.00	15.00	15.00	15.00	15.00	15.00	15.00	90.00	0.00	90.00
e) Financial Audits	0.00	35.00	35.00	35.00	35.00	35.00	35.00	210.00	210.00	0.00
f) Operating Costs MOH	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
GRAND TOTAL:	602.00	6,123.00	5,733.00	5,209.00	4,066.00	4,176.00	3,291.00	30,000.00	18,751.00	11,249.00

17

(AIDMOH:WK1)

ESTIMATE DETAILED MOH PROJECT BUDGET BY PROJECT COMPONENT, LINE ITEM AND PROJECT YEAR

(US $'000)

CATEGORY/line item	PY 1 1994	PY 2 1995	PY 3 1996	PY 4 1997	PY 5 1998	PY 6 1999	PY 7 2000	TOTAL	PL-480	GOP
A) Strengthening M&CH Health programs	916.00	2,092.00	2,092.00	2,822.00	2,057.00	2,057.00	2,057.00	15,693.00	15,693.00	0.00
1. Priority Health Programs	360.00	590.00	590.00	590.00	590.00	590.00	590.00	3,900.00	3,900.00	0.00
a) Maternal-Perinatal Health including FP	150.00	250.00	250.00	250.00	250.00	250.00	250.00	1,650.00	1,650.00	0.00
(1) Prenatal Care	60.00	160.00	160.00	160.00	160.00	160.00	160.00	1,020.00	1,020.00	0.00
- Equipment & Materials	20.00	20.00	20.00	20.00	20.00	20.00	20.00	140.00	140.00	0.00
- Pharmaceuticals	0.00	100.00	100.00	100.00	100.00	100.00	100.00	600.00	600.00	0.00
- Microntrients	40.00	40.00	40.00	40.00	40.00	40.00	40.00	280.00	280.00	0.00
- Operational Research	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
(2) Birth-Related Health	70.00	70.00	70.00	70.00	70.00	70.00	70.00	490.00	490.00	0.00
- Equipment & Materials	20.00	20.00	20.00	20.00	20.00	20.00	20.00	140.00	140.00	0.00
- Operational Research	50.00	50.00	50.00	50.00	50.00	50.00	50.00	350.00	350.00	0.00
- Surveillance Maternal/perinatal Deaths	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Surveys maternal/perinatal mortality	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Short Term Technical Assistance	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
(3) Family Planning	20.00	20.00	20.00	20.00	20.00	20.00	20.00	140.00	140.00	0.00
- Equipment & Materials	20.00	20.00	20.00	20.00	20.00	20.00	20.00	140.00	140.00	0.00
b) Acute Respiratory Infections	65.00	175.00	175.00	175.00	175.00	175.00	175.00	1,115.00	1,115.00	0.00
- Equipment & Materials	15.00	25.00	25.00	25.00	25.00	25.00	25.00	165.00	165.00	0.00
- Pharmaceuticals and microntrients	50.00	150.00	150.00	150.00	150.00	150.00	150.00	950.00	950.00	0.00
- Operational Research	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Surveillance ARI infants mortality	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Surveys antibiotic resistance	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Short Term Technical Assistance	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
c) Breast Feeding/Weaning/Growth Monitoring	15.00	25.00	25.00	25.00	25.00	25.00	25.00	165.00	165.00	0.00
- Equipment & Materials	15.00	25.00	25.00	25.00	25.00	25.00	25.00	165.00	165.00	0.00
- Operational Research	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Short Term Technical Assistance	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
d) Vaccine Preventable Diseases	55.00	65.00	65.00	65.00	65.00	65.00	65.00	445.00	445.00	0.00
- Cold Chain Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Materials & Supplies (TT)	15.00	25.00	25.00	25.00	25.00	25.00	25.00	165.00	165.00	0.00
- Operational Research	20.00	20.00	20.00	20.00	20.00	20.00	20.00	140.00	140.00	0.00
- Models and systems Design	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Vaccine potency testing	20.00	20.00	20.00	20.00	20.00	20.00	20.00	140.00	140.00	0.00
- Short Term Technical Assistance	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
e) Acute Diarrheal Diseases	75.00	75.00	75.00	75.00	75.00	75.00	75.00	525.00	525.00	0.00
- Materials & Supplies (ORS)	75.00	75.00	75.00	75.00	75.00	75.00	75.00	525.00	525.00	0.00
- Operational Research	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Short Term Technical Assistance	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2. Clinical Training	215.00	215.00	215.00	215.00	215.00	215.00	215.00	1,505.00	1,505.00	0.00
a) MPH - including FP	55.00	55.00	55.00	55.00	55.00	55.00	55.00	385.00	385.00	0.00
* Subcontract	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
* Institutional	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Training of Trainers overseas	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Pilot clinical management	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Pilot replica training	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Training of Trainers	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Model hospitals	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
* Community	55.00	55.00	55.00	55.00	55.00	55.00	55.00	385.00	385.00	0.00
- Health Promotor	35.00	35.00	35.00	35.00	35.00	35.00	35.00	245.00	245.00	0.00
- Traditional Birth Attendance	20.00	20.00	20.00	20.00	20.00	20.00	20.00	140.00	140.00	0.00
b) ARI/DDC	70.00	70.00	70.00	70.00	70.00	70.00	70.00	490.00	490.00	0.00
* Subcontract	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
* Training (Institutional)	0.00	0.00	0.00	30.00	30.00	30.00	30.00	120.00	120.00	0.00
- Model hospitals	0.00	0.00	0.00	30.00	30.00	30.00	30.00	120.00	120.00	0.00
* Training (Community)	70.00	70.00	70.00	40.00	40.00	40.00	40.00	370.00	370.00	0.00
- Health Promotor	70.00	70.00	70.00	40.00	40.00	40.00	40.00	370.00	370.00	0.00
c) EBF/W/GM - I	90.00	90.00	90.00	90.00	90.00	90.00	90.00	630.00	630.00	0.00
* Training (Institutional)	0.00	0.00	0.00	50.00	50.00	50.00	50.00	200.00	200.00	0.00
- Model hospitals	0.00	0.00	0.00	50.00	50.00	50.00	50.00	200.00	200.00	0.00
* Training (Community)	90.00	90.00	90.00	40.00	40.00	40.00	40.00	430.00	430.00	0.00
- Health Promotor	90.00	90.00	90.00	40.00	40.00	40.00	40.00	430.00	430.00	0.00

157

ESTIMATE DETAILED MOH PROJECT BUDGET BY PROJECT COMPONENT, LINE ITEM AND PROJECT YEAR

(US $'000)

CATEGORY/line item	PY 1 1994	PY 2 1995	PY 3 1996	PY 4 1997	PY 5 1998	PY 6 1999	PY 7 2000	TOTAL	PL-480	GOP
3. Information, Education, and Communications	341.00	966.00	916.00	916.00	866.00	866.00	866.00	5,737.00	5,737.00	0.00
- Equipment & Materials	50.00	50.00	50.00	50.00	0.00	0.00	0.00	200.00	200.00	0.00
- KAP/ etnographic studies	0.00	50.00	0.00	0.00	0.00	0.00	0.00	50.00	50.00	0.00
- National-level mass-media campaign	0.00	400.00	400.00	400.00	400.00	400.00	400.00	2,400.00	2,400.00	0.00
- Local-level mass-media campaign	100.00	250.00	250.00	250.00	250.00	250.00	250.00	1,600.00	1,600.00	0.00
- National-Seminars	100.00	0.00	0.00	0.00	0.00	0.00	0.00	100.00	100.00	0.00
- Regional-Seminars	0.00	100.00	100.00	100.00	100.00	100.00	100.00	600.00	600.00	0.00
- Training materials & manuals	75.00	100.00	100.00	100.00	100.00	100.00	100.00	675.00	675.00	0.00
- Educational bulletins	16.00	16.00	16.00	16.00	16.00	16.00	16.00	112.00	112.00	0.00
a) Maternal-Perinatal Health including FP	58.00	193.00	193.00	193.00	193.00	193.00	193.00	1,216.00	1,216.00	0.00
- National-level mass-media campaign	0.00	100.00	100.00	100.00	100.00	100.00	100.00	600.00	600.00	0.00
- Local-level mass-media campaign	20.00	50.00	50.00	50.00	50.00	50.00	50.00	320.00	320.00	0.00
- National-Seminars	20.00	0.00	0.00	0.00	0.00	0.00	0.00	20.00	20.00	0.00
- Regional-Seminars	0.00	20.00	20.00	20.00	20.00	20.00	20.00	120.00	120.00	0.00
- Training materials & manuals	15.00	20.00	20.00	20.00	20.00	20.00	20.00	135.00	135.00	0.00
- Educational bulletins	3.00	3.00	3.00	3.00	3.00	3.00	3.00	21.00	21.00	0.00
b) Acute Respiratory Infections	58.00	193.00	193.00	193.00	193.00	193.00	193.00	1,216.00	1,216.00	0.00
- National-level mass-media campaign	0.00	100.00	100.00	100.00	100.00	100.00	100.00	600.00	600.00	0.00
- Local-level mass-media campaign	20.00	50.00	50.00	50.00	50.00	50.00	50.00	320.00	320.00	0.00
- National-Seminars	20.00	0.00	0.00	0.00	0.00	0.00	0.00	20.00	20.00	0.00
- Regional-Seminars	0.00	20.00	20.00	20.00	20.00	20.00	20.00	120.00	120.00	0.00
- Training materials & manuals	15.00	20.00	20.00	20.00	20.00	20.00	20.00	135.00	135.00	0.00
- Educational bulletins	3.00	3.00	3.00	3.00	3.00	3.00	3.00	21.00	21.00	0.00
c) Breast Feeding/Weaning/Growth Monitoring	58.00	193.00	193.00	193.00	193.00	193.00	193.00	1,216.00	1,216.00	0.00
- National-level mass-media campaign	0.00	100.00	100.00	100.00	100.00	100.00	100.00	600.00	600.00	0.00
- Local-level mass-media campaign	20.00	50.00	50.00	50.00	50.00	50.00	50.00	320.00	320.00	0.00
- National-Seminars	20.00	0.00	0.00	0.00	0.00	0.00	0.00	20.00	20.00	0.00
- Regional-Seminars	0.00	20.00	20.00	20.00	20.00	20.00	20.00	120.00	120.00	0.00
- Training materials & manuals	15.00	20.00	20.00	20.00	20.00	20.00	20.00	135.00	135.00	0.00
- Educational bulletins	3.00	3.00	3.00	3.00	3.00	3.00	2.00	21.00	21.00	0.00
d) Vaccine Preventable Diseases	59.00	144.00	144.00	144.00	144.00	144.00	144.00	923.00	923.00	0.00
- National-level mass-media campaign	0.00	50.00	50.00	50.00	50.00	50.00	50.00	300.00	300.00	0.00
- Local-level mass-media campaign	20.00	50.00	50.00	50.00	50.00	50.00	50.00	320.00	320.00	0.00
- National-Seminars	20.00	0.00	0.00	0.00	0.00	0.00	0.00	20.00	20.00	0.00
- Regional-Seminars	0.00	20.00	20.00	20.00	20.00	20.00	20.00	120.00	120.00	0.00
- Training materials & manuals	15.00	20.00	20.00	20.00	20.00	20.00	20.00	135.00	135.00	0.00
- Educational bulletins	4.00	4.00	4.00	4.00	4.00	4.00	4.00	28.00	28.00	0.00
e) Acute Diarrheal Diseases	58.00	143.00	143.00	143.00	143.00	143.00	143.00	916.00	916.00	0.00
- National-level mass-media campaign	0.00	50.00	50.00	50.00	50.00	50.00	50.00	300.00	300.00	0.00
- Local-level mass-media campaign	20.00	50.00	50.00	50.00	50.00	50.00	50.00	320.00	320.00	0.00
- National-Seminars	20.00	0.00	0.00	0.00	0.00	0.00	0.00	20.00	20.00	0.00
- Regional-Seminars	0.00	20.00	20.00	20.00	20.00	20.00	20.00	120.00	120.00	0.00
- Training materials & manuals	15.00	20.00	20.00	20.00	20.00	20.00	20.00	135.00	135.00	0.00
- Educational bulletins	3.00	3.00	3.00	3.00	3.00	3.00	3.00	21.00	21.00	0.00
4.Support System	0.00	1,121.00	1,171.00	1,101.00	386.00	386.00	386.00	4,551.00	4,551.00	0.00
a) Information and Management System	0.00	140.00	140.00	120.00	80.00	80.00	80.00	640.00	640.00	0.00
- Equipment & Materials	0.00	40.00	40.00	40.00	0.00	0.00	0.00	120.00	120.00	0.00
- Short Term Technical Assistance	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Training	0.00	80.00	80.00	80.00	80.00	80.00	80.00	480.00	480.00	0.00
- Training materials & manuals	0.00	20.00	20.00	0.00	0.00	0.00	0.00	40.00	40.00	0.00
b) Supervisory System	0.00	585.00	585.00	585.00	110.00	110.00	110.00	2,085.00	2,085.00	0.00
- Vehicles	0.00	425.00	425.00	425.00	0.00	0.00	0.00	1,275.00	1,275.00	0.00
- Travel/per diem	0.00	100.00	100.00	100.00	100.00	100.00	100.00	600.00	600.00	0.00
- Training	0.00	50.00	50.00	50.00	0.00	0.00	0.00	150.00	150.00	0.00
- Follow-up	0.00	10.00	10.00	10.00	10.00	10.00	10.00	60.00	60.00	0.00
- Short Term Technical Assistance	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
c) Logistic System	0.00	260.00	310.00	260.00	60.00	60.00	60.00	1,010.00	1,010.00	0.00
- Equipment & Materials	0.00	50.00	0.00	0.00	0.00	0.00	0.00	50.00	50.00	0.00
- Warehouse Renovation	0.00	100.00	200.00	200.00	0.00	0.00	0.00	500.00	500.00	0.00
- NGO distribution contract	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- SILOMED Replication	0.00	50.00	50.00	0.00	0.00	0.00	0.00	100.00	100.00	0.00
- Training	0.00	50.00	50.00	50.00	50.00	50.00	50.00	300.00	300.00	0.00
- Follow-up	0.00	10.00	10.00	10.00	10.00	10.00	10.00	60.00	60.00	0.00
- Short Term Technical Assistance	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
d) Infrastructure Repair	0.00	136.00	136.00	136.00	136.00	136.00	136.00	816.00	816.00	0.00
- Basic Maintenance Materials	0.00	136.00	136.00	136.00	136.00	136.00	136.00	816.00	816.00	0.00

158

(AIDMOH'.WK1)

ESTIMATE DETAILED MOH PROJECT BUDGET BY PROJECT COMPONENT, LINE ITEM AND PROJECT YEAR

(US $'000)

CATEGORY/line item	PY 1 1994	PY 2 1995	PY 3 1996	PY 4 1997	PY 5 1998	PY 6 1999	PY 7 2000	TOTAL	PL-480	GOP
B. Initiative for Efficient Management	42.00	64.00	64.00	64.00	64.00	40.00	40.00	378.00	378.00	0.00
a) Cost-Based Programming and Budgeting	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Training	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Follow-up	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Short Term Technical Assistance	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
b) Decentralized Management Improvement Model	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Training	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Follow-up	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Short Term Technical Assistance	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
c) Total Quality Management Model	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Training	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Training materials & manuals	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Follow-up	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Short Term Technical Assistance	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
d) Coordination and Evaluation Meetings	12.00	24.00	24.00	24.00	24.00	0.00	0.00	108.00	108.00	0.00
e) Management training	30.00	40.00	40.00	40.00	40.00	40.00	40.00	270.00	270.00	0.00
- Out-of-Country Long Term Training (15)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Out-of-Country Short Term Training (50)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- In-Service Training (42)	30.00	40.00	40.00	40.00	40.00	40.00	40.00	270.00	270.00	0.00
C. Health Care Financing	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
a) Resource mobilization	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
b) Cost Recovery	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Demand Study	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Development of MOH Fee Structure	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Evaluation/operational research	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
D. Project Administration Support	1,722.00	1,804.00	1,890.00	1,981.00	2,076.00	2,176.00	2,280.00	13,929.00	5,929.00	8,000.00
a) Institutional Contractor	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Personnel	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- Office Support Cost	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
b) AID management support	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
c) Evaluations	50.00	50.00	50.00	50.00	50.00	50.00	50.00	350.00	350.00	0.00
d) Financial Reviews	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
e) Financial Audits	30.00	30.00	30.00	30.00	30.00	30.00	30.00	210.00	210.00	0.00
f) Operating Costs MOH	1,642.00	1,724.00	1,810.00	1,901.00	1,996.00	2,096.00	2,200.00	13,369.00	5,369.00	8,000.00
TOTAL:	2,600.00	4,760.00	4,846.00	4,867.00	4,197.00	4,273.00	4,377.00	30,000.00	22,000.00	8,000.00

159

Annex 4

Waiver to Fully Fund International Travel Costs for Participant Training

Annex 4

Waiver No. FY93-007-527-0366

USAID

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

ACTION MEMORANDUM FOR THE MISSION DIRECTOR

September 14, 1993

FROM: Susan Brems, Acting Chief, Office of Health, Population and Nutrition

SUBJECT: Waiver to Fully Fund International Travel Costs for Participant Training in Project 2000

Action:

The Mission Director is requested to waive the requirement that the host government fully fund international participant travel, thereby allowing resources authorized under Project 2000 to be applied for these purposes.

General Project Overview:

Project 2000 is designed to support the MoH in its efforts to improve the quality and efficiency of its primary health care services, particularly those that target the most vulnerable populations -- women and young children. The goal of the Project is to improve the health and nutrition status of young children and women of childbearing age. The purpose of the Project is to increase the use of child survival and maternal health interventions.

To achieve its goal and purpose, the Project takes a three pronged approach by: (1) providing support directly to child survival and maternal health programs, (2) enhancing the efficiency of those programs through improved management, and (3) supporting the sustainability of those programs through reformed health financing. The majority of Project activities and funding focus on the first component, which provides immediate support to priority health and nutrition programs and is expected to result in a visible reduction in infant and maternal deaths, as well as improvements in the quality of survivorship. The other two components are enabling ones that contribute to the long-term viability of child and maternal health efforts and help ensure the future of those services. Among other activities, they call for out-of-country training in health administration, as a way of institutionalizing expertise in this area.

expertise in this area.

Discussion:

During recent decades, Peru has experienced much destabilizing political turbulence and socio-economic crisis. To promote stability, President Fujimori, elected in 1990, recognized the need for austerity measures in the economy and counter-terrorism to ensure public safety. The achievements of these measures have been notable. Counter-terrorist activities succeeded in capturing Sendero Luminoso's leader, dealing a devastating blow to this movement; Peru has successfully re-entered the international financial community, making it possible to obtain vital loans and payments; and inflation, which reached an all-time high of 3,000 percent in 1990, has diminished markedly, standing at 53 percent in 1992.

Although these successes are critical to long-term development, many Peruvians are paying a price for these measures, with the poor bearing a disproportionate share of the consequences. Unemployment has increased, food costs are high and government-provided services have been cut substantially.

Throughout the public sector, there is an awareness of the need to address these short and medium-term negative consequences. As part of its response, the GOP has founded FONCODES, a foundation whose mission is to address the most pressing problems in the social sector. FONCODES sponsors health, education and food programs. This "social safety net" is an added expense to an already over-taxed budget, but one that should decline over time as more poor benefit from overall economic stabilization.

This leaves Peru at a critical juncture in the immediate term. It must continue with austerity measures so that sustainable development can be achieved but, at the same time, the worst forms of poverty must also be alleviated. Therefore, while the government recognizes the need for training as an integral part of the development process, it is unable to allocate funds for this activity in the prevailing scenario.

A.I.D. would like to support the government by allowing developmental training to proceed under Project 2000 auspices. The GOP counterpart contribution would still not be inconsequential, consisting of continued salary payments to the trainees, as well as additional salaries for their interim replacements. Further, trainees will pledge continued long-term service to the MoH as part of the selection process, thus guaranteeing that their new expertise will be institutionalized within the MoH.

162

Recommendation:

Under these circumstances, it is recommended that the Mission Director authorize a full waiver of the host government responsibility for the procurement of international and U.S. domestic travel costs related to participant training under Project 2000. Handbook 10, Section 16C, provides the authority for this action. (Pursuant to that Section, the Regional Assistant Administrator for LAC and OIT will be notified if this Waiver is approved by you.)

Approved: _____
George A. Wachtenheim, Mission Director

Disapproved: _____
George A. Wachtenheim, Mission Director

Date: 9/16/93

Clearances:
EXO:LFoley _____ Date 9/14/93
CONT:JSanford _____ Date 9/15/93
TSD:VFerrero _____ Date 9/14/93
PDP:JBoyer _____ Date 9/14/93
RLA:JBorns fax Date 9/14/93
RCO:MStevenson fax Date 9/15/93
DD:DBoyd _____ Date 9/15/93

HPN:JVERNOOY:MVla:07/20/93

Recommendation:

Under these circumstances, it is recommended that the Mission Director authorize a full waiver of the host government responsibility for the procurement of international and U.S. domestic travel costs related to participant training under Project 2000. Handbook 10, Section 16C, provides the authority for this action. (Pursuant to that Section, the Regional Assistant Administrator for LAC and OIT will be notified if this Waiver is approved by you.)

Approved: _____
George A. Wachtenheim, Mission Director

Disapproved: _____
George A. Wachtenheim, Mission Director

Date: _____

Clearances:
EXO:LFoley _____ Date _____
CONT:JSanford _____ Date _____
TSD:VFerrero _____ Date _____
PDP:JBoyer _____ Date _____
RLA:JBorns JB Date 9-14-93
RCO:MStevenson _____ Date _____
DD:DBoyd _____ Date _____

HPN:JVERNOOY:MVm:07/20/93

164

Annex 15

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Annex 15

Bibliography

5. USAID/Peru

Mr. Donald Boyd	Deputy Director
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Mr. Paul Cohn	Chief, Office of Health, Population and Nutrition (as of 9/1/93)
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Dr. Richard Goldman	Chief, Office of Economic Recovery
Dr. Jerre Manarolla	Chief, Office of Economics
Mr. Jeffrey Boyer	Chief, Office of Project Development and Programs
Mr. William Egan	Office of Project Development and Programs
Mr. Paul Kramer	Controller (through 7/13/93)
Mr. James Sanford	Controller (as of 7/14/93)
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Mr. Rafael Sanz	Financial Analyst
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Mr. Gerardo Arabe	Child Survival Project Coordinator
Ms. Karin McFarland	SHIP Pharmaceutical Specialist
Ms. Cecilia Yáñez	Contract Negotiator

6. A.I.D./Washington and A.I.D./Regional

Ms. Carol Dabbs	Health, Population and Nutrition Officer, AID/W (LAC/DR/HPN)
Ms. Barbara Feringa	Michigan Fellow, AID/W (R&D/POP/R)

7. Consultants

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Dr. Laura Altobelli	University Research Corporation
Dr. Jack Fiedler	University Research Corporation
Dr. Jorge Jiménez	University Research Corporation
Dr. Ernesto Miranda	University Research Corporation
Ms. Tonya Himelfarb	Independent Consultant

Annex 14
Contributors to the Project Paper

1. Ministry of Health

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Dr. Jaime Freundt-Thurne	Minister of Health (as of 8/31/93)
Dr. Salomón Zavala	Vice Minister of Health
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Ms. Yadira Jiménez	Office of Investment, Financing and External Cooperation
Dr. Ismael Cornejo	Director, Human Health Care
Dr. Carlos Moreno	Director, Integrated Health Programs
Dra. María Tello	Director, Office of Planning
Ms. Duani Puertas	Director, Office of Communications
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Ing. Mario Choy	Director, DIGEMID
Enf. Myriam Strull	Acting Director, Mother-Child Programs
Lic. Jorge Ruiz	Advisor to the Minister
Dr. Alfonso Villacorta	Director, Maternal-Perinatal Health Component
Dr. Andrés Morán	Director, ARI Component
Dra. Milagros Rojas	Director, Diarrheal Diseases Component
Dr. Andrés Mongrut	Director, Reproductive Health Component
Mr. Héctor Solano	Director of Logistics
Dr. Luis Pro	Director, Subregional Health Unit of North Lima
Dr. Félix Hidalgo	Acting Director, Subregional Health Unit of Cuzco
Dr. Jorge Vargas	Director, Antonio Loreno Hospital (Cuzco)
Dr. Gutiérrez	Chief of Pediatrics, Antonio Loreno Hospital (Cuzco)
Dr. José Lizárraga	Consultant

2. Democratic Constitutional Congress

Dr. Jaime Freundt-Thurne	Chair, Health Commission (through 8/30/93)

3. Pan American Health Organization

Dr. Luis Antonio Loyola	Representative
Dra. Rosa María Cardoso	Consultant
Dr. Víctor Huapaya	Consultant

4. UNICEF

Dr. Juan Aguilar	Representative

Annex 14

Contributors to the Project Paper

3. Other Community-level and Ethnographic-type Research

-- A study on indigenous communication channels between rural communities and urban settlements of rural migrants.

-- An evaluation of radio listening habits of rural populations in target Project areas.

-- An evaluation of the relative influence of the advice of family members, community groups, trained community health workers, health professionals, and various forms of mass media communications on preventive health behaviors and health-care seeking behaviors.

-- Periodic surveys of vaccine potency in health establishments, as a control measure for the cold chain.

-- Investigation into the reasons why many families do not complete their children's entire course of vaccinations.

4. Suggested Studies in Total Quality Management and Financing

-- A study on the demand for health care.

-- An evaluation of costs in a random sample of some 50 health establishments of the MoH.

attitude, time constraints, economic and other logistic constraints.

-- A study of the beliefs and practices of health care providers regarding health and the health care needs of women, including their perception of traditional beliefs and practices regarding pregnancy, childbirth, newborn care, and lactation.

-- Operations research on implementing a strategy of maternity homes in a number of rural villages.

-- Operations research on the best communications methodologies to increase knowledge about risk, danger signs, and obstetric emergencies at the community level.

-- A study of the prevalence of anemia in pregnant women living at high altitudes and in the jungle.

-- Qualitative research on the factors that influence compliance with iron folate supplementation of pregnant women.

-- Qualitative research on the acceptability of other preventive measures during pregnancy, such as immunization with tetanus toxoid vaccine and iodized oil capsules.

-- Operations research on mechanisms to channel supplementary feeding programs to isolated rural areas to benefit pregnant and lactating women.

2. Suggested Studies on Acute Respiratory Infections

-- Surveys and case control studies on infant deaths due to pneumonia, investigating the circumstances surrounding individual deaths.

-- A study on the beliefs and practices of women in rural (and periurban) communities on ARI and pneumonia, including the ability to recognize danger signs, knowledge of when to seek care, and constraints to utilization of the formal health system.

-- A study on the knowledge, attitudes and practices of health personnel working at the primary, secondary, and tertiary levels of care regarding prevention and treatment of ARI and pneumonia.

-- Periodic surveys of antibiotic resistance to ARI in Project areas.

-- Operations research on how to reach women with information regarding prevention of ARI, early home treatment of ARI and recognition of danger signs for immediate seeking of treatment at formal health care outlets.

Annex 13

Suggested Field Studies, Ethnographic Research, and Operations Research

During the first 2-3 years of the Project, studies will be conducted in three target subregions. Results will be used to develop training programs and educational activities, as well as to monitor Project orientation, strategies, and methods.

Following are some suggested topics for which little information is currently available in Peru. There is a particular great lack of knowledge on the health beliefs and behaviors of rural populations in Peru. While a fair amount of research has been done in urban areas on diarrheal diseases and nutrition, these topics have remained largely unresearched in rural areas. Additionally, the subjects of maternal-perinatal health and acute respiratory infections/pneumonia in infants and children are largely unstudied in both urban and rural areas.

1. Suggested Studies on Maternal-Perinatal Health

-- A survey on mortality in women of reproductive age and maternal mortality. This would feature in-depth investigation of the circumstances surrounding individual deaths, with analysis of associated causes and factors.

-- A survey on perinatal mortality in health facilities and in the community. This would feature in-depth investigation of circumstances surrounding individual deaths.

-- A study on the beliefs and practices of women in rural (and periurban) communities and of traditional birth attendants. Such a study would identify and classify beneficial, neutral, and harmful practices related to the prenatal period, home attendance of deliveries, and immediate care of the newborn. This includes such specific topics as nutritional practices during pregnancy, utilization of traditional medicines, management of labor, cutting and care of the umbilical cord following delivery, care and feeding of the newborn in the first hours and days, and management of such common problems and complications during pregnancy and childbirth as nausea and vomiting, bleeding, fever, headaches, swelling of limbs, seizures, prolonged labor, postpartum hemorrhage and fever.

-- A study of the factors governing the utilization of informal and formal health care services for prenatal care, delivery, and postnatal care. This would feature an analysis of existing barriers to utilization, including barriers of knowledge,

Annex 13

Suggested Field Studies, Ethnographic Research and Operations Research

entros de Capacitacion Clinica en Hospitales Modelos (PROCAME)

Item	Costo Unitario (US $)	Years												Total	
		1ero		2do		3er		4to		5to		6to			
		Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo
etropoyector 3M 20 voltios	625	20	12,500.00	20	12,500.00		0.00		0.00		0.00		0.00	40	25,000.00
ampara de repuesto ara retropoyector	41	180	7,380.00	120	4,920.00	120	4,920.00	120	4,920.00	120	4,920.00	120	4,920.00	780	31,980.00
ideograbadora VHS e cuatro cabezas	500	20	10,000.00	20	10,000.00		0.00		0.00		0.00		0.00	40	20,000.00
elevisor a colores 7 pulgadas	938	20	18,760.00	20	18,760.00		0.00		0.00		0.00		0.00	40	37,520.00
antallas Ecran ortatiles con pantalla	338	20	6,760.00	20	6,760.00		0.00		0.00		0.00		0.00	40	13,520.00
ax	1,000	20	20,000.00	20	20,000.00		0.00		0.00		0.00		0.00	40	40,000.00
apel sensible para ax 4 rollos/caja	30	180	5,400.00	120	3,600.00	120	3,600.00	120	3,600.00	120	3,600.00	120	3,600.00	780	23,400.00
izarra 8' x 4'	240	20	4,800.00		0.00		0.00		0.00		0.00		0.00	20	4,800.00
izarra 5' x 3'	150	80	12,000.00	80	12,000.00	80	12,000.00		0.00		0.00		0.00	240	36,000.00
TOTAL			97,600.00		88,540.00		20,520.00		8,520.00		8,520.00		8,520.00		232,220.00

174

nformacion, Educacion y Comunicacion

Item	Costo Unitario (US $)	Years												Total	
		1ero		2do		3er		4to		5to		6to			
		Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo
Camara de video formato 3/4. Tipo 3 CCD	10,000		0.00	1	10,000.00		0.00		0.00		0.00		0.00	1	10,000.00
Gravadora formato 3/4	15,000		0.00	1	15,000.00		0.00		0.00		0.00		0.00	1	15,000.00
Gravadoras para entrevistas	119	3	357.00	3	357.00	3	357.00		0.00		0.00		0.00	9	1,071.00
Megafonos	105	3	315.00	3	315.00	3	315.00		0.00		0.00		0.00	9	945.00
Monitores de Tv 14" C/R	379	3	1,137.00	3	1,137.00	3	1,137.00		0.00		0.00		0.00	9	3,411.00
VHS C/R	450	3	1,350.00	3	1,350.00	3	1,350.00		0.00		0.00		0.00	9	4,050.00
Video casetes VHS	6	100	600.00	100	600.00	100	600.00	100	600.00	100	600.00	100	600.00	600	3,600.00
Radio caseles	2	100	200.00	100	200.00	100	200.00	100	200.00	100	200.00	100	200.00	600	1,200.00
Retroproyectores	850	3	2,550.00	3	2,550.00	3	2,550.00		0.00		0.00		0.00	9	7,650.00
TOTAL			6,509.00		31,509.00		6,509.00		800.00		800.00		800.00		46,927.00

.ogistica

Item	Costo Unitario (US $)	Years												Total	
		1ero		2do		3er		4to		5to		6to			
		Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo
Microcomputadoras	900	5	4,500.00	5	4,500.00	3	2,700.00	3	2,700.00	3	2,700.00		0.00	19	17,100.00
UPS	300	5	1,500.00	5	1,500.00	3	900.00	3	900.00	3	900.00		0.00	19	5,700.00
Impresoras de matriz	500	5	2,500.00	5	2,500.00	3	1,500.00	3	1,500.00	3	1,500.00		0.00	19	9,500.00
Modems	300	5	1,500.00	5	1,500.00	3	900.00	3	900.00	3	900.00		0.00	19	5,700.00
Cajas de disquetes 5 1/2	15	100	1,500.00	50	750.00	50	750.00	50	750.00	50	750.00		0.00	300	4,500.00
Cajas de disquetes 3.5" doble densidad	18	100	1,800.00	50	900.00	50	900.00	50	900.00	50	900.00		0.00	300	5,400.00
Cajas de disquetes 3.5" doble / alta densidad	22	100	2,200.00	50	1,100.00	50	1,100.00	50	1,100.00	50	1,100.00		0.00	300	6,600.00
Mesa para computadora	60	5	300.00	5	300.00	3	180.00	3	180.00	3	180.00		0.00	19	1,140.00
Mesa para impresora	40	5	200.00	5	200.00	3	120.00	3	120.00	3	120.00		0.00	19	760.00
Estantes para la colocacion de insumos	60	500	30,000.00	500	30,000.00	500	30,000.00	500	30,000.00	500	30,000.00		0.00	2,500	150,000.00
TOTAL			46,000.00		43,250.00		39,050.00		39,050.00		39,050.00		0.00		206,400.00

nunizaciones

Item	Costo Unitario (US $)	Years												Total	
		1ero		2do		3er		4to		5to		6to			
		Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo
ringas TT c 22Gx1 1/2	0.110	500,000	55,000.00	500,000	55,000.00	500,000	55,000.00	500,000	55,000.00	500,000	55,000.00	500,000	55,000.00	3,000,000	330,000.00
ongeladores K y E FW-791	1,500.000	15	22,500.00	15	22,500.00	15	22,500.00	15	22,500.00	15	22,500.00	15	22,500.00	90	135,000.00
ongeladores E CW-1151	1,658.762	15	24,881.43	15	24,881.43	15	24,881.43	15	24,881.43	15	24,881.43	15	24,881.43	90	149,288.58
efrigeradoras CW 25	2,500.000	10	25,000.00	10	25,000.00	10	25,000.00	10	25,000.00	10	25,000.00	25	62,500.00	75	187,500.00
apuestos para adena de frio			5,000.00		10,000.00		5,000.00		5,000.00		5,000.00		5,000.00		35,000.00
TOTAL			132,381.43		137,381.43		132,381.43		132,381.43		132,381.43		169,881.43		836,788.58

ecimiento y Desarrollo. Lactancia Materna

Item	Costo Unitario (US $)	Years												Total	
		1ero		2do		3er		4to		5to		6to			
		Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo
alanzas de reloj ara 1 ano	150.000	100	15,000.00	100	15,000.00	150	22,500.00	100	15,000.00	100	15,000.00	100	15,000.00	650	97,500.00
alanzas de piato ara los establecimientos	200.000	50	10,000.00	50	10,000.00	50	10,000.00	50	10,000.00	50	10,000.00	50	10,000.00	300	60,000.00
alanzasde pie para dultos	200.000	50	10,000.00	50	10,000.00	50	10,000.00	50	10,000.00	50	10,000.00	50	10,000.00	300	60,000.00
omba electrica xtractora de leche	500.000	5	2,500.00	5	2,500.00	5	2,500.00		0.00		0.00		0.00	15	7,500.00
efrigeradora EW 16	1,000.000	5	5,000.00	5	5,000.00	5	5,000.00		0.00		0.00		0.00	15	15,000.00
omba manual xtractora de leche	25.000	50	1,250.00	50	1,250.00		0.00		0.00		0.00		0.00	100	2,500.00
TOTAL			43,750.00		43,750.00		50,000.00		35,000.00		35,000.00		35,000.00		242,500.00

76

Control de Enfermedades Diarreicas

Item	Costo Unitario (US $)	Years												Total	
		1ero		2do		3er		4to		5to		6to			
		Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo
SRO	0.300	250,000	75,000.00	250,000	75,000.00	250,000	75,000.00	250,000	75,000.00	250,000	75,000.00		0.00	1,250,000	375,000.00
TOTAL			75,000.00		75,000.00		75,000.00		75,000.00		75,000.00		0.00		375,000.00

nformacion y Gestion

Item	Costo Unitario (US $)	Years												Total	
		1ero		2do		3er		4to		5to		6to			
		Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo
Microcomputadoras	900	5	4,500.00	5	4,500.00	5	4,500.00		0.00		0.00		0.00	15	13,500.00
UPS	300	5	1,500.00	5	1,500.00	5	1,500.00		0.00		0.00		0.00	15	4,500.00
Impresoras de matriz	500	5	2,500.00	5	2,500.00	5	2,500.00		0.00		0.00		0.00	15	7,500.00
Modems	300	5	1,500.00	5	1,500.00	5	1,500.00		0.00		0.00		0.00	15	4,500.00
Cajas de disquetes 5 1/2	15	25	375.00	25	375.00	25	375.00	25	375.00		0.00		0.00	100	1,500.00
Cajas de disquetes 3.5" doble densidad	18	25	450.00	25	450.00	25	450.00	25	450.00		0.00		0.00	100	1,800.00
Cajas de disquetes 3.5" doble / alta densidad	22	25	550.00	25	550.00	25	550.00	25	550.00		0.00		0.00	100	2,200.00
Mesa para computadora	60	5	300.00	5	300.00	5	300.00		0.00		0.00		0.00	15	900.00
Mesa para impresora	40	5	200.00	5	200.00	5	200.00		0.00		0.00		0.00	15	600.00
Papel, cintas, suministros de oficina			2,000.00		2,000.00		2,000.00		2,000.00		2,000.00		2,000.00	0	12,000.00
TOTAL			13,875.00		13,875.00		13,875.00		3,375.00		2,000.00		2,000.00		49,000.00

Supervision

Item	Costo Unitario (US $)	Years												Total	
		1ero		2do		3er		4to		5to		6to			
		Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo
Vehiculos doble cabina doble traccion (Pick-ups	21,000	4	84,000.00	4	84,000.00	3	63,000.00		0.00		0.00		0.00	11	231,000.00
TOTAL			84,000.00		84,000.00		63,000.00		0.00		0.00		0.00		231,000.00

:encion del Embarazo y Parto. Planificacion Familiar

Item	Costo Unitario (US $)	Years												Total	
		1ero		2do		3er		4to		5to		6to			
		Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo
.quipos de insercion del DIU	100	50	5,000.00	50	5,000.00	50	5,000.00		0.00		0.00		0.00	150	15,000.00
:quipos de minilaparatomia	1351.5	10	13,515.00	10	13,515.00	10	13,515.00	10	13,515.00	10	13,515.00	10	13,515.00	60	81,090.00
Maletines para atencion de parto (parteras)	70	100	7,000.00	100	7,000.00	50	3,500.00		0.00		0.00		0.00	250	17,500.00
Vitaminas Prenatales	0.05	1,000,000	50,000.00	1,000,000	50,000.00	1,000,000	50,000.00	500,000	25,000.00	500,000	25,000.00	500,000	25,000.00	4,500,000	225,000.00
Grageas de Hierro y Acido Folico	0.04	1,000,000	40,000.00	1,000,000	40,000.00	1,000,000	40,000.00	500,000	20,000.00	500,000	20,000.00	500,000	20,000.00	4,500,000	180,000.00
Especulos Vaginales	6	500	3,000.00	500	3,000.00	500	3,000.00	500	3,000.00		0.00		0.00	2,000	12,000.00
Balanzas para adulto con tallimetro	80	100	8,000.00	100	8,000.00		0.00		0.00		0.00		0.00	200	16,000.00
Balanzas para el recien nacido (parteras)	30	100	3,000.00	100	3,000.00		0.00		0.00		0.00		0.00	200	6,000.00
Cintas obstetrica CLAP	2	500	1,000.00	250	500.00	250	500.00		0.00		0.00		0.00	1,000	2,000.00
Gestometros de pared	10	200	2,000.00	300	3,000.00	100	1,000.00	100	1,000.00	50	500.00	50	500.00	800	8,000.00
Tensiometro	50	200	10,000.00	300	15,000.00	100	5,000.00	100	5,000.00	50	2,500.00	50	2,500.00	800	40,000.00
Estetoscopios	10	200	2,000.00	300	3,000.00	100	1,000.00	100	1,000.00	50	500.00	50	500.00	800	8,000.00
Fetoscopios	10	200	2,000.00	300	3,000.00	100	1,000.00	100	1,000.00	50	500.00	50	500.00	800	8,000.00
Equipo de parto	80	100	8,000.00	50	4,000.00	50	4,000.00	50	4,000.00	50	4,000.00		0.00	300	24,000.00
TOTAL			154,515.00		158,015.00		127,515.00		73,515.00		66,515.00		62,515.00		642,590.00

Los anticonceptivos seran comprados por fondos centrales. Si esto no ocurriera se deberan hacer ajustes posteriores a los fondos del Proyecto para su adquisicion

ILLUSTRATIVE LIST OF COMMODITIES

Acute Respiratory Infeccions (ARI)

ARTICULO	Costo Unitario (US $)	Years												Total	
		1ero		2do		3er		4to		5to		6to			
		Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo	Cantidad	Costo
Cotrimoxazol frcos de 120 ml	0.8	100,000	80,000.00	100,000	80,000.00	125,000	100,000.00	125,000	100,000.00	125,000	100,000.00	125,000	100,000.00	700,000	560,000.00
Cotrimoxazol tab 100 x 20	0.007	500,000	3,500.00	100,000	700.00	75,000	525.00	75,000	525.00	75,000	525.00	50,000	350.00	875,000	6,125.00
Penicilina Procainica 1 000 000	0.24	50,000	12,000.00	50,000	12,000.00	50,000	12,000.00	50,000	12,000.00	122,000	29,280.00	135,000	32,400.00	457,000	109,680.00
Penicilina Benzatinica 600 000 UI	0.42	60,000	25,200.00	64,000	26,880.00	70,000	29,400.00	77,000	32,340.00	85,000	35,700.00	93,000	39,060.00	449,000	188,580.00
Gentamicina 20 mg	0.11	50,000	5,500.00	50,000	5,500.00	25,000	2,750.00	25,000	2,750.00	25,000	2,750.00	285,000	31,350.00	460,000	50,600.00
Cloxacilina inyectable 500 mg	0.3	9,200	2,760.00	5,300	1,590.00	6,000	1,800.00	6,500	1,950.00	7,000	2,100.00	8,000	2,400.00	42,000	12,600.00
Jeringas de 5 cc con aguja	0.1	50,000	5,000.00	50,000	5,000.00	50,000	5,000.00	50,000	5,000.00	50,000	5,000.00	50,000	5,000.00	300,000	30,000.00
Vitamina A capsulas 200 000 UI c/u	0.02	40,000	800.00	36,000	720.00	39,000	780.00	43,000	860.00	47,000	940.00	52,000	1,040.00	257,000	5,140.00
Salbutamol solucion	2	8,000	16,000.00	7,000	14,000.00	7,000	14,000.00	8,000	16,000.00	10,000	20,000.00	11000	22,000.00	51,000	102,000.00
Cronometros manuales sonoros	4.2	2,000	8,400.00	1,000	4,200.00	1,000	4,200.00	1,000	4,200.00	1,000	4,200.00	1000	4,200.00	7,000	29,400.00
Nebulizadores	150	50	7,500.00	50	7,500.00	50	7,500.00	50	7,500.00		0.00		0.00	200	30,000.00
TOTAL			166,660.00		158,090.00		177,955.00		183,125.00		200,495.00		237,800.00		1,124,125.00

Annex 12

Illustrative List of Commodities

C. CRITERIA APPLICABLE TO ECONOMIC SUPPORT FUNDS ONLY N/A

Clearances: PDP:EVarillas i.d
ECON:JManarolla i.d.
CONT:JMartin i.d.
ORD:CAyala i.d.
EXO/PROC:CYañez i.d.
TSD:VFerrero i.d.

181

of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

c. research into, and evaluation of, economic development processes and techniques;

d. reconstruction after natural or manmade disaster and programs of disaster preparedness;

e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;

f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.

24. Capital Projects (Jobs Through Export Act of 1992, Secs. 303 and 306(d)): If assistance is being provided for a capital project, is the project developmentally sound and will the project measurably alleviate the worst manifestations of poverty or directly promote environmental safety and sustainability at the community level? N/A

20. **Population and Health (FAA Secs. 104(b) and (c)):** If assistance is being made available for population or health activities, describe 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 outreach.	The Project will promote user fees for income learning families to enable the Ministry of Health to more effectively respond to the needs of families without financial resources, while focusing on child survival programs.
22. **Education and Human Resources Development (FAA Sec. 105):** If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.	(See Project Description and Training Plan).
23. **Energy, Private Voluntary Organizations, and Selected Development Activities (FAA Sec. 106):** If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is:	N/A
a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative	

of women's status; and (5) utilize and encourage regional cooperation by developing countries?

19. Agriculture, Rural Development and Nutrition, and Agricultural Research (FAA Secs. 103 and 103A): N/A

a. Rural poor and small farmers: If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made.

b. Nutrition: Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people.

c. Food security: Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

repay the loan at a reasonable rate of interest.

b. **Long-range plans** (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?

c. **Interest rate** (FAA Sec. 122(b)): If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter?

d. **Exports to United States** (FAA Sec. 620(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

18. **Development Objectives** (FAA Secs. 102(a), 111, 113, 281(a)): Extent to which activity will: (1) effectively involve the poor in development, by expanding 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 basis, using the appropriate U.S. institutions; (2) 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; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement

N/A

185

sustainable forestry?

e. **Environmental impact statements**: Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment?

14. **Energy** (FY 1991 Appropriations Act Sec. 533(c)): If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases? **N/A**

15. **Debt-for-Nature Exchange** (FAA Sec. 463): If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management. **N/A**

16. **Deobligation/Reobligation** (FY 1991 Appropriations Act Sec. 515): If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and from countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified? **N/A**

17. **Loans** **N/A**

a. **Repayment capacity** (FAA Sec. 122(b)): Information and conclusion on capacity of the country to

186 rev

donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

c. **Forest degradation:** Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

d. **Sustainable forestry:** If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for

a. **A.I.D. Regulation 16:** Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16?

b. **Conservation:** Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other

awarding of contracts, except where applicable procurement rules allow otherwise?	
11. **Disadvantaged Enterprises** (FY 1991 Appropriations Act Sec. 567): What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?	Requests for proposals will include appropriate language on AID policy on contracting with disadvantaged enterprises as well as Hand Book 10 requirements for participant training aspects. Prime contractors will be instructed to make maximum practical use of such entities and include subcontracting plans in proposals submitted.
12. **Biological Diversity** (FAA Sec. 119(g): Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?	N/A
13. **Tropical Forests** (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c)-(e) & (g)):	N/A

189'

a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?	No
b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?	No
c. Are any of the funds to be made available to any organization or program, which as determined by the President, supports or practices in the management of a program of coercive abortion or involuntary sterilization?	No
d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services?	Yes
e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning?	No
f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?	No
g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization?	No
10. **Contract Awards** (FAA Sec. 601(e)): Will the project utilize competitive selection procedures for the	Yes

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141

6. **Special Development Emphases** (FAA Secs. 102 (b), 113, 281(a)): Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) 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.	The project will support self help efforts of developing countries by promoting user fees for public health services.
7. **Recipient Country Contribution** (FAA Secs. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?	Yes
8. **Benefit to Poor Majority** (FAA Sec. 128(b)): If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?	Yes
9. **Abortions** (FAA Sec. 104(f); FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 535):	

publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?	
2. **Tied Aid Credits** (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund"): Will DA funds be used for tied aid credits?	No
3. **Appropriate Technology** (FAA Sec. 107): Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?	Yes
4. **Indigenous Needs and Resources** (FAA Sec. 281(b)): Describe extent to which the activity 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 civic education and training in skills required for effective participation in government and political processes essential to self-government.	(See Project Description and Training Plan)
5. **Economic Development** (FAA Sec. 101(a)): Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?	N/A

192

39. **Commitment of Funds** (FAA Sec. 635(h): Does a Contract or agreement entail a commitment for the expenditure of funds during a period in excess of 5 years from the date of the contract or agreement?	No
40. **Impact on U.S. Jobs** (FY 1993 Appropriations Act. Sec. 599):	
(a) Will any financial incentive be provided to a business located in the U.S. for the purpose of inducing that business to relocate outside the U.S. in a manner that would likely reduce the number of U.S. employees of that business?	No
(b) Will assistance be provided for the purpose of establishing or developing an export processing zone or designated area in which the country's tax, tariff, labor, environment, and safety laws do not apply? If so, has the President determined and certified that such assistance is not likely to cause a loss of jobs within the U.S.?	No
(c) Will assistance be provided for an activity that contributes to the violation of internationally recognized workers rights, as defined in section 502(a)(4) of the Trade Act of 1974, of workers in the recipient country?	No
B. CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY	
1. **Agricultural Exports (Bumpers Amendment)** (FY 1991 Appropriations Act Sec. 521(b), as interpreted by conference report for original enactment): If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy,	N/A

-193.3

37. **Marine Insurance** (FY 1991 Appropriation Act Sec. 563): Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate?	Yes
38. **Exchange for Prohibited Act** (FY 1991 Appropriations Act Sec. 569): Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law?	No

30. **Motor Vehicles** (FAA Sec. 636(i)): Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained?	Yes
31. **Military Personnel** (FY 1991 Appropriations Act Sec. 503): Will assistance preclude use of financing to pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel?	Yes
32. **Payment of U.N. Assessments** (FY 1991 Appropriations Act Sec. 505): Will assistance preclude use of financing to pay U.N. assessments, arrearages or dues?	Yes
33. **Multilateral Organization Lending** (FY 1991 Appropriations Act Sec. 506): Will assistance preclude use of financing to carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)?	Yes
34. **Export of Nuclear Resources** (FY 1991 Appropriations Act. Sec. 510): Will assistance preclude use of financing to finance the export of nuclear equipment, fuel, or technology?	Yes
35. **Repression of Population** (FY 1991 Appropriations Act Sec. 511): Will assistance preclude use of financing for the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?	Yes
36. **Publicity or Propaganda** (FY 1991 Appropriations Act Sec. 516): Will assistance be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress?	No

25. **Communist Assistance** (FAA Sec. 620(h)): Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? **Yes**

26. **Narcotics**

a. **Cash reimbursements** (FAA Sec. 483): Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? **Yes**

b. **Assistance to narcotics traffickers** (FAA Sec. 487): Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance? **Yes**

27. **Expropriation and Land Reform** (FAA Sec. 620(g)): Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with and land reform program certified by the President? **Yes**

28. **Police and Prisons** (FAA Sec. 660): Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? **Yes**

29. **CIA Activities** (FAA Sec. 662): Will assistance preclude use of financing for CIA activities? **Yes**

subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

1. **Competitive Selection Procedures** (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? — Yes

23. **Construction** — N/A

a. **Capital project** (FAA Sec. 601(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used?

b. **(FAA Sec. 611(c)**: If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

c. **Large projects, Congressional approval** (FAA Sec. 620(k)): If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed $100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress?

24. **U.S. Audit Rights** (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? — N/A

g. **Technical assistance** (FAA Sec. 621(a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?	Yes
h. **U.S. air carriers** (International Air Transportation Fair Competitive Practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?	Yes
i. **Termination for convenience of U.S. Government** (FY 1991 Appropriations Act Sec. 504): If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States?	Yes
j. **Consulting services** (FY 1993 Appropriations Act Sec. 523): If assistance is for consulting services through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)?	N/A
k. **Metric conversion** (Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components,	Yes (to the extent possible)

c. **Marine insurance** (FAA Sec. 604(d)): If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S. will commodities be insured in the United States against marine risk with such a company?	N/A
d. **Non-U.S. agricultural procurement** (FAA Sec. 604(e)): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)	N/A
e. **Construction or engineering services** (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)	N/A
f. **Cargo preference shipping** (FAA Sec. 603)): Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates?	No

a. Will assistance be made available to any organization or program which, as determined by the President, supports or participates in the management of a program or coercive abortion or involuntary sterilization?	No
b. Will any funds be used to lobby for abortion?	No
20. **Cooperatives** (FAA Sec. 111): Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life?	No
21. **U.S.-Owned Foreign Currencies**	
a. **Use of currencies** (FAA Secs. 612(b), 636(h); FY 1991 Appropriations Act Secs. 507, 509): Describe steps taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services.	N/A
b. **Release of currencies** (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
22. **Procurement**	
a. **Small business** (FAA Sec. 602(a)): Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed?	Yes (to the extent possible)
b. **U.S. procurement** (FAA Sec. 604(a)): Will all procurement be from the U.S., the recipient country, or developing countries except as otherwise determined in accordance with criteria of this section?	Yes

16. **Metric System** (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to the United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?	Yes (to the extent possible)
17. **Women in Development** (FY 1991 Appropriations Act, Title III, under heading "Women in Development"): Will assistance be designed so that the percentage of women participants will be demonstrably increased?	Yes
18. **Regional and Multilateral Assistance** (FAA Sec. 209): Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs.	No
19. **Abortions** (FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 525):	

purses worn on the person), work gloves or leather wearing apparel?	
13. **Tropical Forests** (FY 1991 Appropriations Act Sec. 533(c)(3)): Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas?	No
14. **PVO Assistance**	
a. **Auditing and registration** (FY 1991 Appropriations Act Sec. 537): If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?	N/A
b. **Funding sources** (FY 1991 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"): If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?	N/A
15. **Project Agreement Documentation** (State Authorization Sec. 159 (as interpreted by conference report)): Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).	Confirmation will be cabled to AID/W within 60 days of signing the Grant Agreement, and copies of the Grant Agreement will be pouched to State L/T and AID/LEG.

202

(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?

(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?

12. **Trade Restrictions** N/A

a. **Surplus Commodities** (FY 1991 Appropriations Act Sec. 521(a)): 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?

b. **Textiles (Lautenberg Amendment)** (FY 1991 Appropriations Act Sec. 521(c)): Will the assistance (except for programs in Caribbean Basin Initiative Countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin

10. **U.S. Private Trade** (FAA Sec. 601(b)): Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).	See A.2
11. **Local Currencies**	
a. **Recipient Contributions** (FAA Secs. 612(b), 636(h)): Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.	Grantee will contribute local currency to the extent possible. No foreign currencies owned by U.S.
b. **U.S.-Owned Currency** (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
c. **Separate Account** (FY 1991 Appropriations Act Sec. 575). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:	N/A
(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?	

the assistance?

6. **Water Resources** (FAA Sec. 611(b); FY 1991 Appropriations Act Sec. 501): If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with principles, standards, and procedures established pursuant to the Water Resource Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)	N/A
7. **Cash Transfer and Sector Assistance** (FY 1991 Appropriations Act Sec. 575(b)): Will cash transfer or nonproject sector assistance be maintained in a separate account and not commingled with other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)?	N/A
8. **Capital Assistance** (FAA Sec. 611(e)): If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively?	N/A
9. **Multiple Country Objectives** (FAA Sec. 601(a)): Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.	See A.1

3. **Congressional Notification**

a. **General requirement** (FY 1991 Appropriations Act Secs. 523 and 591; FAA Sec. 634A): If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified (unless the notification requirement has been waived because of substantial risk to human health or welfare)? — Congress will be notified.

b. **Notice of new account obligation** (FY 1991 Appropriations Act Sec. 514): If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures? — N/A

c. **Cash transfers and nonproject sector assistance** (FY 1991 Appropriations Act Sec. 575(b)(3)): If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted? — N/A

4. **Engineering and Financial Plans** (FAA Sec. 611(a)): Prior to an obligation in excess of $500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance? — N/A

5. **Legislative Action** (FAA Sec. 611(a)(2)): If legislative action is required within recipient country with respect to an obligation in excess of $500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of — N/A

5C(2) - ASSISTANCE CHECKLIST

Listed below are statutory criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to receive assistance. This section is divided into three parts. **Part A** includes criteria applicable to both Development Assistance and Economic Support Fund resources. **Part B** includes criteria applicable only to Development Assistance resources. **Part C** includes criteria applicable only to Economic Support Funds.

CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE?

A. CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS

1. **Host Country Development Efforts** (FAA Sec. 601(a)): Information and conclusions on whether assistance 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.	Project will foster private health sector initiatives and competition, and improved efficiency in public health sector services.
2. **U.S. Private Trade and Investment** (FAA Sec. 601(b)): Information and conclusions on how assistance 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. private sector will provide technical assistance and U.S. manufactured commodities.

1. **Human Rights Violations** (FAA Sec. 116): Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy?

The Department of State has not so determined.

2. **Abortions** (FY 1993 Appropriations Act Sec. 534): Has the President certified that use of DA funds by this country would violate any of the prohibitions against use of funds to pay for the performance of abortions as a method of family planning, to motivate or coerce any person to practice abortions, to pay for the performance of involuntary sterilization as a method of family planning, to coerce or provide any financial incentive to any person to undergo sterilizations, to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

The President has not so certified.

C. COUNTRY ELIGIBILITY CRITERIA APPLICABLE ONLY TO ECONOMIC SUPPORT FUNDS ("ESF")

Human Rights Violations (FAA Sec. 502B): Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvement in its human rights record that furnishing such assistance is in the U.S. national interest?

It has not been so determined.

ability of a country to manufacture a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.)

15. **Algiers Meeting** (ISDCA of 1981, Sec. 720): Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and did it fail to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the "Taking into Consideration" memo.)

Taken into consideration by the Administrator.

16. **Military Coup** (FY 1993 Appropriations Act Sec. 513): Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been terminated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance?

The duly elected Head of Government has not been deposed.

17. **Refugee Cooperation** (FY 1993 Appropriations Act Sec. 538): Does the recipient country fully cooperate with the international refugee assistance organizations, the United States, and other governments in facilitating lasting solutions to refugee situations, including resettlement without respect to race, sex, religion, or national origin?

Yes.

18. **Exploitation of Children** (FAA Sec. 116(b)): Does the recipient government fail to take appropriate and adequate measures, within its means, to protect children from exploitation, abuse or forced conscription into military or paramilitary services?

No.

B. COUNTRY ELIGIBILITY CRITERIA APPLICABLE ONLY TO DEVELOPMENT ASSISTANCE ("DA")

- 209

12. **International Terrorism**

a. **Sanctuary and support** (FY 1993 Appropriations Act Sec. 554; FAA Sec. 620A): Has the country been determined by the President to: (a) grant sanctuary from prosecution to any individual or group which has committed an act of international terrorism, or (b) otherwise support international terrorism, unless the President has waived this restriction on grounds of national security or for humanitarian reasons?	The President has not so determined.
b. **Airport Security** (ISDCA of 1985 Sec. 552(b). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures?	The Secretary has not so determined.
13. **Discrimination** (FAA Sec. 666(b)): Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA?	The country does not so discriminate.
14. **Nuclear Technology** (FAA Secs. 669, 670): Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the	The country has not so delivered, received or transferred such material, equipment, technology or devises.

210

8. **Loan Default** (FAA Sec. 620(q); FY 1993 Appropriations Act Sec. 518 (Brooke Amendment)): (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1990 Appropriations Act appropriates funds?	(a) The government is not in such default (b) N/A
9. **Military Equipment** (FAA Sec. 620(s)): If contemplated assistance is development loan or to come from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? (Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)	Yes, taken into account by the Administrator.
10. **Diplomatic Relations with U.S.** (FAA Sec. 620(t)): Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?	No.
11. **U.N. Obligations** (FAA Sec. 620(u)): What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operational Year Budget? (Reference may be made to the "Taking into Consideration" memo.)	Yes, taken into account by the Administrator.

211

211

obligations toward such citizens or entities?	N/A
4. **Communist countries** (FAA Secs. 620(a), 620(f), 620D; FY 1993 Appropriations Act Secs. 512, 543): Is recipient country a Communist country? If so, has the President: (a) determined that assistance to the country is vital to the security of the United States, that the recipient country is not controlled by the international Communist conspiracy, and that such assistance will further promote the independence of the recipient country from international communism, or (b) removed a country from applicable restrictions on assistance to communist countries upon a determination and report to Congress that such action is important to the national interest of the United States? Will assistance be provided either directly or indirectly to Angola, Cambodia, Cuba, Iraq, Libya, Vietnam, Iran or Syria? Will assistance be provided to Afghanistan without a certification, or will assistance be provided inside Afghanistan through the Soviet-controlled government of Afghanistan?	The country is not communist.
5. **Mob Action** (FAA Sec. 620(j)): Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property?	The country has not so permitted.
6. **OPIC Investment Guaranty** (FAA Sec. 620(l)): Has the country failed to enter into an investment guaranty agreement with OPIC?	No.
7. **Seizure of U.S. Fishing Vessels** (FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5): (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made?	(a) No. (b) N/A

212

certification), that (a) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to satisfy the goals and objectives established by the U.N. Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, or that (b) the vital national interests of the United States require the provision of such assistance?

The President has so certified in the INCR.

(2) with regard to a major illicit drug producing or drug-transit country for which the President has <u>not</u> certified on April 1, has the President determined and certified to Congress on any other date (with enactment by Congress of a resolution approving such certification) that the vital national interests of the United States require the provision of assistance, and has also certified that (a) the country has undergone a fundamental change in government, or (b) there has been a fundamental change in the conditions that were the reason why the President had not made a "fully cooperating" certification.

N/A

2. **Indebtedness to U.S. citizens** (FAA Sec. 620(c): If assistance is to a government, is the government indebted to any U.S. citizen for goods or services furnished or ordered where: (a) such citizen has exhausted available legal remedies, (b) the debt is not denied or contested by such government, or (c) the indebtedness arises under an unconditional guaranty of payment given by such government or controlled entity?

The government is not so indebted.

3. **Seizure of U.S. Property** (FAA Sec. 620(e)(1)): If assistance is to a government, has it (including any government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its

5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to the eligibility of countries to receive the following categories of assistance: (A) both Development Assistance and Economic Support Funds; (B) Development Assistance funds only; or (C) Economic Support Funds only.

A. COUNTRY ELIGIBILITY CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUND ASSISTANCE

1. Narcotics Certification

(FAA Sec. 490): (This provision applies to assistance provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance relating to international narcotics control, disaster and refugee relief assistance, narcotics related assistance, or the provision of food (including the monetization of food) or medicine, and the provision of non-agricultural commodities under P.L. 480. This provision also does not apply to assistance for child survival and AIDS programs which can, under section 542 of the FY 1993 Appropriations Act, be made available notwithstanding any provision of law that restricts assistance to foreign countries.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government):

(1) has the President in the April 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without Congressional enactment, within 45 calendar days, of a resolution disapproving such a

Annex 11

Statutory Checklists

5 c(1): Country Checklist
5 c(2): Assistance Checklist

215
215

SEP 1 5 1993

AGENCY FOR INTERNATIONAL DEVELOPMENT

TECHNICAL NOTIFICATION

($ 000'S)

Project Title & Number	FY 93 CP & Prior Reference	Country/ Program	Appropriation Account	FY 1993 CP AMOUNT OR LATEST CN/TN AMOUNT	Amount Now Required	Amount of Increase	Reason for Change
Project 2000 527-0366	CN No. 537 Dated 08/04/93	Peru	POP	-0-	3,000	3,000	Increase In FY Funding

SEP 0 6 1993

AGENCY FOR INTERNATIONAL DEVELOPMENT

TECHNICAL NOTIFICATION

($ 000'S)

Project Title & Number	FY 93 CP & Prior Reference	Country/ Program	Appropriation Account	FY 1993 CP AMOUNT OR LATEST CN/TN AMOUNT	Amount Now Required	Amount of Increase	Reason for Change
Export, Trade and Development 527-0349	FY 93 CP, Statistical Annex page 552; CN No. 572 Dated 08/05/92	Peru	DAF	1,500	2,800	1,300	Increase In F Funding
Project 2000 527-0366	CN No. 537 Dated 08/04/93	Peru	DAF	6,100	8,200	2,100	Increase In I Funding

AGENCY FOR INTERNATIONAL DEVELOPMENT
ACTIVITY DATA SHEET

PROGRAM: PERU

CP 81-05 (4-85)

TITLE		FUNDING SOURCE	PROPOSED OBLIGATION (In thousands of dollars)		
Project 2000		POP, DAF	FY 93 6,100	LIFE OF PROJECT (Auth.) 30,000	
NUMBER 527-0366 GRANT ☒ LOAN ☐	NEW ☒ CONTINUING ☐	PRIOR REFERENCE None	INITIAL OBLIGATION FY 93	ESTIMATED FINAL OBLIGATION FY 99	ESTIMATED COMPLETION DATE OF PROJECT FY 2000

Purpose: The Project goal is to improve the health and nutrition status of young children and women of childbearing age. The purpose of the Project is to increase the use of child survival and maternal health interventions.

Project Description: In order to achieve its goal and purpose, the Project takes a three pronged approach of: 1) providing support directly to child survival and maternal health programs; 2) improving the efficiency of those programs through improved management; and 3) supporting the sustainability of those programs through improved health financing. The majority of project activities and funding support the first component, Strengthening Child and Maternal Health Services, which provides immediate support to priority health and nutrition programs and is expected to result in a visible reduction in infant and maternal deaths as well as improved nutritional status. The other two components are "enabling" components that contribute to the long-term viability of survival and maternal health efforts and help ensure the future of those services. Cost and demand studies will begin, as soon as the project agreement is signed, to initiate these latter two components.

Sustainability: Recurring costs of Project 2000 services will be addressed by the two "enabling" components of increased efficiency in management and improved health financing. Cost recovery is projected to double during the life of the project, more than covering the recurrent cost of the child survival and maternal health services.

Relationship of Project to A.I.D. Country Strategy: The Mission's Child Survival Strategy presents a plan for helping the country develop and sustain the institutional capacity in both the public and private sectors to reduce infant and child mortality and improve the quality of survivorship. Project 2000 is an integral part of this strategy.

Host Country and Other Donors: The Ministry of Health (MOH) was a direct participant in the project design and views the project as an integral part of it child survival and maternal health efforts. The MOH will also be receiving assistance from the IDB and the World Bank. A.I.D. is already coordinating efforts so that assistance to the sector will be synergistic and not duplicative.

Beneficiaries: The direct beneficiary population of this project are women of childbearing age, and children under age three.

Major Outputs	All Years
Health status of women and young children improved	X
Coverage and quality of child survival and maternal health services enhanced	X
Allocation of MOH resources improved	X

A.I.D.-Financed Inputs:	Life of Project ($000)
Development of Child Survival and Maternal Health Services	6,474
Clinical Training	5,022
Information, Education and Communication	3,319
Support System (MIS, Supervisory, Logistic)	1,656
Management Training and Development	3,880
Restructuring Financial and Cost Recovery Systems	1,085
Technical Assistance and Project Administration	11,164
TOTAL	30,000

U.S. FINANCING (In thousands of dollars)				PRINCIPAL CONTRACTORS OR AGENCIES
	Obligations	Expenditures	Unliquidated	Ministry of Health
Through September 30, 1991	0	0	0	
Estimated Fiscal Year 1992	0	0		
Estimated Through September 30, 1992	0	0	0	
		Future Year Obligations	Estimated Total Cost	
Proposed Fiscal Year 1993	6,100	23,900	30,000	

218

2/7

CN Project 2000

537

AGENCY FOR INTERNATIONAL DEVELOPMENT
ADVICE OF PROGRAM CHANGE

Date: AUG 0 4 1993

Country	:	Peru
Project Title	:	Project 2000
Project Number	:	527-0366
FY 1993 CP Reference	:	None
Appropriation Category	:	Development Assistance Fund (DAF)
Life-of-Project Funding	:	$25,500,000 (DAF) (Grant) $ 4,500,000 (POP) (Grant) $30,000,000
Intended FY 1993 Obligation	:	$ 6,100,000 (DAF)

This is to advise that A.I.D. intends to obligate $6,100,000 in DAF funds in FY 1993 for Project 2000, 527-0366. This is a new project which was not included in the FY 93 Congressional Presentation.

The purpose of the project is to increase the use of child survival and maternal health interventions.

These funds will be obligated under the authority contained in Section 542 of the FY 1993 Appropriations Act, if Peru remains under 620(q) sanction at that time.

Annex: Activity Data Sheet

219

Annex 10

Congressional and Technical Notifications

for Project 527-0366

220

UNCLASSIFIED STATE 23

ACTION: AID INFO: AMB DCM ECON

VZCZCPE0530
RR RUEHPE
DE RUEHC #9012 2180700
ZNR UUUUU ZZH
R 060700Z AUG 93
FM SECSTATE WASHDC
TO AMEMBASSY LIMA 3878
BT
UNCLAS STATE 239012

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USAID/LIMA

06-AUG-93 TOR: 12:51
CN: 65227
CHRG: AID
DIST: AID
ADD:

AIDAC LIMA FOR J.VERNOOY AND C.AYALA

DUE DATE: 8/16

ACTION COPY

E.O. 12356: N/A
TAGS:
SUBJECT: ENVIRONMENTAL THRESHOLD DECISION FOR CHILD SURVIVAL SUSTAINABILITY (PROJECT 2000) (527-0366)

1. LAC CHIEF ENVIRONMENTAL OFFICER, JAMES HESTER, HAS REVIEWED AND HEREBY APPROVES MISSION REQUEST FOR A CATEGORICAL EXCLUSION.

2. IEE NUMBER IS LAC-IEE-93-35. COPY OF THE ENVIRONMENTAL THRESHOLD DECISION IS BEING SENT TO MISSION FOR INCLUSION IN PROJECT FILES.

WHARTON
BT
#9012

NNNN

ACTION:HN(FILES)
INFO:HPN
PENR
DD

UNCLASSIFIED STATE 239012

Annex 9

Cable Approving a Categorical Exclusion from an Initial Environmental Evaluation for Project 527-0366

222

HN

AGENCY FOR INTERNATIONAL DEVELOPMENT
USAID / ECUADOR

U.S. ADDRESS: AMEMBASSY, Quito (USAID) UNIT 5330, APO AA 34039-3420
FAX NUMBER: 593-2-500-502 PHONE NUMBER: 593-2-521-100

TELEFAX CONTROL No.

TO: Heather Goldman
USAID/Lima

FAX No.: 5114-337034
DATE: April 23, 1993
No. of PAGES: 1 (include cover sheet)

FROM: for Jeff Borns

OFFICE: RLA

SUBJECT: Action Memorandum on Child Survival PID

By this fax, RLA provides clearance of subject Action Memorandum.

223

HPN

AGENCY FOR INTERNATIONAL DEVELOPMENT
USAID / ECUADOR

U.S. ADDRESS: AMEMBASSY, Quito (USAID) UNIT 5330, APO AA 34039-3420
FAX NUMBER: 593-2-500-502 PHONE NUMBER: 593-2-321-160

TELEFAX CONTROL No.

TO: USAID/Lima
Heather Goldman, HPN

FAX No.: 511-4-337034
DATE: April 29, 1993
No. of PAGES: 1 (include cover sheet)

FROM: Marcus L. Stevenson

OFFICE: RCO/Quito

SUBJECT: Action Memorandum on Child Survival PID

This constitutes my clearance of the subject Action Memorandum.

Sorry for the delay, however, I located my documentation immediately after our conversation yesterday. Please send me another copy of the fully executed PID.

Regards.

224

Clearances:

PDP:EKerst EMcEw

CONT:JMartin

RLA:JBorns per attached fax 4/23

RCO:MStevenson per attached fax 4/29

DD:DBoyd

Issues: The issues raised in the Mission reviews closely paralleled those raised in the AID/W review of the New Project Description as reported in STATE 58479. First was the need for the Mission to take optimum advantage of policy dialogue and conditionality opportunities. As mentioned in the PID, with the up-coming Interamerican Development Bank (IDB) and World Bank projects, the Mission will use the already established donor coordination meetings and the proposed project to bring about policy change, especially in the health financing and decentralization areas. Whether to include specific conditionality to release of funding has to be carefully evaluated at the PP stage. The MOH does not control its budget independent of the MEF. Use of conditionality carries the risk that failure of MEF, e.g., to meet CPs on budget allocations for the MOH could endanger funding availability for important MOH child survival services.

In addition, there was concern whether the new project could achieve institutionalization of selected child survival services in the face of entrenched public sector personnel and budget constraints. The PID component has been revised to stress strengthening of child survival services, since it is difficult to influence personnel policy in the GOP. However, the MOH is making important and positive changes in their personnel system. Also, one of the main components of the project is to improve MOH resource allocations which will result in better institutionalized services.

A further point of clarification was the weight given to family planning in the proposed project. LAC/DR/HPN's understanding is correct that family planning is included as a key element of our assistance to the MOH maternal Health program and that approximately 15 percent of project obligations are planned for the population earmark.

In addition, there are several outstanding issues that will need to be addressed during the design of the PP: the geographic and target group focus of the project (the highest mortality rates are found in the rural sierra and selva which are the most difficult areas to reach); strategies to restructure health budgets early in the project (including local retention of user fees); definition of AID's interventions to promote decentralization (while avoiding the political problems associated with the on-going regionalization process); and USAID staffing levels and approval for U.S. technical advisors. The PP team will work closely with authorities in the Ministry of Health (MOH) and the Ministry of Economy and Finance (MEF) to design realistic interventions and policy studies which address these issues.

Recommendation: In accordance with the authority given in the attached cable STATE 58479 (Attachment 2) to the USAID/Peru Mission Director to approve project design documents at post, it is requested that you approve the SCSP PID by signing the PID facesheet and that you concur in the recommended Environmental Threshold Decision by signing the IEE (Annex II to the PID).

224

ACTION MEMORANDUM FOR THE DIRECTOR

FROM: Heather W. Goldman
Chief, HPN

SUBJECT: Project Identification Document for Sustaining Child Survival Programs Project (527-0366)

DATE: April 15, 1993

Action Requested: Your approval is requested for the attached Project Identification Document (PID) for the proposed Sustaining Child Survival Programs Project (527-0366).

Background: Peru is a Child Survival Emphasis country for the Agency. Five years ago, Peru's infant mortality rate was the third highest in the Latin American and Caribbean (LAC) region. Today, according to the recent national Demographic Health Survey, the rate has improved significantly from approximately 88 deaths per 1000 livebirths to approximately 55 per 1000 livebirths. Much of this impressive decline can probably be attributed to the immunization program which received more than 6 million dollars in assistance through the AID-financed Child Survival Action Project. The major killers of children are now malnutrition and/or mismanaged pneumonias and diarrheal diseases or perinatal complications which are related to poor maternal health. The Sustaining Child Survival Programs Project (SCSP) will continue our successful assistance, improving the quality and efficiency of services to tackle these killers so that Peru can further reduce infant deaths to around 35/1000 livebirths by the year 2000.

Discussion: This seven-year Child Survival Project provides 30 million dollars in grant funds to the Government of Peru to improve the health status of young children and women. This goal is completely consistent with the Mission's strategic objective to improve health status through increasing access to quality primary health care. Since improved health care is one of the cornerstones upon which the future productivity and social welfare of a nation depend, the proposed project supports the Agency and LAC Bureau objectives to accelerate economic growth and promote democracy.

The project purpose is to improve and sustain child survival programs in Peru through reallocation of Ministry of Health resources and improved efficiency in child survival services. Thus, the project will have three components:

i) strengthening child survival services;
ii) health financing, particularly cost-recovery; and
iii) decentralization of health administration.

Reviews: The Deputy Director chaired two reviews of the PID which were attended by Office Chiefs or their representatives. These reviews were held on 11 March and 2 April. Since the PID recommends a significant participant training component, the Mission's Training Officer attended both meetings.

237

USAID

MEMORANDUM

DATE : May 4, 1993

TO : HPN, Heather Goldman

SUBJECT : Sustained Child Survival Programs Project

FROM : George A. Wachtenheim, Director

I have approved the Child Survival PID. The Action Memorandum was very well done, as was the PID. One suggestion, however, is to make sure that the project paper contains a much more detailed description of the project activities. In fact, if possible, I would like to see the PID contain a few more specifics of exactly what the project funding would be used to finance. To the extent possible, if we could add a bit more description to the project component section of the PID I would be more comfortable.

Thanks.

cc: DD, DBoyd

228

Annex 8

Memo Approving Project 527-0366

Project Implementation Document (PID)

229
224

FOR SUCCESS OF THE PROJECT, CONCERNED WHETHER THE NEW PROJECT COULD ACHIEVE INSTITUTIONALIZATION OF SELECTED CHILD SURVIVAL SERVICES (E.G., ARI AND MATERNAL HEALTH SERVICES) IN THE MOH IN THE FACE OF THE ENTRENCHED DIFFICULTIES FACING PUBLIC SECTOR AGENCIES IN PERU -- E.G., EXTREMELY LOW SALARIES, CONSTANT STRIKES, STAFF TURNOVER AND INADEQUATE BUDGETARY RESOURCES. IT WAS NOTED THAT THESE CONDITIONS HAVE AFFECTED THE ABILITY OF THE CURRENT CHILD SURVIVAL ACTION PROJECT TO ACHIEVE INSTITUTIONALIZATION OF SELECTED CHILD SURVIVAL SERVICES AND, ABSENT A CHANGE IN THESE CONDITIONS, PROVIDING RESOURCES AND COMMODITIES OVER THE SHORT TERM WILL NOT LEAD TO SUSTAINABILITY, NOR WILL TRAINING STAFF THAT TURNS OVER FREQUENTLY. THE MISSION IS ASKED TO BE MORE EXPLICIT ABOUT WHAT IT MEANS BY QUOTE INSTITUTIONALIZATION UNQUOTE, AND TO EXPLAIN HOW IT THINKS THE PROJECT CAN ACHIEVE INSTITUTIONALIZATION IN THE FACE OF THE ABOVE-MENTIONED CONDITIONS. THE NPD DOES NOT DISCUSS WHETHER THE PROJECT WILL DO ANYTHING TO DIRECTLY ADDRESS THESE CONSTRAINTS.

3. THE FOLLOWING CLARIFICATION WAS RAISED: SINCE APPROXIMATELY 15-20 PERCENT OF PROJECT OBLIGATIONS ARE PLANNED FROM THE POPULATION EARMARK, THE PID MUST MENTION THAT FAMILY PLANNING SERVICES ARE AMONG THOSE ACTIVITIES WHICH WILL BE SUPPORTED BY THE PROJECT. THE NPD DOES NOT DO SO, BUT LAC/DR/HPN'S UNDERSTANDING FROM DISCUSSIONS WITH MISSION HEALTH STAFF IS THAT FAMILY PLANNING WILL BE A KEY ELEMENT OF THE MATERNAL HEALTH PROGRAMS TO BE SUPPORTED UNDER COMPONENT THREE, AND THE MANAGEMENT AND FINANCING ELEMENTS OF THE PROJECT WILL RELATE TO FAMILY PLANNING AS AN ESSENTIAL CHILD SURVIVAL SERVICE.

4. THE BUREAU REQUESTS THAT THE MISSION PROVIDE FEEDBACK ON HOW THESE ISSUES ARE RESOLVED ONCE THE PID REVIEW IS CONCLUDED.
WHARTON
BT
#8479

NNNN

230

ACTION: AID INFO: AMB DCM ECON

HPN

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P FUFHPE
DE RUEHC #8479 0570330
ZNR UUUUU ZZH
P 262326Z FEB 93
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TO AMEMBASSY LIMA PRIORITY 1600
LI
UNCLAS STATE 058479

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MAIL ROOM
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USAID/LIMA

26-FEB-93 TOR: 11:39
CN: 29666
CHRG: AIL
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ADD:

AIDAC

E.O. 12356: N/A
TAGS:
SUBJECT: SUSTAINING CHILD SURVIVAL PROGRAMS (527-0366)

REF: LIMA 00933

1. A REVIEW OF THE SUBJECT NEW PROJECT DESCRIPTION (NPD) WAS HELD ON FEBRUARY 17, 1993. DEPUTY DIRECTOR, LAC/DR, KEN ELLIS CHAIRED THE REVIEW AND REPRESENTATIVES FROM LAC/DR/SA, LAC/DR/HPN AND LAC/DPP ATTENDED. THIS NPD REPLACED THE EARLIER NPD, NON-PROJECT ASSISTANCE IN HEALTH POLICY REFORM, PRESENTED IN THE FY 93-94 ACTION PLAN. THE SUBJECT NPD WAS APPROVED AND AUTHORITY IS HEREBY DELEGATED TO THE USAID/PERU MISSION DIRECTOR TO APPROVE SUBSEQUENT PROJECT DESIGN DOCUMENTS AT POST. THE FOLLOWING ISSUES AND CLARIFICATIONS WERE RAISED AT THE REVIEW AND THE MISSION IS ASKED TO DISCUSS THEM IN THE UPCOMING PID REVIEW AND REPORT BACK TO AID/W ON THEIR RESOLUTION.

ACTION:POP(FILES)
INFO:HPN
PDP
CONT
D
DD

2. THE FIRST ISSUE CONCERNED WHETHER USAID/PERU WAS TAKING OPTIMUM ADVANTAGE OF POLICY DIALOGUE/CONDITIONALITY OPPORTUNITIES IN LIGHT OF THE SUBSTANTIAL AMOUNT OF OTHER DONOR FUNDS BEING COMMITTED TO THE HEALTH SECTOR IN PERU AND THE DEPENDENCE OF THIS PROJECT ON PARTICULAR POLICY CHANGES. THE CHAIR NOTED THAT THE PROJECT'S SUCCESS

DEPENDS ON A SERIES OF POLICY CHANGES TAKING PLACE (E.G., RESCINDING OF ARTICLE 19, INCREASING THE PERCENTAGE OF MINISTRY OF HEALTH (MOH) BUDGET ALLOCATED TO CHILD SURVIVAL AND FAMILY PLANNING, IMPROVING MOH COMMITMENT TO INSTITUTING EFFECTIVE COST-RECOVERY SCHEMES, AND STRENGTHENING OVERALL GOP COMMITMENT TO DECENTRALIZATION) AND SUGGESTED THAT THE MISSION SEEK TO COORDINATE WITH OTHER DONORS (IDB, WORLD BANK, UN) TO DETERMINE WHETHER THEY COULD AGREE TO A UNIFIED SERIES OF POLICY CONDITIONALITIES TO THEIR COMBINED ASSISTANCE. IN THIS WAY, THE MISSION COULD SUBSTANTIALLY INCREASE ITS ABILITY TO LEVERAGE THE KIND OF POLICY CHANGE THAT IS CRITICAL TO THE SUCCESS OF THIS PROJECT.

2. THE SECOND ISSUE, ALSO RELATED TO CONDITIONS REQUIRED

231

Annex 7

Cable Approving Project 527-0366

New Project Description (NPD)

232

11. A statement of the actions, if any, the agency may take to remove or overcome any barriers to competition before any subsequent acquisition for the supplies or services required:

The UNICEF system provides USAIDs worldwide with the most practical, useful and reliable system currently available to procure suitable, tested cold chain equipment, accessories and spare parts. **Any procurement through UNICEF will follow guidelines set up in Handbook 15, Chapter 6.**

12. Contracting Officer certification that the certification is accurate and complete to the best of the contracting officer's knowledge and belief:

The contracting office so certifies through the act of clearing this memorandum.

Recommendation:

That in accordance with the authorities cited herein, you approve a waiver of full and open competition to enable USAID/Peru and AID/W to make use of UNICEF/New York for the procurement of A.I.D.-financed cold chain commodities up to a value of $500,000, including ocean transportation costs, in support of the MoH national vaccination program under the auspices of Project 2000.

Approved:_____
George Wachtenheim, Mission Director

Disapproved:_____
George Wachtenheim, Mission Director
Date:_____

Clearances:
PDP:JBoyer Date 9/10/93
EXO:LFoley Date 9/10/93
CONT:JSanford Date 9/10/93
RLA:JBorns Date 9/14/93
RCO:MStevenson Date 9-10-93
A/DD:JBoyer Date 9/10/93

11. A statement of the actions, if any, the agency may take to remove or overcome any barriers to competition before any subsequent acquisition for the supplies or services required:

The UNICEF system provides USAIDs worldwide with the most practical, useful and reliable system currently available to procure suitable, tested cold chain equipment, accessories and spare parts. **Any procurement through UNICEF will follow guidelines set up in Handbook 15, Chapter 6.**

12. Contracting Officer certification that the certification is accurate and complete to the best of the contracting officer's knowledge and belief:

The contracting office so certifies through the act of clearing this memorandum.

Recommendation:

That in accordance with the authorities cited herein, you approve a waiver of full and open competition to enable USAID/Peru and AID/W to make use of UNICEF/New York for the procurement of A.I.D.-financed cold chain commodities up to a value of $500,000, including ocean transportation costs, in support of the MoH national vaccination program under the auspices of Project 2000.

Approved: _____
George Wachtenheim, Mission Director

Disapproved: _____
George Wachtenheim, Mission Director

Date: 9/16/93

Clearances:
PDP:JBoyer _____ Date 9/10/93
EXO:LFoley _____ Date 9/10/93
CONT:JSanford _____ Date 9/10/93
RLA:JBorns fax Date 9/14/93
RCO:MStevenson _____ Date 9-10-93
A/DD:JBoyer _____ Date 9/10/93

234

Western European sources.

As WHO/UNICEF have incorporated into their catalogue all known, suitable and tested cold chain items available worldwide, and as the competent PAHO technician has recommended particular items from that catalogue as being especially appropriate for the Peruvian program, the appropriate Mission technical office has concluded that procedures of less than full and open competition are justified to carry out these procurements.

6. Description of efforts made to ensure that offers are solicited from as many potential sources as possible:

For determination of suitable, tested equipment, accessories and spare parts that meet required specifications, USAID is dependent on the WHO/UNICEF catalogue. There is an established history, reported by FA/OP/COMS, of worldwide use by USAIDs of the UNICEF channel for procurement of cold chain equipment.

7. A determination by the Contracting Officer that the anticipated cost to the Government will be fair and reasonable:

The contracting officer so determines by clearing this memo.

8. A description of the market survey conducted:

See item 5 above

9. Any other facts supporting the use of other than full and open competition:

The Child Survival Action Project (1987-1994) procured over one million dollars worth of cold chain equipment through the same source. A similar waiver was approved in December of 1988. The equipment procured for Project 2000 should be compatible with equipment previously purchased. To standardize and simplify Peru's vaccination distribution system, cold chain equipment should originate from the same manufacturer.

10. A listing of the sources, if any, that expressed, in writing an interest in the acquisition:

N/A

1. Identification of the agency and contracting activity:

USAID/Peru.

2. Nature/description of action being approved:

Procurement through other than full and open competition.

3. Description of commodities required:

Specialized cold chain refrigeration equipment, accessories and spare parts are required for the strengthening of vaccination programs in Peru; their value, including the cost of ocean transportation, should not exceed $500,000.

4. Identification of statutory authority permitting other than full and open competition:

10 U.S.C. 2304(C)(1) or 41 USC 253(C)(1) FAR 6.302.1 Only are responsible source and no other type of supplies or services will satisfy Agency requirements.

5. Demonstration that the nature of the acquisition requires use of the authority:

This waiver request is based on FAR Part 6.302-1 which states, "Only one responsible source and no other supplies or services will satisfy agency requirements." The proposed responsible source for these procurements will be UNICEF/NY, with its commodity stock in Copenhagen and procurement resources as described in the WHO/UNICEF cold chain catalogue.

Cold chain equipment differs significantly from refrigeration equipment designed for home or commercial use, as well as from the cold boxes and vacuum bottles used for picnics and lunches. It must be rugged, have extra thickness for insulation, function on alternative sources of energy (electricity, LP gas, kerosene, batteries), make large quantities of ice, and have a substantial "holdover time of coldness", especially in those situations where the availability of power is limited and/or erratic.

The market for cold chain equipment is relatively small, with producers limited in number and mostly found in Western Europe. The World Health Organization (WHO) and UNICEF have collaborated in developing a catalogue that includes all of the dependable, tested models of cold chain equipment and accessories. UNICEF also stockpiles models of cold chain items in Copenhagen, most of these coming from

U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

Annex 6

Waiver FY 93-008-527-0366

ACTION MEMORANDUM FOR THE MISSION DIRECTOR

September 13, 1993

FROM: Susan Brems, Acting Chief, Office of Health, Population and Nutrition

SUBJECT: Request for Waiver of Full and Open Competition of Cold Chain Equipment for Project 2000.

Action:

The Mission Director is requested to waive full and open competition to enable USAID/Peru to purchase refrigeration equipment, accessories and spare parts ("cold chain" items) not to exceed a total value of $500,000, under Project 2000 in support of Peru's national immunization program.

Equipment to be procured by A.I.D. during the life of the project includes 1.7-liter vaccine carriers, ice packs, compressors, relays, and 20 liter vaccine storage chests for transporting vaccines and thermostats. These items are available from U.S. suppliers and thus no waiver is necessary to procure them. The remaining items, which are the subject of this waiver request, are not available from U.S. suppliers but are available from Geographic Code 899 countries. They include the following: 1) large vertical icepack freezers, powered by 220 volt electricity; 2) large freezer chests for vaccines, also 220 volt; 3) combination refrigerator/freezers that function on either kerosene or electricity, for storing vaccines, freezing icepacks and making ice; 4) similar refrigerators/freezers that use either liquid propane gas or electricity; 5) refrigerators with ice lining, electrically powered, for storing vaccines; and 6) accessories and spare parts for the above listed items.

Additional background information can be found in the accompanying source/origin and transportation waiver request.

Justification:

In accordance with Part 6.3 of the Federal Acquisition Regulations (FAR) and Part 706.302 of the AIDAR, the following justification is submitted for your review and approval:

Annex 6

Waiver of Full and Open Competition for Procurement of Cold Chain Equipment

Approved: George Wachtenheim, Mission Director

Disapproved: George Wachtenheim, Mission Director

Date: _____

Clearances:

PDP:JBoyer _____ Date 9/10/93

EXO:LFoley _____ Date 9/10/93

CONT:JSanford _____ Date 9/10/93

RLA:JBorns _____ Date 9/14/93

RCO:MStevenson _____ Date 9-10-93

A/DD:JBoyer _____ Date 9/10/93

HPN:JVERNOOY:MVin:08/17/93

Approved: George Wachtenheim, Mission Director

Disapproved: George Wachtenheim, Mission Director

Date: 9/16/93

Clearances:
PDP:JBoyer Date 9/10/93
EXO:LFoley Date 9/10/93
CONT:JSanford Date 9/10/93
RLA:JBorns fax Date 9/14/93
RCO:MStevenson Date 9-10-93
A/DD:JBoyer Date 9/10/93

HPN:JVERNOOY:MVia:08/17/93

240
241

Among other activities, the nationwide vaccination program, which has already made tremendous strides in recent years, will be further strengthened, with a view toward completing institutionalization of capabilities in that area. A major part of this strengthening will be to ensure that the distribution system of vaccines is efficient and reliable. Project 2000 has budgeted $500,000 dollars to purchase cold chain equipment for this purpose, following up on equipment purchases made under the Child Survival Action Project, (CSAP 527-0285, 1987-1994). Under CSAP a waiver was obtained for the procurement of over one million dollars of cold chain equipment from other than Code 000 sources. It is essential to the efficiency and standardization of the national vaccination distribution system that compatible cold chain equipment be procured under Project 2000.

Discussion:

Equipment to be procured by A.I.D. during the life of the project includes: 1.7 liter vaccine carriers, ice packs, compressors, relays, and 20 liter vaccine storage chests for transporting vaccines and thermostats. These items are available from U.S. suppliers and thus no waiver is necessary to procure them. The remaining items, which are the subject of this waiver request, are not available from U.S. suppliers but are available from Geographic Code 899 countries. They include the following: 1) large vertical icepack freezers, powered by 220 volt electricity; 2) large freezer chests for vaccines, also 220 volt; 3) combination refrigerator/freezers that function on either kerosene or electricity, for storing vaccines, freezing icepacks and making ice; 4) similar refrigerators/freezers that use either liquid propane gas or electricity; 5) refrigerators with ice lining, electrically powered, for storing vaccines; and 6) accessories and spare parts for the above listed items.

Information concerning cold chain equipment was requested from AID/W, which consulted with PAHO's expert on cold chain equipment, Peter Carrasco. Mr. Carrasco confirmed that equipment with the specifications needed for Project 2000 is not available in the United States.

For items such as freezers and large cold boxes, U.S.-made items are designed as consumer items for home and camping use and are not sufficiently rugged, nor insulated, for cold chain use in tropical countries. For example, PAHO recommends equipment 10 cm of insulation for large vaccine chests, whereas the maximum provided in U.S. models is 4 cm. A 10 cm insulation is absolutely necessary for the time periods of transit and storage normally associated with the realities of tropical developing countries, as is the case

in regions of Peru where the equipment will be used.

In the case of the icepack freezer, cold chain models from Code 899 countries have interior dimensions designed for maximizing space for the ice packs used in the larger vaccines storage chests. Since U.S. models are designed for American kitchens, interior dimensions consequently do not maximize such space, nor do they have the heavy insulation usually built into cold chain equipment. Additionally, the U.S. models are normally 110V instead of 220V.

Further, U.S. manufacturers do not make refrigerators or combination refrigerators/freezers that can be operated on either kerosene and electricity or liquid propane gas and electricity. There is also nothing made in the U.S. that even approximates the ice-lined refrigerator. The latter will be especially useful in many rural areas of Peru where the electrical power source functions erratically. Such refrigerators can maintain the vaccines at a specific temperature ("cold life") for at least 16 hours without power. The PAHO-recommended product is designed to do so for up to 78 hours at 32°C and up to 62 hours when the outside temperature is 43°C. The European models of vaccine storage chests, some with 26 liter capacity, have insulation capability providing a cold life of up to 198 hours. In contrast, models on the U.S. market, designed for picnics, have a cold life of only 20 hours.

Ice-making capacity is of great importance in cold chain operations. The Italian ice pack freezer model, tested by PAHO and requested by the MoH and IPSS, makes 32 kilos of ice, while the U.S.-made Frigidaire makes only 9.09 kilos, is 110V (requiring a transformer) and costs over twice as much (about $1000, compared with $500). Ice packs are procured with refrigeration equipment, as they are designed to fit in, and to fill up, the particular equipment ordered. Thus, the source/origin of ice packs must follow the source/origin of the refrigeration equipment being ordered.

All of the Geographic Code 899 source/origin equipment discussed herein is available in the UNICEF/WHO catalogues. If the waiver is approved, equipment will be obtained through UNICEF, so that new equipment will be compatible with cold chain equipment purchased by CSAP. **Any procurement through UNICEF will follow guidelines set up in Handbook 15, Chapter 6.**

Since a separate justification for less than full and open competition must be prepared, that request for a waiver accompanies this document.

With respect to ocean transportation from the European ports from which the Code 899 country items will be shipped, 86 STATE 105127, paragraph F, cites Delegation of Authority (DOA) 40.13 (now replaced by DOA 454), which gives the Mission Director the authority to approve ocean transportation waivers with values of up to 25 percent of the commodity cost being waived. The cable states that A.I.D. experience demonstrates that ocean transportation costs range between 15-20 percent of the value of commodities. From research that was done for CSAP, it is known that there is no U.S. flag carrier providing services between European ports and Peru. Therefore, approval of a transportation waiver is warranted, in keeping with waiver criteria set forth in A.I.D. Handbook No. 1, Supp. B, Chapter 7B4a, Criteria 2 and 5.

During the life of Project 2000, there will be many shipments required from various European ports to carry out incremental procurements of cold chain commodities. 941 country vessels (dependant countries other than the cooperating country) would be the next option after U.S. vessels to transport goods. We are requesting that this requirement be waived because the Mission does not now know which ports will be used and cannot state with certainty that a vessel of Code 941 registry will always be available. However, the Mission does know that in many or undoubtedly most cases, such vessels will not be available to meet required delivery schedules. The U.S. currently has no vessels operating on the Europe-Peru route; the same is true of most developing countries other than Peru. In authorizing a transportation waiver to Code 935, the Mission Director must certify that it is in the "best interest" of the U.S. Government to expand the Code beyond Code 941 countries. It is not in the best interest of the U.S. Government to issue a waiver covering only Code 941 countries when, in most cases, vessels of such registry would not be available. Allowing only Code 941 vessels to transport cold chain equipment would mean that each time a vessel of Code 941 registry were not available, the Mission would have to prepare yet another waiver, which is inefficient and an unnecessary additional burden on Mission staff. However, in implementing these procurements, the Mission will ensure that A.I.D. policy of giving preference to Code 941 registry over Code 935 registry will be followed in those instances where vessels of Code 941 registry are available.

<u>Authority</u>:

Under Delegation of Authority 752, the USAID/Peru Mission Director has been redelegated authority to waive source/origin requirements. Under A.I.D. Handbook 5, one of the seven applicable criteria for waiving source/origin requirements is that the particular

commodities, as specified, are "not available from countries or areas included in the authorized geographic code." As indicated above, the types of "cold chain" equipment of the proper specifications needed for this project are neither manufactured nor sold in the U.S. nor in Code 941 countries. For ocean transportation, Delegation of Authority 454 permits the USAID/Peru Mission Director to waive ocean transportation when the cost does not exceed 25 percent of his authority to waive commodity requirements, which is the case in this instance. Also, there is no U.S. flag carrier operating between the European ports to be used for this procurement and Peru.

Certification:

In approving the commodity waiver, the Mission Director must certify that "exclusion of procurement from Free World countries, other than the Cooperating Country and countries included in Code 941, would seriously impede attainment of U.S. foreign policy objectives and objectives of the foreign assistance program."

In approving the transportation waiver to Code 935, which would include Peruvian vessels, the Mission Director must certify that "the interests of the United States are best served by permitting financing of transportation services on ocean vessels under the flag registry of Free World countries other than the Cooperating Country and countries included in Code 941."

Recommendation:

That you approve this request for: (1) a source/origin waiver from Code 000 to Code 899 to permit the procurement of the indicated cold chain equipment, with related supplies and spare parts; (2) a transportation services waiver from Code 000 to Code 935 to permit the use of ocean vessels under flag registry of Free World countries, including Peru; (3) certifying that "exclusion of procurement from Free World countries, other than the Cooperating Country and countries included in Code 941, would seriously impede attainment of the United States foreign policy objectives and objectives of the foreign assistance program;" and (4) certifying that "the interests of the United States are best served by permitting financing of transportation services on ocean vessels under flag registry of Free World countries other than the Cooperating Country and countries included in Code 941."

Annex 5

Waiver FY 93-009-527-0366

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

ACTION MEMORANDUM FOR THE MISSION DIRECTOR

September 13, 1993

FROM: Susan Brems, Acting Chief, Office of Health, Population and Nutrition

SUBJECT: Waiver for Cold Chain Commodity Source/Origin and Nationality of Ocean Transportation Services

Action:

The Mission Director's approval is requested for: 1) a procurement source/origin waiver from Geographic Code 000 (U.S. only) to Geographic Code 899 (Free World) for cold chain equipment for Project 2000; and 2) a transportation services waiver from Code 000 to Code 935 (Special Free World) for ocean shipment of these commodities.

General Project Overview:

Project 2000 is designed to support the MoH in efforts to improve the quality and efficiency of its primary health care services, particularly those that target the most vulnerable populations -- women and young children. The goal of the Project is to improve the health and nutrition status of young children and women of childbearing age. The purpose of the Project is to increase the use of child survival and maternal health interventions.

To achieve its goal and purpose, the Project takes a three pronged approach by: (1) providing support directly to child survival and maternal health programs; (2) enhancing the efficiency of those programs through improved management; and (3) supporting the sustainability of those programs through reformed health financing. The majority of Project activities and funding focus on the first component, which provides immediate support to priority health and nutrition programs and is expected to result in a visible reduction in infant and maternal deaths, as well as improvements in the quality of survivorship. The other two components are enabling ones that contribute to the long-term viability of child and maternal health efforts and help ensure the future of those services.

Annex 5

Waiver of Requirements Regarding Cold Chain Commodity Source/Origin and Nationality of Ocean Transportation Services

Recommendation:

Under these circumstances, it is recommended that the Mission Director authorize a full waiver of the host government responsibility for the procurement of international and U.S. domestic travel costs related to participant training under Project 2000. Handbook 10, Section 16C, provides the authority for this action. (Pursuant to that Section, the Regional Assistant Administrator for LAC and OIT will be notified if this Waiver is approved by you.)

Approved: _____
George A. Wachtenheim, Mission Director

Disapproved: _____
George A. Wachtenheim, Mission Director

Date: _____

Clearances:

EXO:LFoley _____ Date _____

CONT:JSanford _____ Date _____

TSD:VFerrero VF Date 9/14/93

PDP:JBoyer JB Date 9/14/93

RLA:JBorns fax Date 9/14/93

RCO:MStevenson M Date 9-15-93

DD:DBoyd _____ Date _____

HP:NIJVHRNOOY:MV(a:07/20/93

247

Recommendation:

Under these circumstances, it is recommended that the Mission Director authorize a full waiver of the host government responsibility for the procurement of international and U.S. domestic travel costs related to participant training under Project 2000. Handbook 10, Section 16C, provides the authority for this action. (Pursuant to that Section, the Regional Assistant Administrator for LAC and OIT will be notified if this Waiver is approved by you.)

Approved: _____
George A. Wachtenheim, Mission Director

Disapproved: _____
George A. Wachtenheim, Mission Director

Date: 9/16/93

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EXO:LFoley _____ Date 9/14/93
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DD:DBoyd _____ Date 9/15/93

HPN:JVERNOOY:MVia:07/20/93

248
244